INSURANCE 101 – MITIGATING RISK AND PROMOTING COMPLIANCE

CAHF 2021 ANNUAL CONVENTION & EXPO


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QUICK OVERVIEW

- Why are we here?
  - Importance of building systems to mitigate risk and promote a culture of compliance
  - You want to get money for your communities in the event they are sued or have claims made against them and/or suffer property losses. Depending on the insurance coverage and how the claim is handled, the community may be covered for their defense fees and/or indemnity in the event of a claim and may be able to recover for a loss of property.
  - You want to maximize potentially available insurance resources.
- Today's Topics: types of coverage, tendering/noticing of claims, dealing with defense of claims with an insurer and dealing with declination of claims as well as a discussion on building a culture of compliance and its potential impact on coverage decisions.

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TYPES OF COVERAGE THAT HEALTHCARE PROVIDERS HAVE

- Errors & Omissions/Professional Liability Coverage, which cover for errors, acts and omissions of the Community and their Employees
- General Liability Policies
- Directors & Officers/Management Liability Policies
- Employment Practices Liability Policies, frequently a coverage which is part of a Directors & Officers/Management Liability Policy
- Fiduciary Liability Policies, Property Policies, etc.

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ERRORS & OMISSIONS/PROFESSIONAL LIABILITY COVERAGE - Primary Coverage Healthcare Lawyers Deal With

- Almost always Claims Made, i.e., Coverage is triggered by a Claim Made during the policy period, or extended reporting period
- Typically a claim is defined as a lawsuit or a written demand for money or services (demand letter from an attorney seeking damages, would generally constitute a claim).
- It is important to recognize when you have a claim. Understanding that a lawsuit is a claim, is relatively easy for staff to understand. However, demand letters or threats can also constitute claims under many policies. It is also important to provide notice as soon as possible. Additionally, it is important to communicate to staff the importance of prompt attention to claims, notification to management and that there will be no repercussions for reporting claims. Educating your staff to the manner and importance of reporting claims to management can be particularly challenging when you have multiple facilities.

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LET'S TALK ABOUT RISK

How do we work to mitigate risks?

- Systems for prevention of risks
  - Recognizing potential risks
    - Training, processes, in-services, etc.
  - Implementation of systems
    - Clinical and operational, hotlines, etc.
  - Executives
    - Risk management, privacy, clinical compliance, etc.
- Systems for handling risk post-occurrence
  - Dealing with the aftermath of an event
    - Safety, investigations, reporting, tendering, etc.

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CREATING A CULTURE OF COMPLIANCE

- Potential benefits to community
  - Helps identify areas of risk
  - Creates opportunities for proactive change
    - Education
    - QAPI review
    - Internal monitoring/audits

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CREATING A CULTURE OF COMPLIANCE

- Other reasons to create a culture of compliance
  - Potential regulatory impact
    - 42 CFR § 483.85 (F895): Phase 3 implementation of full compliance and ethics program
    - Abuse reporting (42 CFR § 483.12 (F600-604), mandatory reporters, state reporting)
    - 22 CCR 72541 : Unusual Occurrence
    - Liability for actions of employees
  - Civil litigation
    - Whistleblowers
    - Residents and family members

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EXAMPLE 1:

In January 2020, a resident with dementia snuck into an elevator and traveled to a lower floor of the community. When she exited the elevator she tripped on a set of steps, suffering serious injuries.

Prevention?

Post-occurrence?

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TENDERING/NOTICING CLAIMS

- What: Notify your community's insurers and any other parties' insurers, which provided additional insured ("AI") coverage to your community, of the claim
  - First-party claims v. third-party claims
    - Third-party claims: a demand or lawsuit from a third party that allegedly suffered a loss, is a third-party claim and your community will want a defense and indemnity.
    - First-party claim: If your community suffered the loss themselves. Common examples might be cyber or property losses. Then you're notifying the insurer of a loss and seeking payment.
- Why: Prerequisite to getting coverage
- Why not: Usually no reason not to. That's why your community bought insurance. If your community is concerned about renewals and premiums, it may choose not to tender or provide notice of a loss. Specific concerns in this regard should be discussed with the community's insurance broker.

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TENDERING/NOTICING CLAIMS *(continued)*

- How to Tender: Send a letter with a copy of the claim in the third-party context, or with a succinct general description of the loss in the first-party context.
  - "Claim" – Traditionally, a demand or a lawsuit. Might also include a subpoena, a government investigation, DFEH notice for employment claims etc.
  - Bare bones tender – Just ask for coverage without discussion. You don't know why the carrier might accept or deny coverage, and you don't want to give the carrier any ideas about denying coverage. You can always address any alleged bases for denial upon receiving a denial or reservation of rights letter from the insurer.
- From Whom: Your community or the broker
- To Whom: All the carriers (including AI carriers) via certified mail, fax numbers, and e-mail addresses. Frequently, claims notification addresses are specified in the policy.

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TENDERING/NOTICING CLAIMS *(continued)*

- When: Do it ASAP-coverage for defense costs does not begin until a claim is reported.
  - You do not need to evaluate the policy for coverage before tendering. It may help the community to know their potential for coverage as soon as possible. However, if the carrier accepts coverage, a delay for analysis will have likely been unnecessary and time-consuming exercise and it may have the financial impact of disallowing pre-tender costs.
  - Some policies provide claims-made-and-reported coverage, meaning that the claim must be made against the insured within the policy period and reported to the insurer within the policy period or some (usually brief, if available at all) extended reporting period.
  - Others are occurrence-based, which means the occurrence which led to the injury took place during the policy period. (i.e. slip and falls of non-residents/patients) All carriers expect notice of a claim as soon as the client is informed of it and sometimes within a certain number of days.

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TENDERING/NOTICING CLAIMS *(continued)*

  - Other policies that do not have a claims-made-and-reported feature still have de facto time limits within which a claim or loss must be timely submitted due to contractual limitation periods (sometimes as short as one year from the date of loss)—i.e., shortened periods for suing the insurers.
  - Notice-prejudice rule – Usually, in California, if notice is provided late and there is no prejudice to the insurer, coverage cannot be denied for that reason alone, unless the policy is claims made, where timely reporting is a prerequisite to coverage. However, Courts will enforce a claims made policy's reporting provisions.
  - Coverage for defense purposes begins on day of tender and no earlier. In other words, there is no coverage for pre-tender defense expenses.

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ENCOURAGING A CULTURE OF COMPLIANCE?

- How do we create a culture of compliance?
  - Visible leadership
  - Frequent education and testing, evaluations
  - Clear anti-retaliation policies/practices
  - Staff invested in the success of the community
    - Professional licensure
    - Mandatory reporters
    - All working together
    - Performance reviews
    - Competitive/regulatory advantage
  - Clear, effective, anonymous methods for reporting

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EXAMPLE 2:

The van driver secured a wheelchair bound resident with bungee cords because the restraint mechanism was broken. During transport the resident tipped over and was injured.

- Option 1: This incident was not reported to management. A lawsuit is later filed.
- Option 2: This incident is investigated by CDPH and brought to the attention of management through this investigation 8 months after the incident. No lawsuit has yet been filed.

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THE COVERAGE DETERMINATION

- Your tender was rejected – now what?
  - Are there grounds to rebut the denial?
    - You only need the potential for coverage for a defense
    - If the denial is based upon differences in policy language interpretation, California courts and many other state courts will favor the policyholder.
    - Consider whether you have additional facts to provide to the insurer or whether additional facts can be developed?
  - Is there an opportunity to settle?
- Your tender is accepted - now what?
  - You will likely receive a "Reservation of Rights" letter – That means the insurer will provide coverage but reserves its rights to withdraw or seek reimbursement if coverage is found to be unwarranted.

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THE COVERAGE DETERMINATION *(continued)*

- Carrier might assign panel counsel at the insurer's negotiated rates. Such attorneys are in a tripartite relationship and have a duty to both the community and the carrier, with their primary duty to the community/insured.
  - You may want your own independent ("*Cumis*" or "independent") counsel, Cal. Civ. Code Sec. 2860. The insurer does not have to pay for independent counsel unless there is a potential conflict of interest with the insurer. For example, if panel counsel might take a defense position that could, if prevailed upon, take the community out of coverage, then the client is entitled to *Cumis* counsel.
- If you decide to retain independent counsel the carrier will likely only pay defense rates which it regularly pays its panel, which may be lower than what charge.
  - An insurer may be able to seek reimbursement of defense costs paid if they reserve their rights to do so at the outset after assuming the defense and it is subsequently determined there is no potential for coverage.
  - Settlement - make sure any settlement is final and the insurer has agreed it cannot seek to recoup or be reimbursed funds it has paid toward defense or indemnity, if at all possible.

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COMPREHENSIVE RISK AND COMPLIANCE

- Compliance program broad enough to cover a broad range of potential issues
  - Regulatory risks
    - OSHA, CDPH, CMS, OIG, DOJ, etc.
  - Personal injury
    - Accidents, clinical care, etc.
  - Employment issues
    - Staffing, harassment, retaliation, etc.
  - Cyber activities
    - Ransomware, etc.
  - Other

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WHAT'S COVERED? WHAT'S NOT?

- Scope of types of policies and what they cover CGL, Professional Liability/E&O/D&O, EPLI, Property, Cyber, Crime, Auto, Workers Comp/Employers Liability, Excess.
- Community needs to review all potential coverages to determine which insurance policies should respond to a given claim. Assistance of a broker or coverage attorney is recommended.
  - What's typically not covered? Examples:
    - Contract liability (except for contractual indemnity obligations and liabilities referenced in a contract
    - Pollution (except under pollution policies)
    - Intentional acts (subject to certain exceptions/limitations)
    - Business interruption due to coronavirus and/or injuries caused by coronavirus

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WHAT'S COVERED? WHAT'S NOT? *(continued)*

- Excess concerns – If it's not covered under the primary policy, it generally won't be covered under excess. There may also be another retention and/or other exclusions in the excess policy restricting coverage.
- Allocation clauses – If the policy has such a clause, the carrier may be able to limit its defense to covered claims.
- If your client is an AI under a policy, it may only be covered for acts or omissions arising out of the actions/activities of the named insured (i.e., vicarious liability).

– What are the real limits?

- Deductibles and self-insured retentions
- Eroding/wasting limits – defense fees may count towards the limit

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