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THE INSURANCE NEWSLETTER

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Commercial Umbrella Liability Insurance

Most of our clients these days buy an umbrella or excess liability policy. It's a sensible thing to do, with multi-million dollar jury awards becoming increasingly commonplace. If you have any business relationships that require you to provide evidence of insurance, like leases or contracts for example, you'll also see requirements for high limits that can only be covered at reasonable cost by an umbrella policy.

Umbrella policies sit over the policies that lie under them. Typically, these will be, at minimum, your general and auto liability policies, and the employers liability section of your workers compensation policy. Other lines of underlying insurance may also fall under the umbrella depending on your particular situation. Since the umbrella policy(ies) sit over these underlying policies and limits, umbrella underwriters can't offer a proposal until they know what they are covering over. For that reason it will usually be the last policy we arrange for you.

In terms of what they cover, umbrella policies can do two things. Umbrella policies all provide additional insurance limits over the primary underlying liability insurance policies carried by the insured in the event that those primary underlying limits are exhausted by one large loss or several losses. These additional limits are the main reason to buy these policies; it's an economical way to buy higher limits. Although the umbrella will cover over several underlying policies, it has, in effect, a very large deductible built in, equal to the limits of the underlying polices. Large deductibles equal lower premiums, and with required underlying limits typically starting at $1,000,000, umbrella policies can be written relatively inexpensively.

True umbrella policies also offer another advantage. They may provide coverage for liability exposures or claims that might not be covered by the primary underlying policies. This happens with true umbrellas because they are unique, separate policies, with their own terms, conditions and insuring agreements. Since these true umbrella policies may drop down to provide some primary coverage in limited circumstances, there will be a separate deductible included for these types of claims; usually $10,000, it is commonly described in the policy as a self-insured retention (SIR).

The presence of an SIR in an umbrella quote is a pretty good indicator that you are looking at a true umbrella policy. Unfortunately, many policies commonly referred to as "umbrella" policies these days really aren't. The other variation in these types of policies is properly called an excess liability policy. These policies give you the same advantage as umbrellas in terms of adding limits to underlying policies. The difference is that they are written on a "follow form" basis; if something is covered in an underlying policy it will be covered in the excess liability policy; if it's not, it's not.

That's basically the insuring agreement in a true excess liability policy, so it doesn't take a lot of paper or verbiage to write such a policy. That is a tip off you are looking at an excess liability policy versus a true umbrella; it will only have a few pages. And that's a good rule of thumb to distinguish between umbrellas and excess liability policies. If the declaration pages show an SIR, it's probably an umbrella; if there are just a few pages to the policy, it's probably an excess liability policy. That rule will be pretty accurate in the majority of cases.

So, why does all this make a difference? Both these types of policies are still commonly referred to as "umbrellas", even though often they are not. The main reason people buy either of these policies is to get higher limits cheaply, and either will do that. When umbrella policies were first developed decades ago there might have been some extra coverage built in, but that's mostly gone away by now. Arguably, umbrella policies are less desirable right now; as separate policies with their own terms and conditions they require separate analysis to

make sure they mesh with underlying policies; follow form policies make things much easier.

Either way, here are some things to be aware of when buying one.

1. Pricing Variability
Pricing for these policies can vary widely. Umbrella policy rating is almost entirely a matter of individual insurance company and underwriter judgment, and market appetite of the insurer. As long as you are dealing with financially sound insurance companies, it pays to shop around. We do this for you routinely.

2. Underlying coverage
Umbrella policy conditions usually call for maintenance of underlying coverage. The umbrella insurer's part in a loss is determined as if the underlying policy were in force, even if it's not. The only exception is when an underlying policy is totally exhausted by payment of loss, in which case the umbrella policy "drops down" to replace the exhausted underlying protection. In some umbrellas drop-down coverage also may become effective if the primary insurer is insolvent. In any event, remember, if an underlying policy is not scheduled in the umbrella policy declarations, there is probably no coverage in the umbrella, and certainly no coverage in a follow form excess liability policy.

3. Defense coverage
A significant variation in policies has to do with defense coverage. Almost all umbrella liability contracts have provisions that, in effect, protect the right of the umbrella insurer to take over or participate in the defense of a claim that it may become involved in. Also, some contracts include defense coverage of losses when, because the underlying insurance is exhausted by the loss payment, the umbrella policy comes in as primary coverage. Some policies may include defense and appeal costs within the limits of coverage while others provide them as supplementary payments outside the limits of coverage.

4. Additional insured
Any additional insured under any policy of underlying insurance should automatically be an insured under the umbrella policy. The coverage isn't any broader than the coverage provided by the underlying insurance.

5. Indemnity or pay-on-behalf-of policy
Indemnity policies only require the insurer to make payment to the insured after the insured has first paid for covered damages or expenses. The language requires you to use your own money first and then seek reimbursement from the insurance company. With the far better pay-on-behalf-of policy the insurer promises to pay damages on behalf of the insured; the policyholder does not have to write any checks. Expenses for defense are normally paid by the insurer as they are incurred if the umbrella insurer has taken over defense, even with a pay-on-behalf-of policy.

6. Exclusions
Both umbrella and excess liability policies can contain exclusions not found in underlying policies. Don't assume that if something is covered in the underlying policies the umbrella also covers; look for any added exclusions.

An umbrella (or excess liability) policy might be right for you, but be sure you understand what the policy covers and what it excludes before buying. Like all things about insurance, it's not a simple purchase.

Surplus Lines Policy Disclosure Language - What Does It Mean?

It's more common than ever these days for insurance buyers to find themselves buying policies from non-admitted insurance companies. Seeing the words "not licensed", "insolvency" and "payment of claims may not be guaranteed" on an insurance policy can understandably cause concern, especially for insurance buyers with limited experience with the excess and surplus (E&S) marketplace.

State insurance regulatory authorities will also typically require some form of disclosure to buyers of policies from surplus lines insurance companies. You may be presented with such a form, along with a request for your signature, so it's worth taking a look at what these disclosures mean, and what you should know.

Here's a fairly typical sample of wording from a fairly representative state surplus lines disclosure form: "This insurance has been placed with an insurer that is not licensed as an admitted carrier by the State of XXX."

Wording like this that references an unlicensed carrier means that the policy in question is offered by a non-admitted insurance company. A non-admitted insurance company is one that is not licensed in the state where the risk or insured is located, and does not file rates in that state. It's important to remember that "not licensed" as an admitted carrier doesn't mean unregulated; each insurer must meet certain criteria to be an eligible non-admitted market, including regulations for financial strength and solvency. It does mean that the carrier has the ability to set their own rates and terms for the classes of business they write, leading to the flexibility in rate and form that is a key differentiator in the E&S marketplace, and key advantage to insurance buyers. It's for these reasons that these carriers and policies are most often found in specialty types of insurance policies.

Here's another phrase often seen in these various state disclosure forms: "In case of insolvency, payment of claims may not be guaranteed."

Most states have guarantee funds, paid into and supported by admitted carriers, that will offer some limited claims recovery to policyholders affected by the insolvency of an admitted insurance company. Non admitted carriers are not covered by these funds. This means that the guaranty fund of the state in question will not step in to compensate a qualified insured if the non-admitted carrier goes bankrupt and cannot pay claims. While that may seem pretty intimidating on the surface, as a practical matter there is not a substantial difference in the risk posed by a potential insurance company insolvency to an insured.

The fact that an insurance company may be non-admitted in your state has no bearing on their financial strength. In fact, insurance ratings agencies generally rate the financial strength of surplus lines insurance companies somewhat higher than admitted carriers. Almost 97% of surplus lines insurers have A.M. Best ratings of A- (Excellent) or higher, compared with 77% for the total P&C industry. And even though financial impairments in the U.S. admitted insurance industry in 2013 were at their lowest level since 2007, for the surplus lines market, 2013 marked the 10th consecutive year without any reporting financial impairment; none at all.

It's also important to note that State guarantee funds ability/authority to pay claims in case of an admitted carrier insolvency is typically very limited. Guaranty funds vary by state and can impose significant limitations on the payment of funds to policyholders of insolvent insurers. Insureds with significant assets may be excluded or limited in their ability to file a claim; coverage does not apply to all lines of business and limitations on the amount of a claim payment either through a maximum cap or deductibles is the norm. You may get some money, but coverage won't be as broad nor limits as high as what you originally paid for. All this negates much of the perceived value of admitted over non-admitted paper.

So what does this all mean? Non-admitted insurance companies are not something to fear, and due to their greater flexibility in rates and forms, may often be preferable. Whether admitted or non-admitted, you need to be careful to deal only with financially sound insurance companies. This is just common sense; an insurance policy is basically just a promise to pay at some point in the future if some covered event happens, you want to have some comfort the policy is written by a company that will be around when the time comes to start cutting checks.

For our part expect us to only deal with financially sound insurance companies. There may be times when we show you a carrier with a less than top rating, but those will be unique and unusual situations. We'll always fully disclose any carrier we show you with less than excellent ratings, and explain why we are showing them to you. And we keep an eye on the insurance companies we use, so we can keep you informed of any changes with those you buy from.

Work injury reporting rules raise concerns

We reported in last year's Spring edition about changes in OSHA's reporting requirements for fatalities and serious injuries. The new standard, effective January 1, 2015, requires that OSHA be notified within eight hours of a fatality and 24 hours of an employer learning of a serious injury.

Last December the agency also introduced a new reporting website giving employers the option of reporting online instead of telephonically to the local OSHA office or the 24-hour hotline. In its first month of use OSHA reported receiving 252 reports online. That compares to the average of 200 to 250 new reports each week in 2015 when the revised rule went into effect and when reports were only made over the phone. Now, however, some attorneys are recommending that employers avoid using the website to report injuries, for fear the information will be used against them.

OSHA does not care what method employers use to report injuries or fatalities, what is most important to them is that employers meet their obligation to report these types of severe injuries within the required time frames. The website does make it more convenient for employers to report such incidents timely, and it's important that employers do so since OSHA has cited employers for failing to do so. The problem is with the information that must be supplied in order for the online report to be accepted. The website requires more extensive information than is required when phoning OSHA to report such incidents, and employers cannot submit an online report through the website without filling out all mandatory fields. That includes much of the same information that OSHA seeks during its rapid response investigations.

That's a particular concern given the short reporting time frames. As a practical matter it's almost impossible for an employer to complete an effective and thoughtful incident investigation in eight hours or even twenty-four hours. Attorneys working in this area counsel caution, saying that it's premature to commit in writing to some version of an incident before a full investigation has been done. A phone call does not commit an employer in writing to any version, whereas an employer's own

written words on the website are their words, and they are married to them throughout the process.

That's a concern because OSHA can use the information from the website reports against an employer during a subsequent enforcement action or as a road map for an inspection, and the reports will be accessible to the public under the Freedom of Information Act, meaning unions, competitors or plaintiff lawyers can access them. Information submitted in haste and without careful thought could be used as an admission of fault. Once made, that admission is hard to back away from, even if the employer found out after the initial report that things were not exactly what they thought at the outset.

The reporting rule has broad applicability; all employers under OSHA jurisdiction must report workplace fatalities and serious injuries, even those who are normally exempt from routine OSHA recordkeeping because they have 10 or fewer employees or they operate in low-hazard industries. For those employers, or any who do not normally deal with these types of workplace injuries and who may be unfamiliar with the process and potential repercussions, a phone report may continue to be the best option. Even then, and even on the phone, at this early stage just report the facts that you are absolutely sure are the correct facts, and avoid adding any conjecture, analysis or speculation.

And mind those deadlines.

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