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Risk Management (cont'd)

How do I review my organization's insurance contracts?

An insurance policy is a contract that defines the obligations of the two parties involved, the insured (your organization) and the insurer (insurance company). Most non-insurance people believe that insurance policies are incomprehensible. However, with a little insight into the mysteries of insurance contracts, you can make sense of your policies. Remember that besides providing coverages, policies also assign certain responsibilities to the insured. If you do not meet your obligations, you may impair the policy's coverage. The following review process will help guide you through the maze of insurance contracts.

Policy Parts

Every insurance policy has four parts: Declarations, Insuring Agreements, Exclusions, and Conditions. Use these sections as guideposts in reviewing a policy. Examine each part to identify its key provisions and requirements. You need not undertake this process alone. Remember that your insurance advisor, whether an agent, broker or consultant, can be a valuable resource in analyzing your organization's policies.

Declarations

The Declarations or "dec" page is usually the first page of the policy. It summarizes key information specific to the policy. The dec page shows the insured's name and address, the policy dates, a brief description of the business, coverages provided, coverage limits, premiums and the forms applicable to the policy.

Beyond the Declarations, the policy will also contain "schedules." A schedule identifies the location(s) of the insured's operations (including values or limits), the various assigned rating classifications, the rates and rating basis, and any special property covered (cameras, fine arts, contractors' equipment, etc.).

Insuring Agreements

The Insuring Agreements specify what the insurance company has agreed to pay for or to provide in exchange for the premium. Often a policy contains a section clearly marked "Insuring Agreements," although there may be additional agreements buried in the policy. Also, the policy may call an insuring agreement a "coverage" and many policies include more than one coverage. For example, a commercial general liability policy may provide Coverage A - Bodily Injury and Property Damage, Coverage B - Personal and Advertising Injury, and Coverage C - Medical Payments. Policies also call insuring agreements Supplemental, Additional or Extended Coverages.

An insurance policy begins by declaring what it covers and then proceeds to restrict, limit and exclude coverages. Therefore, you cannot just read the insuring agreements to understand the coverage. You

must read the entire policy and refer back to the various insuring agreements and other provisions.

Patience and a clear head are invaluable tools as you undertake this process.

One insuring agreement that is often easy to identify explains what triggers the policy's coverage. The two possible coverage triggers are "occurrence" or "claims made." Under an occurrence policy, the policy "triggers" or provides coverage based upon when the loss occurred. If the loss occurred during the policy's period, the policy will cover the loss. For example, if the policy period is January 1 - December 31, 1999 and a loss occurs in June 1999, barring the denial of the claim for other reasons, the policy will cover the loss. If the policy initiates coverage by a claims made provision, the policy is in force when the insured submits the claim is the policy that responds. For example, assuming the same policy period as before, an organization reports the filing of a wrongful termination suit on January 10, 1999. The suit alleges that the organization terminated the employee on December 31, 1998 (one day before the policy took effect) for unlawful reasons. Assuming the company does not deny the claim for other reasons, the reporting of the "claim" during the policy period triggers the coverage. The policy responds despite the fact that the alleged wrongful act (the termination) took place before the policy was in effect. Claims made policies include many provisions that impact coverage and the implications of timely reporting of claims are quite complex. If your policy is claims made, ask your insurance advisor to explain the policy.

Definitions

Insurance policies contain many common words that have special meaning within the context of insurance. The policy identifies these words usually by bold print or quotation marks. Most policies contain a section entitled "Definitions" where they explain the special meaning of the designated words. Since definitions may restrict or limit coverage, it is essential that policyholders read definitions carefully and seek clarification whenever a definition is unclear.

Exclusions

Every insurance policy has exclusions or policy provisions that eliminate coverage for specified exposures. Exclusions serve as a way to clarify the coverages granted by the policy. Most policies have a section entitled, "Exclusions." However, an exclusionary provision can be anywhere in the policy. Furthermore, an exclusion may also contain a broadening provision. In the commercial general liability policy, the Aircraft, Auto, or Watercraft Exclusions eliminate coverage for the ownership, maintenance, use or entrustment of these vehicles or vessels. However, the exclusion has five exceptions where the policy covers watercraft such as while ashore on your premises and for certain nonowned watercraft. Read the policy carefully and note the provisions that apply to your operations.

Conditions

Conditions within an insurance policy qualify the various promises made by the insurance company. The insurer does not promise to cover all losses. The company will impose certain requirements or conditions on the insured, such as premium payment or duties to follow after a loss. Another example is that the insurer promises to pay and provide other services only if the insured event occurs and the insured has fulfilled its contractual obligations. Review the policy to identify the conditions that you must follow. If you do not meet your obligations, the policy can void or otherwise restrict coverage.

The Review Process

Review your organization's insurance policies when you receive them. Before buying any new coverage, always request and review sample policies. Many people find it difficult to fully understand the scope of coverages without considering a specific loss. One approach is to identify the risks or types of losses you expect your organization to experience -- an office fire, windstorm, injury (suffered by an employee, volunteer, client), auto accident, theft or other risks. Then, determine if you think the policies will cover these expected losses. Your insurance advisor can assist you in the review process. Here are the steps.

1. Review the policy for accuracy.

Insurance companies are notorious for issuing policies incorrectly. The policy may contain spelling errors, the wrong Named Insured, incorrect additional insureds, the wrong forms or not include a purchased coverage. Refer any errors to your insurance agent or broker immediately. If you do not address an error, it can become a problem if a loss related to the error occurs.

2. Review the rating classifications and other schedules.

Check to see what rating classifications the company assigned to your organization. The company calculates the premium charge based on certain rating classifications. There can be substantial differences in the rates among the classifications. One insurance company assigned a "circus" rating classification to a workers' compensation policy for a nonprofit sports organization. The circus rates were much higher than the appropriate classification of "outside sales" and did not reflect the insured's exposures. Ask your insurance advisor to explain any classifications that do not seem to describe your operations.

3. Read the policy and answer these questions.

- Is the expected claim covered by the insuring agreement?
- Is there any exclusion or other provision that eliminates or restricts coverage?
- Are there any exclusion exceptions that restore coverage?
- What policy conditions must the organization comply with?
- Are the people or operations affected by the conditions aware of them? If the policy requires that a burglar alarm always be operational, have you informed the office manager, maintenance staff or other appropriate personnel?
- If the loss is covered, is there a deductible? The amount?
- How much will the policy pay?

Summary

An insurance policy is a complex contract that often contains conflicting and confusing provisions. With a little patience and practice, you can learn to understand your policy's format and coverages. As a legal document, the courts have scrutinized insurance policies and argued over their meaning. Consequently, various courts have rendered conflicting interpretations. If judges and juries continue to disagree about the meaning of insurance policies, how can a nonprofit manager be confident about the coverages he or she has purchased? Most losses do not involve complex policy interpretations and the insurance company and insured quickly agree that the policy covers the loss. However, you must know

and understand the many responsibilities placed on your organization by an insurance policy. Your noncompliance with a policy provision could have an adverse impact on coverage. So sit back, relax, and try to enjoy the learning process.

What is the role of an insurance advisor?

Most nonprofits require a network of professional support personnel in order to operate effectively. Many small organizations utilize the board recruitment process to assure the availability of professional expertise in key areas. Large or more mature nonprofits may strive to build a staff that includes experts in various professional disciplines.

While board members bring tremendous insight and wisdom from their professional backgrounds, the use of an independent insurance advisor is a wise and affordable alternative. An independent insurance advisor avoids potential conflict of interest problems that arise when the agent is also a board member. In addition, the insurance advisor offers an objective perspective on some issues.

The need for an independent insurance advisor

Insurance companies (also called "markets," "carriers," or "insurers") rarely sell policies directly to organizations. Companies that sell directly to organizations are referred to as "direct writers." More often, insurance companies use intermediaries to market and explain insurance products to the client or insured. Due to the complexity of insurance coverages, every nonprofit organization needs a trusted insurance advisor -- either an agent, broker, or consultant -- to counsel it on insurance matters.

The distinction between agents and brokers is worth noting. State insurance departments license brokers to place insurance on behalf of clients (individuals and organizations) with any number of insurance companies. States also license insurance agents. However, insurance laws restrict agents to only market and place coverage with carriers with whom they have a contractual relationship. Some agents have relationships with a number of companies, while others represent a single insurer. A broker technically represents the client, while an agent represents the company or companies with whom he or she has a relationship. However, keeping their customers and the insurance companies where they place business happy is important to both agents and brokers.

Minimum qualifications of an agent or broker

At a minimum, the insurance agent or broker advising your nonprofit should be:

Knowledgeable about "commercial lines" insurance (insurance for corporations and organizations) and the commercial insurance market. An agent who specializes in "personal lines" coverage, such as homeowners insurance, may not have the breadth of knowledge and experience your agency needs in a professional advisor.

Experienced with regard to the special risks facing nonprofits and the insurance products best suited to finance those risks. Some of the exposures facing your agency are common to other businesses, such as an equipment fire loss or a wrongful termination claim. However, other exposures are truly unique to nonprofits. For example, only a nonprofit has to worry about risks such as liability for a volunteer's actions, working with vulnerable populations, contractual liability due to a volunteer's apparent

authority, or liability from an auto accident involving an employee or volunteer using his car to transport clients.

Willing to take the time to learn about your agency's operations and to provide thoughtful advice and counsel about the agency's exposures and insurance needs. To some extent, every nonprofit has unique operational components. An effective insurance advisor must be familiar with the unique aspects of your agency in order to provide the advice about exposures and coverages you need.

Assertive in advocating your interests

While a wide range of coverages is now readily available to most nonprofits, many insurance company underwriters fall back on past experiences or stereotypes in deciding whether to offer coverage to a nonprofit. An underwriter may very well judge the merits of your application on his or her assumptions about the organization's work. The underwriter may not understand fully your nonprofit's mission and operations. For example, an underwriter can believe that birth parents sue adoption agencies frequently to "reclaim" the infant. Your agency may never have had such a suit in its 25 years of existence. An effective insurance advisor will be assertive in advocating the insurability of your nonprofit and articulate in emphasizing the reasons why your organization's operations represent an acceptable risk.

Well connected with various insurance markets and able to offer you competitive choices with respect to pricing and coverage terms. As indicated previously, brokers and agents generally have contacts with a number of insurance markets. In some cases, an agent may only represent a single insurer. The chances of obtaining competitive quotations from an agent or broker increases with the number of contacts he or she has in the industry.

Organized to meet deadlines

For most nonprofit managers, the purchase of coverage and the annual renewal of existing policies is a dreaded but necessary task. As a result, it may not receive the priority it deserves. An effective insurance advisor will ease the burden of the process by assisting his clients with initial or renewal applications and reminding the nonprofit about approaching deadlines.

Responsive to your changing needs -- he or she should return your phone calls, assist with claims filing, notify insurers of any changes, issue certificates of insurance, and assist with the design of risk management strategies. An agent who is not responsive when you pose questions or appears uninterested in your concerns after you have renewed a policy, is probably not an appropriate advisor for your agency. An effective advisor will help your agency with risk management and insurance matters long after you pay the premium and receive the policies.

While any agent or broker can help arrange the purchase of specific coverages, most nonprofits require advice and support that goes beyond the simple placement of coverage. By selecting an agent or broker with these characteristics, you will get the help you truly need. A good insurance professional can be an invaluable asset and an excellent resource.

What are the essential components of a nonprofit D&O policy?

The D&O landscape for nonprofit organizations

Directors' and Officers' liability (D&O) policies provide protection for risks associated with the governance activities of a nonprofit organization. In the business world, corporate D&O policies exist primarily as protection against shareholder initiated actions against a board. While shareholder actions are not a factor in the nonprofit sector, other potential claimants may question the actions of nonprofit boards in a legal proceeding. Potential plaintiffs include representatives of government agencies, service recipients alleging injury from the nonprofit's actions or failure to act, or employees and volunteers.

Less than 10 years ago, many nonprofits encountered great difficulty in securing affordable and comprehensive D&O coverage. Only a handful of insurers offered a policy for nonprofits, and these policies often provided inadequate coverage. For example, a nonprofit board's greatest exposure is the organization's employment practices. Early nonprofit D&O policies excluded employment-related claims. In addition to limited coverage, many insurance companies refused to provide coverage because of their perceptions of the "risky" aspects of a nonprofit's operation. Nonprofits with a non-traditional approach to service delivery and those offering critical human services, such as community health clinics and adoption agencies, often faced reluctant insurers.

During the last decade, the nonprofit D&O landscape has improved substantially. Today, a growing number of insurers offer competitive, affordable coverage that addresses the principal governance and management exposures of nonprofit organizations. Furthermore, insurance companies have tailored and refined their D&O policies to reflect the specific needs of nonprofit organizations -- such as including volunteers (other than board members) as insureds.

However, even with the favorable insurance climate, many nonprofit organizations remain uninformed about the D&O coverage options and differences. As the number of claims increases, the importance of understanding the various policies becomes critical.

The frequency and nature of D&O claims

The number-one source of D&O claims against nonprofits is employees alleging wrongful employment acts. The nonprofits' experience reflects the national increase in employment-related claims in all economic sectors. In 1996, Americans filed more than 23,000 lawsuits in federal courts alleging discrimination based on impermissible considerations in employment, including race, sex, disability, and age. This is more than double the number of suits filed in 1992. Overall, job discrimination lawsuits have been rising at an average rate of 20 percent per year. Contributing factors to the growth in employment practices lawsuits include:

The 1991 Civil Rights Act increased the availability of money damages to plaintiffs of successful discrimination claims.

The 1990 Americans with Disabilities Act prohibits discrimination against physically or mentally handicapped workers.

The 1992 Supreme Court confirmation hearings of nominee Clarence Thomas. Human resource professionals credit the hearings with raising the awareness of the issue of sexual harassment and

causing a record number of complaints and suits. Complaints filed with the Equal Employment Opportunity Commission (EEOC) grew to more than 15,000 in 1996 from slightly more than 6,000 in 1990.

Growing employee anger and resentment following an unprecedented period of corporate downsizing in the early 1990's.

Nonprofits are not immune from these national trends. The growth in D&O claims and the resultant intense media scrutiny has led to growing concern among current and prospective board members about their personal liability on these and other issues.

Other D&O claims include allegations of injury or financial losses caused by the nonprofit. Potential plaintiffs include clients, vendors, donors and employees alleging financial mismanagement.

Government agencies such as the state attorney general can also file charges of violation of government regulations.

While nonprofit D&O claims are rare when compared to other types of claims, defending a D&O claim can be costly and disruptive to a nonprofit. Therefore, the organization's use of sound risk management practices to minimize the likelihood of a claim is important. In addition, the purchase of an appropriate D&O policy provides the availability of funds for defense and settlement costs.

Protection afforded by D&O policies

D&O policies protect against claims alleging harm attributable to the governance or management of an organization. Most policies do not list specific types of covered claims. Instead, the policy covers "wrongful acts" which is a term that the policy may define broadly. The definition of "wrongful act" can include actual and alleged acts, errors, and omissions, misleading statements, and neglect or breach of duty. The policy may narrow coverage by limitations and exclusions. Exclusions usually exist for one of two reasons. First, an exclusion can eliminate coverage for an exposure offered in another insurance policy such as bodily injury, employee benefits liability, and professional liability. Second, an exclusion can eliminate coverage for uninsurable exposures (i.e., illegal or dishonest conduct).

Every organization should examine its policy exclusions. A common exclusion with possible adverse consequences is the "insured versus insured" exclusion. Initially designed to eliminate coverage for struggles over organizational control, this policy provision may eliminate coverage for employment-related suits. For example, if the policy definition of insured includes the executive director, the policy would exclude his or her wrongful termination claim against the board of directors. If your policy includes an "insured versus insured" exclusion, look for language that makes clear that the exclusion does not apply to employment practices claims.

Insurance companies write D&O policies on a "claims-made" basis. A "claims-made" policy requires that (1) the claim be made against the insured during the policy period; and (2) the incident giving rise to the claim occur within the policy period. Regarding the second requirement, many insurers will extend the policy period retroactively by providing "prior acts coverage" or extending the retroactive date to the date of the initial policy's inception. Prior acts or retroactive coverage is critically important with claims-made coverage. Without it, an organization faces a gap in coverage any time it changes

insurance carriers.

The desirability of other policy features depends upon the needs of a particular organization. Nonprofits should consider the following features when selecting appropriate D&O coverage:

Scope of coverage. The broad coverage offered under many nonprofit D&O policies is ordinarily preferable. Look for policies that offer:

- A broad definition of "insured". Look for a policy with a broad definition of "insured." The definition should include the organization (often called "entity" coverage) and all past, present and future board members, employees, and volunteers. A savvy plaintiff's attorney alleging injury will name everyone connected to the event or decision in the suit. A broad definition of insured ensures protection if a defendant falls outside the narrow definition of "director" or "officer."
- A broad definition of "wrongful act" and "claim." The definitions of "wrongful act" and "claim" determine the policy's scope of coverage -- what actions the policy covers. The "best" policy offers the widest range of coverage. Considering the growing probability of an employment-related claim, coverage for employment practices liability is a necessity for most nonprofits. Preferable policies provide coverage for claims for wrongful termination, discrimination, and harassment. An insurer may agree to provide a defense for claims filed with administrative agencies (for example, the EEOC or local human rights commission) in addition to coverage for lawsuits seeking money damages. A final consideration is whether the policy includes coverage for defense costs for certain categories of otherwise excluded claims (such as allegations of intentional wrongdoing or criminal acts).

Deductibles

Most nonprofit D&O policies offer several options for the policy deductible. The premium generally increases when the insured selects a lower deductible (also known as the "retention"). In recent years, insurers serving the nonprofit marketplace have become increasingly willing to offer deductibles as low as \$500 or \$1,000 as an option. Consider the amount you can afford as your policy deductible. Also important is whether the deductible is on a "per claim" or "aggregate" basis.

Type of coverage for defense costs

A growing number of nonprofit D&O policies require that the insurer pays the litigation costs as the organization incurs them. "Duty to defend" policy defines the insurer's obligation to pay defense costs as incurred. For most nonprofits, this provision is essential. The alternative is for the insurer to reimburse the insured for defense costs after the dispute. While this may be appropriate for large nonprofits or those with substantial reserves, it is generally problematic for small, resource-constrained agencies. One major nonprofit D&O insurer reports that its defense costs for an employment claim average between \$35,000 - \$103,000.

Annual premium

Many nonprofit insurance buyers regard the annual premium as the most important determining factor in comparing D&O policies. Nonprofits generally purchase insurance to finance risks that the organization is otherwise unable to eliminate or retain. Buying a low-cost policy that provides inadequate coverage is a waste of precious financial resources. Conversely, choosing the most expensive policy will not guarantee the best coverage. Obtaining appropriate coverage should be the

organization's first concern. Buyers should compare premiums only after they have carefully considered policy wording and coverage differences.

Nonprofit managers should review and understand the provisions of D&O coverage. Policies differ in several areas. In recent years, many insurers have designed policies that recognize the needs and resource constraints of nonprofits. While most nonprofits and their boards will not encounter a D&O claim, purchasing D&O insurance can prevent the financial ruin of the directors and the organization itself if there is a claim.

D&O Insurance Buying Tips

1. Present your nonprofit in the best light, emphasizing your activities to minimize losses (internal controls, employment practices). Do not view the application as a burdensome paperwork requirement, but consider it an opportunity to protect your nonprofit and conserve resources.
2. Share the expiring premium, limits, and deductible from your existing carrier with prospective insurers for your account. Competition for your business will help you negotiate the best terms for your nonprofit.
3. Allow sufficient time for an underwriting review -- particularly with a carrier unfamiliar with your organization.
4. Fully complete the insurance company's application and attach all requested supporting information when you initially submit it. The information requested usually includes the organization's bylaws, board roster, employee manual, and audited financial statements or Form 990.
5. Be accurate and truthful in answering questions on the application. Misstatements on the application can void coverage if discovered upon the filing of a claim.
6. Respond to the underwriter's questions (generally conveyed through your broker or agent) in a prompt fashion.
7. Fully disclose your agency's prior losses and provide detail on corrective action taken to avoid future losses.
8. Remember that coverage and pricing terms are, to some extent, negotiable. On occasion, the insurance company bases its preliminary quotations on inappropriate assumptions. If specific terms of the proposal are unacceptable, propose alternatives.
9. Request a sample copy of the complete policy. Carefully compare the policy wording and coverages summary to a list of features you require. Also, seek help from your legal counsel or insurance agent if you do not understand the policy wording.
10. When you are buying any form of "claims made" coverage and changing carriers, make certain that

your new policy includes "full prior acts" coverage or the retroactive date is the inception date of your original policy.

11. Knowledge of any "incidents" that may lead to a claim must be indicated on any application or renewal form by the applicant. If you note any such incidents on an application for a new carrier, make sure that you reported the "incidents" to your current carrier. The new company will exclude these incidents from their policy.

12. Request information on an insurer's financial strength and status ("admitted" versus "surplus lines") from your agent when he or she submits proposals for your consideration.