Is your insurance coverage adequate?

Operators face a slew of new challenges, from policy restrictions to payout caps

By Linda E. Klamm and Samantha Wolff

The first elder care claims began plaguing the senior living industry in the 1990s. Providers' insurance was called upon to respond to these claims. Over the ensuing decades, this has led to changes in how insurance coverage for senior living providers is structured and applied.

Claims-made policies require prompt reporting

One of the biggest changes in coverage is that most policies providing coverage for senior living claims are now of the "claims made" variety: Coverage starts when a claim is initiated by the resident or his or her estate. "Occurrence" policies begin when the injury occurs.

Many of the policies are also "claims made and reported," which means that for coverage to attach, the claim must be initiated by the resident and reported to the insurer within the policy period, or within a specified time period after the policy expires.

This is usually not an issue when the first notice of a claim is a lawsuit. However, the term "claim" is broader than mere lawsuits and may include threats of lawsuits (such as a letter from an attorney on behalf of the resident or the estate), notifications of displeasure from the family and investigations by governmental agencies.

This broad definition creates a reporting dilemma for providers, who must determine whether they are on notice of a claim such that their duty to report it to the insurer has been triggered.

It is imperative that a senior living provider know whether it has a "claims made" policy. If so, claims must be reported in a timely fashion.

When in doubt, always report. Although your premium may increase, it will not rise to the cost of an uncovered claim. Further, you must disclose even uncovered claims on future applications for coverage in response to questions regarding loss history.

Most policies contain a provision so that the reporting of an incident, which does not yet constitute a claim, is covered under the policy it was originally reported under if and when it becomes a claim.

Worst-case scenario: If a provider does not report a claim within the policy period, it will not be covered. It won't even be covered under subsequent policies, as it is considered a pre-existing claim.

Insurers will exclude from coverage pre-existing claims that should have been reported under previous policies. Insurers tend to analyze these issues using a 20-20 hindsight that is unfavorable to the provider.

Certain policies may deplete money available for settlements

Most policies covering senior living providers are now burning, wasting or self-consuming limits policies. This means that defense costs and fees deplete available coverage limits.

For instance, a $1 million-per-claim policy limit means that there is a maximum in available coverage limits of $ 1 million for defense and indemnity (settlement, damages, etc.). Other policies have limits for defense costs broken out separately.

Know whether you have a wasting limits policy or a sub-limit for defense costs. If you do, it is essential to assess a claim as soon as possible as to liability and value, so that limits are not unnecessarily depleted by defense costs. If there is a sub-limit for defense costs, the provider needs to make sure it has sufficient remaining limits to fund the defense.

Exclusions for allegations of abuse

Recently, policies have been issued with new and problematic exclusions and sub-limits. There is a new version of the "abuse and molestation" exclusion which insurers will apply even if there are merely allegations of abuse, irrespective of proof.

Since most claims arising out of senior living community operations include claims of abuse, these exclusions effectively eliminate coverage under the policy.

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Some insurers provide coverage, but have a dollar limit on abuse and molestation claims. If a policy has such a limitation, coverage for resident claims is restricted to the abuse limit.

Many insurers will issue excess coverage that does not apply to abuse and molestation claims, arguably limiting coverage to the primary abuse and molestation coverage limit for resident care claims.

A number of recently issued policies seek to exclude plaintiffs' claims for attorneys fees, either by an exclusion or as an exception to the policy's definition of damages the insurer covers.

Avoid such exclusions and limitations wherever possible. Have your broker prepare a summary of coverages whenever a new policy is obtained and specifically inquire whether such limitations exist.

Is your coverage adequate?

Given the increase in verdict and settlement ranges for claims arising out of senior living communities, it is always important to consider what limits should be purchased and whether excess coverage is warranted.

Most primary policies have $1 million-per-claim and $3 million aggregate limits, which will cover as many residents and facilities as are insured under a given policy. Recently, the California legislature set minimum insurance coverage limits for residential care facilities.

Providers should expect more such regulatory legislation in the future and monitor applicable state insurance requirements for compliance.

Operators must carefully consider how the number of residents and facilities insured may impact coverage. Think about whether coverage is sufficient given past loss experience and/or whether there are available assets to reasonably respond to expected claims and losses.

Class action considerations

In the last few years there has been a proliferation of class-action claims. Such claims pose numerous coverage issues for senior living providers.

Initially, class actions constitute only one claim under a policy, regardless of class size. Additionally, many policies have anti-stacking provisions that may prevent more than one policy from responding to a claim, even though multiple facilities may be involved and insured under separate policies.

Insurers faced with class-action claims tend to try to limit coverage further by arguing that class actions seek restitutionary remedies, i.e. the return of fees and payments, which are excluded under the policies. Insurers also argue that they do not cover the types of claims being asserted.

Given the recent rise in class actions arising out of senior living community operations, many of these and other coverage issues have not yet been addressed by our legal system. The typical risks inherent in class-action litigation — including the risk of large judgments and drawn-out, expensive litigation — are only compounded by these coverage issues.

Operators must retain the best defense counsel they can afford and have them work in tandem with coverage counsel from the outset to maximize your coverage potential. ■

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