

There Aren't Any Real Differences In Coverage Among Policies . . . Are there?

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We have been managing the same E&O professional liability program for RIA's for more than ten years. That's ten years of phone calls, letters, requests for clarification and, in general, a significant amount of misunderstanding and confusion about what E&O insurance is all about. We also speak a lot, and will typically field a wide variety of questions from the audience. Whether by phone, in person, through correspondence, or from an audience, the questions don't vary a lot -- they underscore just how broad the level of misunderstanding really is. Lacking understanding, many advisors will rely upon the "school yard" as their primary source of information. In short, there is a crying need to shine light into the darkness.

The E&O professional liability policies available for financial advisors are **not** commodities, unlike other policies such as private passenger automobile, homeowners insurance and many commercial policies. The professional trying to evaluate various policies, therefore, needs a working understanding of their terms and conditions.

An insurance product is complex and technical -- even the shortest policy will take 15 or more pages and thousands of words to define the conditions under which coverage may, or may not, apply. While it is unlikely that the layman will be able to understand all of the nuances of coverage, it is possible to evaluate the appropriateness of different policies and insurance programs. This article will attempt to do precisely that -- wish us luck, as it is a tall order. Please note that this article addresses basic concepts of E&O policies, and the law in a particular state may be applied differently.

We all know one of life's unwritten rules -- for every benefit there is an offsetting price to be paid. In other words, there really and truly is "no free lunch", also known as "The NFL Rule".

As the NFL Rule applies in this case, all or nearly all E&O policies available for Financial Advisors are written in an unregulated market. This is the market of choice because the profession is highly fractured and complex. Accordingly, any insurance product must meet the needs of a variety of different types of practices. Only in the unregulated market can coverage terms be tailored as circumstances dictate.

Equally this also means that an E&O insurer can legitimately offer policy terms and conditions which simply would not pass muster in the regulated markets. For that matter, it can also change policy terms and conditions from one renewal to the next without having to disclose to policyholders what has changed.

Defense Provisions

Although it is not generally recognized outside of the insurance industry, it is typical for an insurer to pay, on average, at least as much for the defense of claims as is paid in damages to claimants. In other words, the defense provisions of the policy are a critical part of the overall insurance policy.

There are two clauses commonly used in E&O policies. Under the first, the insurer has "the right and duty to defend". Under the second, the insurer has only "the right **but not the duty** to defend". What is the difference between these innocent sounding words "right and duty" as compared with "right but not the duty"? (Right about now might be a good time to "get smart" about "duty to defend". Type in the phrase "duty to defend", quotes included, into any of the general internet search engines and browse through what pops up -- it will be a real eye-opener when you see the body of case law defining the extent of the duty to defend.) Here's where we go "techie" on you.

Under a right and duty to defend policy, the carrier is required to provide a defense if only a single allegation potentially brings the case within the scope of coverage. Alternatively, if a claim alleges only acts that are excluded, the carrier will deny coverage for the entire claim.

Nonetheless, in nearly all complaints, a count of some form of ordinary negligence will be included, if only to trigger coverage for the defendant. Failing to include at least one complaint of a covered act would result in a coverage denial of the claim by the defendant's insurer. As a result, the defendant would have no available funds, other than his or her personal assets, with which to defend the claim and / or to pay damages. Surely the defendant's lack of a "war chest" takes all the fun out of the game for the plaintiff and his or her attorney.

But if the insurer has no such duty to defend in the first place -- that is, if its policy is a "right, but not a duty to defend" contract -- the carrier may simply elect not to provide a defense. Thus, if a plaintiff alleges wrongdoing that is covered, the insurer under a "right but not the duty to defend" policy may elect not to provide a defense, leaving the policyholder to shoulder the considerable expense of a defense lawyer. While it may be appropriate in certain types of policies (e.g. excess or "umbrella" policies, and commercial reinsurance contracts) for the carrier not to assume the duty to defend, the advisor's primary E&O policy should **always** include the insurer's duty to defend. Anything less is simply unacceptable.

The Right To Select An Attorney

If the carrier has a duty to defend, then it is only reasonable that it also have the ability to control the conduct of the insured's defense. Some reasons why the insurer may retain the right to select the attorney are to capitalize upon their advantageous negotiating position in setting billing rates; and to avoid the insured's selecting an attorney lacking the experience to adequately represent the insured.

If the insurer cedes the right to the insured to select an attorney, however, the NFL rule should pop into the forebrain. When the insurer retains the right to select and appoint counsel, it also remains responsible for the adequacy of the defense provided – if you select the attorney, then the carrier can hardly be expected to assure the quality of the defense counsel. As soon as the insurer delegates the right to select an attorney, it simultaneously cedes responsibility for the quality of the defense counsel's work. There is no free lunch.

When the carrier in addition has no duty to defend, it has neatly taken itself off of several hooks -- no duty to defend; an ability to avoid a defense entirely; and no assurance that the defense will be adequate, since the insured selects counsel. But the insurer will proclaim loudly for all to hear that you the insured have the right to select your own attorney. Be careful what you wish for.

The Truth About Punitive Damages

Punitive, exemplary or multiplied damages (as contrasted with compensatory damages) are intended to punish or to make an example of the defendant's conduct. Many courts do not allow insurance coverage for punitive damages, to discourage persons from engaging in the type of intentional or reckless conduct that punitive damages are designed to punish. Insurance coverage for punitive damages has the effect of taking the punishment out of punitive damages, and passing the punishment onto an insurer and, ultimately, other insureds, which are not deserving of punishment. This is the effect of case law in many states in which punitive damages are uninsurable. These states include the industrialized, heavily populated states including California, Florida, Illinois, Massachusetts, New Jersey, New York, Ohio, Pennsylvania and others. (The Notes point to a more complete discussion of punitive damages by state ¹).

By their very nature, punitive damages can arise when the defendant's conduct is found reckless, willful or wanton or done with the knowledge that it was wrong. There is no need to make an example of ordinary negligence as the world already has a more than ample supply, and in full view for all to see – we need no reminders, thank you.

But the typical professional liability policy will contain two exclusions, one pertaining to willful misconduct; and, the other to harm that the insured expected or intended to cause.

When the policy contains these exclusions, it also effectively excludes punitive damages, because the policy will cover only ordinary negligence allegations, upon which punitive damage awards may not be based. In other

words, coverage for punitive damages may be an illusion. Even if a policy does not expressly exclude punitive damages, its other exclusions may deny coverage for the types of conduct that give rise to punitive damage awards in the first place.

The Incident Trigger For Coverage

Losses arise most frequently from execution errors, best described as “dumb mistakes” – similar to what we all do every day as we muddle our way through the complexities of daily life. They are nearly always reported as an act which may reasonably be expected to give rise to a claim. A claim, by contrast is an actual demand for damages.

Execution errors share the following characteristics:

- There is typically little if any question of liability;
- Damages can be readily ascertained and are generally not significant;
- The error surfaces rapidly, usually within hours or days of its occurrence.

In short, if detected promptly and attended to quickly, incidents can be settled with minimal disruption to the relationship between the insurer and its policyholder or to that of the advisor and his or her client. And they can be settled without significant legal costs. The mantra for these incidents should be “Settle quickly and don't haggle a lot”. Unlike fine wine, these claims do not get better with age.

You may remember the old line about investing in commodities “If you want to make a small fortune in commodities trading, start with a large fortune”. A sure-fire way turn a small incident into a large claim is to deny coverage of the incident because it doesn't meet the strict criteria of a claim, as the client has not demanded damages

The Law of Perverse Effects also applies. If insureds expect to be treated in a punitive manner when they report an incident (as they are required to do under all E&O policies), then guess what – they'll engage in “self-help”, by attempting to settle the matter quietly on the side. And with self-help comes the very real possibility of “claim implosion”. To make matters worse, failing to report a claim as an incident may trigger a coverage denial for the entire matter, regardless of the nature of the claim, as the policyholder has not met his or her obligations under the insurance contract.

And yet we see it again and again and again – because a policy lacks provisions under which the carrier recognizes an incident before a demand is presented, the insured then either goes the self-help route; or, if he or she reports the matter without a demand having been made by the insured's client (as is always required), the insurer denies coverage. In the latter case, the insured then goes to his client and informs him that without a demand there will be no coverage for the loss under the advisor's E&O policy. With that, the genie is out of the bottle, setting off an irreversible chain of events. The client, having been told that he must demand damages, or perhaps wondering what else he might be able to wring out of the claim, hires

a lawyer. The lawyer then piles on everything he can think of. *Voila*, the magical transformation of a small incident into a large claim, similar to the Biblical miracle of the loaves and the fishes.

The Incident Trigger – Part II

Under some E&O insurance policies, the carrier's coverage obligation begins once the insured has reported an incident. With other policies, the carrier's duties do not commence until the insured actually receives and reports a demand for damages.

Consider what happens if a policyholder changes carriers. The (new) carrier issuing replacement coverage will always exclude coverage for matters known to exist at the inception of its coverage. Therefore, unless the expiring policy provides for coverage as of the date on which the incident was first reported (the first type of "claims made" coverage described above), there is usually no available coverage when a demand for damages is received or when suit is brought after the policyholder has changed carriers.

The Role and Importance of Price

If the premium offered by one carrier is significantly higher or lower than that offered by others, that should prompt a series of questions:

The carrier charging the highest premium may in fact have a level of service unequalled by competitors; or, it may be engaging in practices that will virtually guaranty adverse selection and therefore its early demise.

By contrast, the carrier offering the lowest premium may be either trying to buy its way into the market, only to race for the exits when its underwriting practices begin to generate a significant level of claims activity; or it may have a well-reasoned rationale based upon extensive experience with the profession to charge a rate consistent with exposure.

But the critical point is ***the premium should not be the primary consideration***. This product is about as far away from the commodity insurance lines as you can get. Whatever price differences exist at the time of quotation, they will be overwhelmed by the financial exposure arising from a mis-handled claim.

A related issue is the stability of the premium -- if the insurer is constantly chasing premium dollars and renewal quotes are a continuing surprise having no rational explanation, the chances are high that their long-term objective is opportunistic and not strategic.

Sorting it all out

This line of insurance is one where a number of carriers have come – and gone – throughout the years. As the insurance relationship is long term in nature, you need to assess the carrier's seriousness of purpose – an uncommitted carrier that no longer writes the coverage which you purchased from them is hardly likely to be responsive in handling a claim on your behalf. And the carrier's response to a claim is really the only measure of whether the coverage provided is or is not adequate.

When a claim is presented, the only language that matters is what is contained in the policy in effect when the claim is presented. Whatever the broker may have told you before you purchased coverage is superceded by the language of the policy. If the underwriter or the broker cannot present a reasonable answer to your questions, you should continue to ask questions until you get an answer that you understand. A clear answer. Failing that, have the broker either put his response in writing, or ask that an appropriate endorsement be issued.

The professional should not accept what the carrier offers without question. Rather, just the opposite is true - in this, the unregulated "buyer beware" market, it is all the more important that you make an informed choice and select a carrier and a policy which provides you with the appropriate insurance protection.

To ascertain the insurer's seriousness of purpose, the most effective questions to ask center on just how committed, knowledgeable and experienced the carrier is with your profession. The simplest question is what experience do the underwriters and / or the insurer have with the profession? Another way to get at this same issue is to listen carefully to the way in which your questions are answered. You can pretty quickly tell if the broker or underwriter has a deep understanding of your profession by what they say (or don't say), and by how they say it.

Summary

Because of the relatively small number of professionals in the financial planning profession, as well as their diverse insurance needs, the unregulated market is ideally suited to the meeting of these needs. But in the same breath, this very same market presents a minefield to the uninformed. Obtain AND read a sample policy; ask a lot of questions; and, make sure you get answers that are clear and which you understand before buying any insurance policy.

¹ McCullough, Campbell & Lane,
[The Insurability Of Punitive Damages](#)

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