Common misconceptions and misunderstandings in the world of professional liability insurance

Insurance, not unlike many other industries, seems quite straight forward for those who spend their day-to-day lives engrossed in its terminology and practices. However, for those people who have never had to call on their insurance, or who may only have had occasional contact with the industry, the practices and procedures may not seem quite so straight forward. Insurers and brokers alike try to educate consumers with respect to the insurance process, but sometimes the lines of communication get a little fuzzy. When that happens, it creates gaps in knowledge, and when there are gaps, they tend to get filled in with rumour and speculation, which almost always leads to a negative perception.

The purpose of this article is to address some of the most common misconceptions and misunderstandings that we have encountered over the past few years, and to provide some context so as to fill in the knowledge gaps and dispel the misconceptions that have, no doubt, fostered negative perceptions in the minds of consumers of professional liability insurance.

Common misconception no. 1 – all insurers look for ways to deny coverage

While it’s true that not every claim reported under a professional liability policy is covered, the majority of claims reported are covered in whole or in part. However, for the individual insured whose claim is being denied, it is understandable that they may develop a negative perception with respect to the motivation of the insurer. This may be especially true in situations when the insured is not very knowledgeable about the scope of professional liability coverage and may be of the view that coverage is provided for any and all potential claims made against them, including claims that fall outside the realm of professional services. In those situations, it may be helpful for the insured to have an understanding of the process that is followed by an insurer when assessing coverage under their policy. The process followed by ENCON, which we believe to be generally consistent throughout the industry, is as follows.

ENCON’s claims analysts are trained to look for coverage when reviewing notice of a new claim. What is important to note is that in looking for coverage, one may encounter impediments such as exclusions in the body of the wording or endorsed on the policy which ultimately lead to the conclusion that coverage is not afforded under the policy or that only partial coverage is afforded. This process of looking for coverage follows a common path.

The first step in assessing coverage is to determine that there is, in fact, a current policy in place. The claims analyst will therefore look to the underwriting file to obtain the policy information. He will confirm that the policy period is current and that the claim is being reported in accordance with the notice provisions of the policy. If there is a current policy, but the claim was made against the insured in the previous policy period and, therefore, should have been reported in the prior policy period, the claims analyst must then determine whether the insurer has suffered any prejudice as a result of the late notice. The claims analyst will also confirm that the person on whose behalf the claim is being reported is an insured as defined by the policy.
Once these basic “insurance” issues are determined, the claims analyst will then turn his attention to the allegations made against the insured in the context of the policy wording. This phase of the coverage analysis begins with a review of the insuring agreements and the definitions referred to in those insuring agreements. In the event that the allegations against the insured fall within the scope of the insuring agreements, the last step in the coverage analysis is to rule out the possibility of any exclusions applying to the claim. If the answer to that question is no, coverage will be confirmed to the insured in writing, and the broker will be copied on that letter.

If there is mixed coverage, in the sense that some of the allegations fall within the scope of coverage while others do not, the claims analyst will send what is commonly referred to as a Reservation of Rights or “R of R” letter to the insured. The purpose of the letter is to confirm that the insurer will defend the insured with respect to the covered allegations without prejudice to the insurer’s right to decline coverage with respect to the uncovered allegations. The insurer will most often also reserve its right to reassess coverage in the event that the matter moves from the demand letter stage to formal litigation or, in the event that the matter is already litigious, if the statement of claim is amended and the allegations change as a result.

**Common misconception no. 2 – ENCON is the only company that issues Reservation of Rights letters**

This is a comment that has been made by several brokers over the past couple of years. The fact is that R of R letters are very common in the world of professional liability insurance. What appears to be somewhat unique, however, is that ENCON appears to be one of the few providers of professional liability insurance that provides the broker with a copy of the R of R letter that is issued to their client. Since the broker is not being copied on the R of R letters issued by other carriers, they are left with the impression that the other insurers are not issuing such letters.

The R of R letter serves a very important function. It allows the insurer to provide the insured with a defence, paid for by the policy, while at the same time preserving the insurer’s right to reassess or revise its coverage position if there is a change in the nature of the claim. As mentioned earlier, coverage is initially determined on the basis of the allegations made against the insured in the notice document, whether that notice is a demand letter or statement of claim. However, the allegations set out in a demand letter can change if the matter proceeds to litigation and a statement of claim can be amended to add or remove allegations made at the time the claim was first reported. Moreover, the claim may include covered as well as uncovered allegations. Experience, documented by case law, has taught insurers that if they do not advise the insured of areas of potential non-coverage or reserve their right to revise their position in light of new or amended allegations, they will be prevented or “estopped” from doing so later. Therefore, the R of R letter was borne out of the necessity for the insurer to protect its rights, while at the same time honouring its obligations to defend the insured under the policy. The R of R letter should not be feared, but it is important that the insured understands its purpose. The reason that ENCON copies the broker on the R of R letter is to ensure that they are fully informed of the position that ENCON has taken on coverage and to give them the opportunity to ask any questions with respect to coverage so that they are in a position to respond to any questions that are asked of them by the insured.
Common misconception no. 3 – reporting a claim will automatically lead to an increase in premium at renewal

When inquiring as to why an insured reported a claim late, it is not uncommon to be advised by an insured that they “didn’t think the claim would develop into anything significant,” and they “didn’t want to risk a premium increase.” Similarly, insureds sometimes contact ENCON’s Claims department to advise that while they want the insurer to be aware of a claim, they do not want to report it “as a claim” because they don’t want to risk an increase in premium. What most insureds do not realize is that they are exposing themselves to an even greater risk by not reporting the claim in a timely manner.

Most professional liability policies require the policyholder to report a claim as soon as possible after becoming aware of the claim. By failing to report the claim as required by the policy, they are actually acting in breach of the terms of the contract and could therefore jeopardize their rights under that contract.

Our experience is that insureds are rarely correct in their assumption that the claim will not develop into anything significant. In fact, it almost always gets worse, and if the insured failed to report the claim in a timely manner, he could find himself in the position of potentially being without coverage when it’s needed the most. It is almost a certainty that the cost of defence the insured would then have to fund would far exceed any increase in premium as a result of having reported the claim.

In those cases where the insured reports a minor matter that is easily resolved without significant expense, or when circumstances that could give rise to a claim are reported but no claim ever materializes, it is unlikely that the mere fact of the notice or the expenditure of nominal defence costs will have any impact at all on the premium. The insured may well experience an increase in premium at renewal, but it is extremely unlikely that such increase would be related to the notice of a claim or potential claim that amounted to nothing.

The best way to avoid misconceptions or misunderstandings is regular and clear communication. Therefore we encourage brokers to contact the Claims department with respect to any questions or concerns that they or their clients have with respect to the claims process.