



Is Your ASC Properly Insured?
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If you have an interest in an Ambulatory Surgery Center (ASC), you should be aware of the difficulties in adequately insuring against professional liability exposure. Many of the existing policies that cover these entities have serious deficiencies. Fortunately, the insurance market for ASCs has improved, so owners and administrators can now secure proper coverage, as long as they know what to look for.

The following is a summary of some of the most important issues faced when covering ASC professional liability.

Important Coverage Provisions:

Occurrence vs. Claims-Made Coverage:

An occurrence policy provides permanent protection, so is generally the preferred coverage for a surgery center. Only recently has this coverage become readily available, as has the ability to convert from a claims-made policy to an occurrence policy.

An occurrence policy will respond to a claim as long as coverage was in place when the professional services at issue were rendered (or “occurred”). A claims-made policy, by contrast, only responds to a claim if the coverage is in place when a claim is made. Many physician owners, management companies and even administrators fail to appreciate the potential future liability associated with claims-made coverage.

When a claims-made policy is terminated, all coverage is lost unless extended reporting coverage (a “tail”) is secured. The customary free tail options associated with physician claims-made policies are generally not available on facility policies. As a result, obtaining a tail may be expensive. What’s worse is that the tail options on many existing claims-made policies can be severely limited, and can lapse before the statute of limitations runs out, thus leaving the facility and all of its members potentially exposed.

Medical Director:

Most healthcare facilities are required to name a medical director that is in charge of setting certain medical protocols, policies and procedures. Many physicians that serve as medical directors wrongly assume that their individual medical malpractice insurance policies will cover them for this exposure.

The most common and sound way to cover a medical director is through the facility’s professional liability policy. Policies that do not include this important coverage should be avoided whenever possible.

Professional Liability Specialists

Consent to settle clauses:

Surgery centers should also attempt to secure a policy that provides them with the absolute right to determine whether to settle a case. Policies that omit this clause will put the unilateral decision to settle a case in the hands of an insurance company. Often, settling a case may be less expensive than the high cost of litigation, while also removing the risk of a large verdict. Unfortunately, facilities may experience long terms problems by settling claims.

“Hammer” Clause

Lesser known than its relative the consent to settle clause, the hammer clause is a different means to achieve the same end: Settlement. Under a hammer clause, the policyholder typically retains the ultimate right to settle a case. However, if the company recommends settlement, and the policyholder refuses, that policyholder will be liable for some portion of a judgment, if a jury finds in favor of the plaintiff. For example, a hammer clause may provide that the policyholder will be responsible for any amount above a settlement figure that the plaintiff was willing to accept before trial.

Company Selection:

Admitted v. Non-admitted:

When an insurance company properly files and receives approval from a state for its rates and underwriting guidelines, it becomes an “admitted” carrier.

While the coverage terms between an admitted and non-admitted carrier may be similar, the difference is profound.

Admitted carriers are required to follow the guidelines (e.g. premium setting) they file with the respective states in which they write coverage. To change these guidelines, companies must file the appropriate documentation and adhere to the approval processes. A non-admitted carrier has no similar obligation, and has full discretion to change premiums, and even to decide whether to renew or not renew coverage.

To protect insureds from being sold “Non-Admitted” policies, New Jersey, for example, requires brokers to attempt to place coverage with admitted carriers before going to non-admitted carriers. However, these guidelines are easily, and often irresponsibly, circumvented. It is therefore up to the facility to work with a specialist that will secure coverage with the most suitable carrier, instead of the most accessible.

Ability to Handle Claims:

In addition to selecting an admitted carrier, administrators should also seek companies with strong financial reserves *and* experience in handling claims in the state in which the



center is located. Even if a carrier has a strong financial strength rating, it may lack the necessary expertise both in managing risk and litigating claims specific to ASCs.

Other important Provisions:

Facilities should always ensure that deductibles are reasonable and limits are sufficient. If written on a claims-made form, the policy should have an “incident” reporting trigger, which allows a policyholder to report an incident and have immediate coverage. By contrast, a “written demand” trigger requires the policyholder to receive a demand for monetary compensation in writing before a claim is covered. If coverage is on a claims-made form, a written demand trigger can make it difficult for a policyholder to switch companies, as no company wants to accept responsibility for a potential claim.

Risk management must be a continuing priority for ambulatory surgery centers. Working with specialists who are familiar with professional liability issues is essential for the protection of both the facility and the professionals associated with it.

Brian S. Kern, Esq., is a Co-Founder and Partner of Argent Professional Insurance Agency, LLC, an agency specializing in healthcare professional liability.