

General Liability Insurance Companies Make Major Changes In Veterinarian's Insurance

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Major changes have occurred in the comprehensive general liability (CGL) insurance policy that many companies now provide for insuring veterinarians. CGL insurance provides coverage for premises (buildings) and operations, products and completed operations and liability situations not covered under professional liability insurance. The sale of drugs and health products for use by your customers is an example of what would be covered under the CGL policy.

An important concern for insurance companies is the determination of which insurance policy will be responsible for the payment of any claim that is filed. This is important, not only when there is a change from one company to another, but also when there has been a change of coverage from one policy period to another, even though the company remains the same. In the past, all CGL policies provided that a claim would be paid on an "occurrence" basis—that is, the policy in effect *at the time of the occurrence* will pay the loss. Many companies are now changing to policies that provide that the policy in effect *at the time the claim is made* will be responsible for payment. This is referred to as a "claims-made" policy.

This dramatic change by some companies in the method of determining the responsibility for losses has created a number of changes which will affect your coverage and which are of special importance and concern to you if your policy is now in the "claims made" form. These include:

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- a. Coverage trigger
- b. Retro date
- c. Extended reporting period
- d. Aggregate limits

Let's take a look at each of these in greater detail.

Coverage Trigger

This provision relates to the notification event which will trigger the coverage. In an occurrence-type policy, notification to the company of a claim was not of concern, since the policy in effect at the time the loss occurred was the policy responsible for payment. However, in a "claims-made" policy, the notification of a claim is the determining factor in deciding which policy is responsible for payment. Therefore, determining *when* the claim has been made (and when coverage has been triggered) is of prime concern. It is important, not only in situations where there has been a change of companies, but also where there is a concern as to which policy year the claim is relevant. As we will see, the triggering of coverage can affect the aggregate limits and which policy limits apply.

Originally, companies had anticipated that any notification of a potential loss, either to the company *or* to your agent would "trigger" the coverage—that is, would be sufficient notice to determine the applicable policy. However, the companies soon realized that this would mean more claims to be paid in the earlier years of the policy. This would require higher initial premiums. It has been the hope of the companies adopting the "claims-made" form that they could provide a substantial discount for the first few years of the "claims-made" policy.

These companies then proposed that the coverage would "trigger" only upon the actual filing of a claim by an injured party. No longer would it be an acceptable notice of a claim for Doc to tell his agent that, "Farmer Jones may file a claim

against me because some serum didn't work'. The practical effect of this would be to push the losses to later years. Companies soon realized, however, that this would also provide an opportunity for the insured (who thought he had a claim coming) to say to his agent, "I may have a loss coming, so I'd better get more coverage." Since that would NOT constitute notification of a claim to trigger coverage, he might be able to do that. So now, these companies are back to the position that an informal notification to the agent by the insured or the claimant will "trigger" coverage.

The Retro Date

The "retro date" is a term which means the date to which the policy will be retroactive—that is, when the coverage will commence for this "claims-made" policy. Let's take a "claims-made" policy that might begin 1-1-88 and end 12-31-88. If there is no "retro date," then any claim filed during the policy period would be covered, no matter when the loss occurred. If the "retro date" is 1-1-88, then any claim filed for a loss occurring *prior* to 1-1-88 will NOT be covered, even if the claim is filed during the policy period. Coordinating the "retro date" of a "claims-made" policy with the termination date of an occurrence policy is critical to assurance of continuous coverage for any losses. If you had an occurrence policy which terminated 12-1-87 and a "claims-made" policy with a "retro date" of 1-1-88, there would be a gap of no coverage for the period from 12-1-87 to 1-1-88.

It might be appropriate to note here that although veterinarians' professional liability insurance has been on a "claims-made" basis for several years, it has not always included a "retro date" feature and so this problem may be a new one that most practitioners have not faced.

Some companies may propose moving the "retro date" on each policy renewal and may offer substantial discounts on premiums if you do so. However, this can create quite a problem. To illustrate, a "claims-made" policy with a "retro date" of 1-1-88 will provide coverage for any loss which occurred after that date, if the claim is filed during the term of the policy. Moving the "retro date" to 1-1-89 would mean that the policy would cover losses occurring after the new date, 1-1-89, but not before. Therefore, if the "retro date" is moved, the insured risks the filing of a claim during 1989 for a loss which occurred in 1988; this loss would not be covered. It is obvious that any change of the "retro date" after it is first estab-

lished should be done only with the greatest of care and after careful study. The potential for a gap in coverage with such a change is significant.

Extended Reporting Period

The extended reporting period is a provision which becomes important when taken in context with the two prior topics. Most "claims-made" policies will contain an automatic extended reporting period of 90 days after the end of the policy year. It might appear that the extended reporting period is of no great importance as long as you are continuing coverage. The interpretation of the period does, however, present some potential problems. The effect of this automatic extended reporting period is to put 15 months of claims filed against the policy limits that were set for 12 months of coverage. If, for example, you had a calendar year policy with \$300,000.00 as limits and had \$300,000.00 of claims filed in 1988, an additional claim filed during the first 90 days of 1989 would not be covered. And since the policies now usually include defense costs as part of the aggregate limits, this could be significant. It could also be important in the matter of how the aggregate limits affect umbrella coverage as we shall see later. It is not hard to see that managing WHEN claims are made could become as important as whether a claim is filed.

A second form of extended reporting is particularly important at the time of retirement. At that time, you will not want to continue your liability policy but unless you continue some form of coverage, when the policy terminates, coverage also ends. The policy is only good for the claims made during the policy period.

To accommodate retiring practitioners, "claims-made" companies will allow the purchase of additional "extended coverage" which will provide continued coverage for 1 year, 5 years, lifetime, etc., as a period. Of course, the expense of this coverage must be weighed against the risk of a claim. This coverage is called a "tail".

Aggregate Limits

We have made reference to aggregate limits several times. Aggregate limits means that the policy coverage provides a total limit on the amount the company will pay for claims during the policy period. If the aggregate limits of a policy are \$300,000.00, then that would be the maximum amount the company would pay on all claims filed during the policy period—including

the extended reporting period. Also, it would probably include any costs of defense paid on your behalf, regardless of whether the claim was valid.

Two things, the extended reporting period and the inclusion of the defense costs in the aggregate limits, will affect any decision regarding the aggregate limits of coverage you might select. If your practice is one where the claims could amount to substantial dollars and/or there could be a significant risk of several claims, an increase in the aggregate limits might be warranted.

One further factor, the integration of the limits of your CGL policy with those of the umbrella liability policy you might select, is important. "Umbrella" liability is the coverage which is the excess over the underlying coverage. "Underlying coverage" is that coverage which is provided by your basic CGL policy. Umbrella companies are now moving to higher and higher limits required for the underlying coverage. Most are now requiring a minimum of \$500,000.00 of underlying coverage.

A potential problem which has not been addressed, is whether the existence of a claim on underlying coverage, which would reduce the remaining underlying aggregate below the minimum required by the umbrella carrier, would create a gap in coverage. For instance, if you maintained a \$500,000.00 underlying CGL and \$1,000,000.00 of umbrella coverage and had a loss of \$100,000.00 in February (assume a calendar year policy) and a second loss of \$600,000.00 in November, would the umbrella carrier pay \$200,000.00, \$100,000.00, or nothing? The umbrella carrier might take any one of the following three positions:

1. Since you did not have underlying coverage of \$500,000 at the *time* of the loss they would be expected to cover, the company would not be required to provide *any* coverage at all.

2. The company is only required to provide coverage in excess of the required underlying coverage (\$500,000.00) and so would only pay \$100,000.00.

3. If you have the required underlying coverage at the beginning of the year, the fact that it has been used, partially or in full, will not diminish the umbrella carrier's responsibility to pay the excess. Obviously, you will want the 3rd option as your result.

Two possible solutions exist for this dilemma. One is to obtain an agreement in writing from your umbrella carrier that will accept the \$500,000.00

of underlying coverage at the beginning of the policy as sufficient to satisfy its requirements regardless of the amount of coverage at the time of the claim. The second is to obtain agreement with your CGL carrier that, for an additional premium, you could "buy" additional coverage to build the unused coverage back to the umbrella requirements. This area is one that is a great unknown at this point.

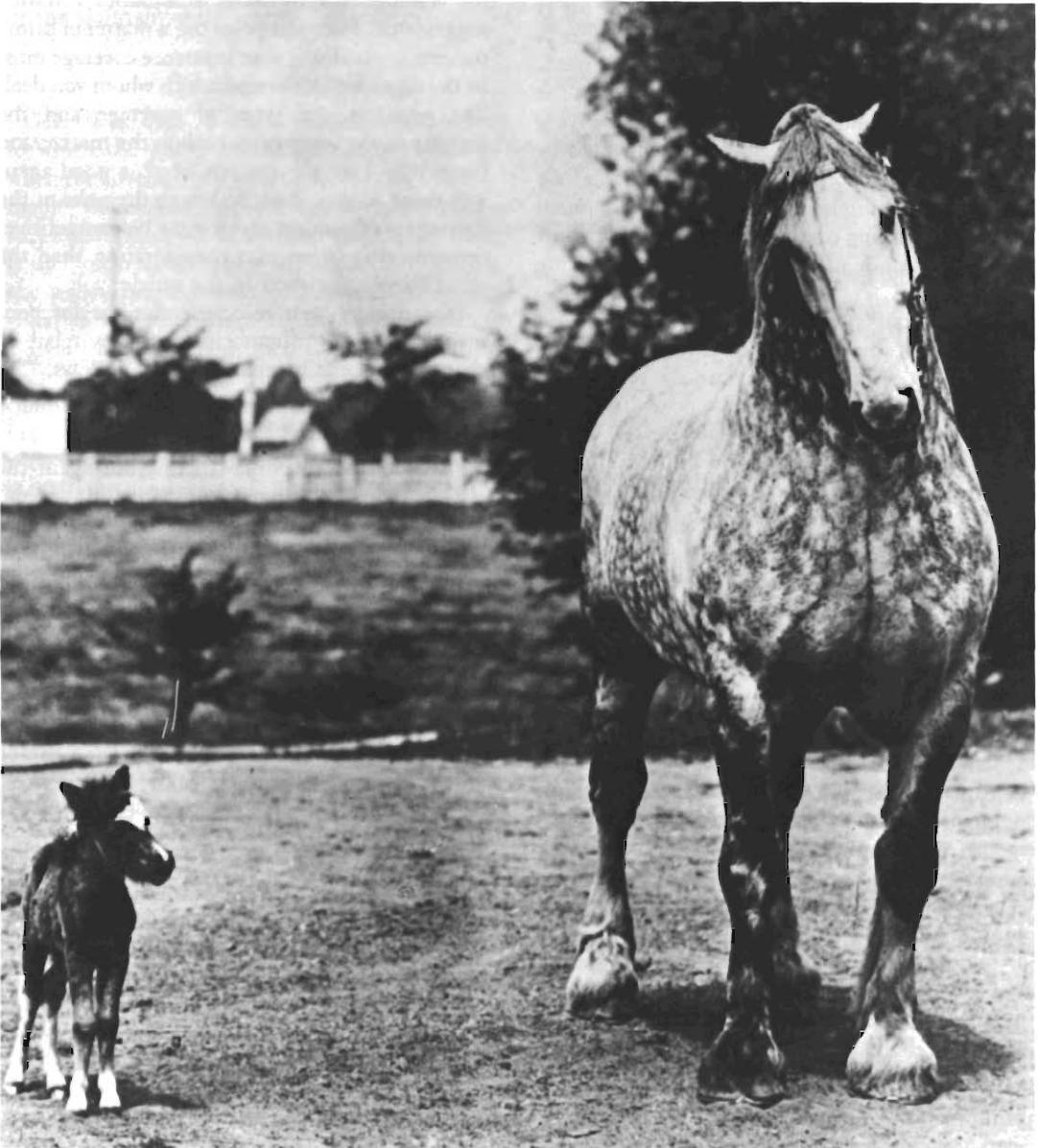
These significant changes in the CGL insurance for veterinarians by some companies certainly suggest that, from this point on, a matter of prime concern in obtaining your insurance coverage must be the capability of the agent with whom you deal. The amounts and types of coverage and the stability of the company—both in the market and financially—are also matters which a good agent will assure to you. And, although the price of the coverage is of concern and it must be competitive, certainly that is less of a consideration than the other factors discussed in the article.

In summary, our recommendations for your management of insurance risks as they relate to changes by some companies are as follows:

1. Be sure you discuss with your agent the type of policy your company is providing. If you prefer "occurrence" over the "claims-made" form, see if your agent can offer that type. If not, you will need to understand the consequences of your form of the CGL policy.
2. Retro date—select the retro date that will provide coverage from the moment of termination of the prior "occurrence" policy and NEVER CHANGE IT!!
3. Make sure that the amount of insurance coverage is sufficient to cover claims made during the extended reporting period.
4. Purchase a 1 to 5 year extended reporting coverage "tail" upon retirement.
5. When possible, select a coverage trigger that will accept the most informal of notice as the claim.

6. Be sure the aggregate limits of the CGL policy are sufficient to meet the minimums for your umbrella coverage *and* be sure you understand what, if anything, the umbrella company will do, related to the reduction of aggregate underlying limits.
7. Finally, and probably most important, be sure that you have selected a stable and

competent general agent to advise you. The capability of your insurance professional to maintain an up-to-date understanding of your coverage needs along with the changes in the insurance industry, will be the best insurance management effort you can spend.



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