Malpractice Insurance: A Primer for Urgent Care Clinicians

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The possibility of being sued for medical malpractice, while not a pleasant prospect, is not something that should be causing you sleepless nights. Much like flood insurance, malpractice insurance exists for times when an unexpected event occurs and may require some payment for damages. Your goal should simply be to have adequate coverage for those times. And, let's face it, there may be such times. Good providers do get named in malpractice suits. Being sued for malpractice is a cost of doing business.

With this in mind, let's consider what is important to know about malpractice insurance.

The Insurance Contract

Insurance contracts are enforced by the terms of the written policy. Basically, they contain a promise by the insurer to pay or indemnify and to defend all claims covered by the policy against the provider (in insurance-speak: the "insured"). This duty to defend is very broad but not unlimited. For example, in an Arizona case, a malpractice insurer was not required to defend a physician when the plaintiff sought damages for sexual assault since the policy did not cover intentional misconduct.

An insurer may still defend the insured even if the insurer does not believe coverage exists under the policy; the insurer may then seek redress for the coverage issue. For example, if a claim alleges both negligence and intentional misconduct, the insurer is required to defend both; however, if the provider is found liable for both causes of action, the insurer may have no duty to pay damages arising out of the intentional misconduct claim.

Types of Coverage

There are two types of malpractice coverage: claims-made and occurrence. Claims-made policies provide coverage for claims made against the insured during the policy period. For example, if a provider is notified that he is being sued for malpractice on the day before his policy expires, and the provider in turn notifies the insurance company on the day after the policy expires, the provider may still be covered.

But please review your policy. Some policies require that the claim must be sent to and accepted by the insurer while the policy is in force. In this case, notice to the insured does not constitute the claims trigger. Also, if a plaintiff files a suit against a provider on the last day of coverage but does not serve the summons for 30 days, coverage still exists. However, if the suit is filed after coverage lapses, coverage does not exist even if the event occurred during the policy period.

Claims-made policies are easier for the insurer to price since they allow the carrier to better predict the limits of their liability and thus more accurately predict the premium necessary to cover their exposure. Claims-made policies also provide a prior-acts clause or retroactive date. Depending on the date, this could either include or exclude coverage for prior medical services. The specifics in your policy should be based on what your needs and situation are. Typically, prior coverage is obtained when changing from one claims-made policy to another claims-made policy.

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Occurrence policies provide coverage if the event (the "occurrence") happened during the policy period, regardless of when the claim was filed. Some problems are inherent in these types of policies (especially for the insurer). For example, if treatment extends over a lengthy period of time, it may be difficult to determine when the actual occurrence took place.

Take a provider who is working in an urgent care center and sees a patient on Sunday when Policy A is in place and diagnoses the patient with abdominal pain of unknown etiology. The patient returns on Tuesday when Policy B is in effect and has a ruptured appendix, which results in a malpractice suit. Which policy was in effect at the time of the occurrence? This is something the insurers must determine.

In addition, occurrence policies create significant underwriting challenges secondary to the long tail exposure, which results from their open-ended nature.

Extended-Reporting Endorsements

Extended-reporting endorsements, also known as "tail" coverage, are required when a provider discontinues a claims-made policy and does not have his new insurer assume the prior liability. For example, a provider may be selling his practice or have had claims for which his new insurer does not want to assume any prior liability.

A prior-acts endorsement may be part of the policy or it may be purchased separately. These policies can extend the ability to report claims from past services from one year up to an unlimited period of time. They protect the insured against events that occurred during the reporting period but for which claims were filed after the expiration of the claims-made policy.

Extended-reporting endorsements are typically priced at a multiple of the last year's premium. The multiple varies by specialty and region of the country but is typically 200%-300% of the mature claims-made policy amount. For example, if an urgent care provider paid $30,000 per year for his mature policy, a tail coverage policy could cost him up to $90,000.

Some insurance carriers provide "complimentary" tail coverage if a provider who is retiring has not had any claims. However, free tail coverage for retirement is not available when the policy is written on a clinic as a whole rather than on each individual provider.

Another way to end a claims-made policy without purchasing a tail provision is to purchase "prior-acts" coverage with the subsequent claims-made policy. Prior-acts provisions insure the provider against loss after a specific start date. For example, if a provider has had a claims-made policy for two years and then has to cancel the policy and changes jobs, he can obtain a prior-acts policy for the two preceding years and negate the need for tail coverage. Sometimes, however, a new employer may be loathe to assume prior-acts coverage for the provider's prior work; in this event, tail coverage must be purchased.

Gaps in Coverage

An incident sparking a malpractice suit may occur during the policy period, but if the claim has not filed until after the policy has expired, the insurer is not obligated to defend it. If the provider does not obtain an extended-reporting endorsement or prior-acts coverage, a gap can occur in his coverage. Such gaps can lead to significant cost issues if the provider allows himself to go completely uncovered. Moreover, once a provider has gaps in his insurance coverage, he becomes much more difficult to insure during subsequent policy periods.

This being the case, be sure to keep copies of your declarations page ("dec sheets"), which prove that you have no gaps in your insurance coverage.

Discovery Clause

When a policy is renewed, an insurance company typically requires an applicant to complete a document itemizing facts or circumstances that have already transpired that might give rise to a claim. If a provider knows of circumstances that may result in a claim and fails to disclose them, he will be accused of fraudulent misrepresentation in the event of a malpractice suit arising from an undeclared but known event.

On the other hand, if a provider does provide full disclosure, the insurer may not cover him against the possibility of a malpractice suit for that particular event. On a positive note, with a claims-made policy, a provider is advised to notify the insurer if he becomes aware of an incident that may give rise to a cause of action. This way, even if the eventual claim is filed after the policy terminates, the claim is usually considered to be made during the policy period.

Deductibles and Policy Limits

You can purchase insurance that either has "first-dollar coverage" (ie, no deductable amount) or that has a deductable amount. Obviously, the higher the deductable amount, the lower the cost of the insurance. The deductable is applied to the cost of the associated court or attorney fees or to the actual dollar amount of any judgment.

"Policy limits" are the amount the insurer is obligated to pay on your behalf. Typically, limits are divided by the amount payable on any one occurrence and the amount paid out during one policy year. For example, a $1 million/$3 million policy means that the insurance company will pay up to $1 million on any one claim and up to $3 million in any policy year.

Some policies are known as "diminishing-limits" policies. These policies wrap the cost of legal defense into the payout limits. Diminishing-limits policies are of much less benefit to the insured because the defense cost will continually reduce the net amount available to pay damages. Typically, these policies are less expensive than policies that are cost-exclusive.

The determination of appropriate policy limits is essential

to ensure that both the provider and the practice are adequately covered. If the provider is an independent contractor, a judgment in excess of the policy limits could place his personal assets at risk. If the provider is an employee, the practice is typically responsible for covering any judgment that exceeds policy limits.

Settlement of Claims

A malpractice insurance policy often gives the insurer the right to decide whether to settle a claim. The insurer owes a fiduciary duty to the insured to protect his interests. This means that the insurer has an obligation to settle a claim to protect against a judgment exceeding the policy limits. This obligation is a trigger. When the demand is within policy limits, a reasonable insurer would settle the claim, although it is possible that a verdict could exceed policy limits.

When an insurance company refuses to settle a case and the judgment exceeds the insured's limits, thereby exposing the insured to additional costs, the insured has a potential "bad faith" claim against the insurance company. When this occurs, the plaintiff's attorney may actually indemnify the defendant and then together they would pursue a bad-faith claim against the insurer.

Some malpractice insurance policies contain a clause giving the insured consent rights regarding settlement. This means that the insurer cannot settle a case if the insured refuses to consent to the settlement. When deciding not to settle, however, the insured must consider the possibility that the verdict could exceed his policy limits.

Occasionally, policies with a consent clause also contain a "hammer clause." A hammer clause is a provision stating that if the insured refuses to settle and the verdict is in excess of the proposed settlement amount, the insured is liable to the insurance carrier for the amount paid in excess of the proposed settlement.

Finally, whether a case is settled or lost, any time a payment is made on behalf of a defendant to a plaintiff, the defendant must be reported to the National Practitioner Data Bank (NPDB). I know of some provider groups that are covered under a hospital's high-deductible policy and that have been forced to settle claims for actions for which they did not believe they were culpable. In other words, the providers felt that they were "thrown under the bus" so that the hospital could settle the claim. Consequently, they were reported to the NPDB and ended up with a black mark on their records.

In the end, malpractice insurance is a cost of doing business. A good insurance broker can steer you in the best direction regarding the type and amount of coverage that makes the most sense for you. ■