EVACUATION AND DISASTER COVERAGE CONCERNS
WHEN DISASTER STRIKES AND EVACUATION DECISIONS FOLLOW:

PROFESSIONAL AND GENERAL LIABILITY COVERAGE CONSIDERATIONS FOR LONG-TERM CARE OPERATORS

The challenges faced by health care facilities during and after a disaster are serious and legion. Evacuation of such a facility is difficult enough; insurance tangles afterward only add insult to injury. In the aftermath of Katrina, the interpretation and application of insurance policy provisions proved murky at best, and at worst – contentious. Disputes have arisen over the interpretations of flood vs. windstorm, the application of limits, the determination of deductibles and the insured's requirements in the event of a loss. And Katrina is only one example of the type of event that can lead to an evacuation. The floods in Nashville and Iowa in 2010, tornadoes across the plains states, earthquakes and wildfires in California – these are a few of the natural disasters that can compel the evacuation of a health care facility. Even those facilities in areas not prone to natural disasters can have facility-specific incidents that precipitate an evacuation, such as noxious fumes caused by bleach and ammonia dumped in a laundry drain.

These events highlight the need to examine and amend insurance contract language in the context of what can happen in extraordinary evacuation situations. Health care providers experience their own unique problems in dealing with the evacuation-related coverage issues. Some of these issues, with recommendations, follow.
EVACUATIONS: WHAT TYPE OF CLAIM OCCURS...

GL (GENERAL LIABILITY) OR PL (PROFESSIONAL LIABILITY)?

Many health care facilities, including long-term care (LTC), senior housing and hospitals, may have residents or patients who are injured during a hurricane or other disaster and who may bring suit. The dilemma starts when the insurer and policyholder must agree on what constitutes a general liability vs. a professional liability claim. Policy definitions are essential to any analysis of claim triggers.

Typically, general liability policies are triggered by claims as a result of an Occurrence whether the coverage is written on an occurrence or claims made basis, defined as:

An accident, including continuous or repeated exposure to substantially the same general harmful conditions.

The Professional Liability/Medical Malpractice counterpart to the GL Occurrence trigger is a claim alleging a Medical Incident in the rendering or failure to render Professional Services. One London syndicate defines Professional Services in part as:

(a) services performed by an Insured at the Facilities of the Named Insured in the treatment and/or care of any Resident, and shall include:

i) Nursing, medical, dental, therapeutic, or other professional care or services to any person

ii) The furnishing of food, beverages, medications or appliances in connection with such services

iii) The furnishing or dispersing of drugs, blood, blood products and medical, surgical, or dental supplies and appliance [emphasis supplied] (Beazley 371029)

TIP: It’s important for both the carrier and policyholder to agree on what is a general liability vs. professional liability claim. If a patient/resident in assisted living is evacuated and dies en route (i.e., not “at the facilities of the Named Insured”), is this a professional liability claim? What about a resident or patient who dies while being lifted from his or her bed to an ambulance to evacuate? Is this a general liability or a professional liability claim?

Some policies, particularly but not exclusively Bermuda-issued policies, are triggered by Occurrences that result in Personal Injury; there is a shared PL-GL limit and deductible/retention, together with common terms, that make this parsing unnecessary. (MaxRe Max CLM 01) Many others, such as the London syndicate form, are the opposite: explicit in excluding from the General Liability coverage part “claims for bodily injury sustained by any Resident.”

To the extent that there is ambiguity because there is no explicit patient/resident injury exclusion, and PL and GL do not share common terms and conditions (e.g., when one is claims-made and the other occurrence-based, or when different carriers pertain [such as when the PL is self-insured or in a state fund while the GL is not]), these differences are, to say the least, problematic.

We explore this in two contexts below:
1) The impact of “batching” or “related claims” provisions
2) The fallout when criminal acts are alleged – as they were in the Katrina evacuation aftermath

One interesting side note on the question of which policy is triggered when the evacuation of patients or residents goes awry has recently surfaced in Louisiana. Pneumonia patient, Althea Lacoste, had walked into Methodist Hospital with her portable ventilator a day before Hurricane Katrina struck and died there before rescuers arrived at the flooded, powerless building in eastern New Orleans.

In subsequent litigation, this question emerged before the Louisiana Supreme Court: “[Is] the hospital’s alleged lack of an adequate backup power system and evacuation plan an issue of medical malpractice” as claimed by the plaintiff? Or is it a management liability claim, as defendants assert – essentially saying that the board of directors and hospital officers would have liability given their lack of oversight, as they ostensibly did not have the proper policies, procedures, monitoring/auditing controls and the like to mitigate the loss? (Associated Press Alert April 12, 2007 reported by Advisen on April 13, 2007. Lacoste et al v Pendleton Methodist Hospital, LLC, 2006 C 1268, 947 So. 2d 150, La. App 4 Cir. 12/6/06)
TIP: This type of litigation underscores the need to consider management liability carve-backs (exceptions) from the Directors & Officers liability policy's typical exclusions for Medical Malpractice and Professional Services. The D&O policy will not provide direct coverage for bodily injury, professional services and similar exposures, as there are other policies that are more appropriate (e.g., Medical Malpractice and GL). This being said, in most instances, the Professional Liability/Medical Malpractice and General Liability policies do not address the breach of fiduciary duty and mismanagement claims for indirect bodily injury actions – but perhaps they should, if D&O carve-backs for indirect bodily injury arising out of mismanagement cannot be negotiated.

“BATCHING” OF “RELATED CLAIMS”

Batching occurs when a carrier deems “related claims” to be a Single Claim, subject to one deductible and one per-claim policy limit. Batching is common in defective product claims, involving multiple persons injured by the same defective product. A parallel situation occurs during an evacuation. When evacuations occur, it is possible that multiple patients/residents will be injured during transport. In fact, many long-term care operators experienced patient/resident fatalities as a result of the Katrina evacuation. The question is, “If a single event leads to an evacuation, are all claims that result from the evacuation deemed a single claim, subject to one deductible and one policy limit?”

For example: Let’s assume that a government order for evacuation has been given to a health care facility on the east coast of Florida. During transfer, one patient/resident is jarred and sustains a subdural hematoma, while a different resident suffers oxygen loss as his ventilator runs low on oxygen. Finally, a third resident who did not get her medications expires. How would the insurance carrier treat these three resident injuries?

In General Liability-speak: If not otherwise excluded, would the carrier treat the evacuation as a “repeated exposure to substantially the same general harmful conditions” and treat this as one occurrence? Or would the carrier insist that the three events each arose from a different “exposure” and only indirectly occurred as a result of the evacuation?

In Professional Liability-speak: Does the Related Claims condition apply to all related medical incidents to any one injured patient or resident or to all related medical incidents to one or more injured patients or residents?

Consider this question in the context of professional liability/medical malpractice policies that generally are triggered by a Claim alleging a Medical Incident in the rendering or failure to render Professional Services. At one end of the spectrum is the same London syndicate's Medical Incident definition and SIR Provisions read together with its Insuring Agreement, explicitly restricting claims and related claims to injury to any one resident or person. At the other end, the Bermuda forms through their integrated occurrence (XL) and specific personal injury (MaxRe) language will likely treat all the medical incident claims arising out of an evacuation as a single related (batched) claim. Two domestic LTC insurers also fall into this “batched” position; neither of their medical incident nor professional services definitions is limited to injury to any one person, and their how per claim limits apply language explicitly says the per claim limit applies “regardless of the number of claims made...or persons making claims.” (Lexington 74881 HC0023 01/05, C N A G-141442-A 06/06)

A third domestic carrier’s form is less clear: The claim trigger is a Medical Services act, error or omission. Its Medical Services definition (comparable to the London syndicate Professional Services definition quoted earlier) reads, “Medical Services means health care,
medical care or treatment provided to any individual…” The third domestic carrier’s language indicates that a single claim arises out of treatment to any individual – but then suggests that a number of injured individuals, for example asserting their claims as a class, would be deemed a related single claim:

“All Related Claims, whenever made, shall be deemed to be a single Claim, regardless of:

1. The number of Related Claims
2. The number or identity of claimants
3. The number or identity of Insureds involved or against whom Related Claims have been or could be made
4. Whether the Related Claims are asserted in a class action or otherwise
5. The number and timing of the Related Claims, even if the Related Claims comprising such single Claim were made in more than one Policy Period” (One Beacon G16817 01/06)

TIP: Batching negotiations are indeed possible. But as the third domestic carrier’s language makes clear, it is critical to first understand underwriter intent and decide whether batching is something to negotiate for. Batching is a two-edged sword that will potentially affect:

- The number of deductibles or self-insured retentions that will be applied
- Whether the loss will exceed the deductibles or self-insured retentions
- The erosion of the per-claim limits under the policyholder’s primary policy
- Whether the policyholder will need to access his or her excess layers of insurance

Policyholder and insurance carriers have often disputed the interpretation of the “related claims” or “batch clause.” There are no easy answers; what is certain is that all health care organizations should explore an underwriter’s willingness to further define how evacuations will be covered/not covered/handled by their respective claim departments.

**COVERAGE FOR DEFENSE COSTS FOR ALLEGED CRIMINAL ACTS**

Katrina also led to a criminal action being filed against a skilled nursing facility operator in New Orleans: “St. Rita's Nursing Home was built in 1985 on one of the highest elevations in the city, land which had not flooded during Hurricane Betsy in 1965. That fact figured prominently in the decision by Sal and Mabel Mangano, St. Rita’s owners, to ride out Hurricane Katrina in their one-story brick building rather than follow an order by St. Bernard Parish to evacuate the home’s 60 residents. The Manganos even invited their relatives, staffers and the staff’s relatives to use St. Rita's as a shelter, and nearly 30 people accepted the offer. For a few moments after Hurricane Katrina barreled through on the morning of Aug. 29, it seemed the Manganos had made the right decision: The parking lot was dry, the roof intact. Then disaster struck. When Sal Mangano and several other men stepped outside to inspect the grounds, they heard a low rumbling sound. A wall of water appeared, rolling toward them. The men raced back inside and fortified the doors and windows. The water hit the building, rose up the sides and then burst inside. While the Manganos and their workers frantically tried to save residents, they were unsuccessful and 35 residents died. On September 13, 2005, the Manganos were charged with 35 counts of negligent homicide [emphasis added].”*


The point of insurance is to compensate a party for harm resulting from an “accident,” i.e., an unintended act or event. When LTC operators or their employees are charged with crimes, carriers typically exercise the “intentional acts” exclusion denying both indemnification and defense for the insured. While we do not know if the owners of St. Rita's were afforded coverage by their insurance carrier, we assume that under their PL/GL coverage that their carrier is proceeding in defending the civil action under a Reservation of Rights letter with the typical policy exclusions being quoted.
What about the criminal allegations? Do carriers have an obligation to defend insureds for alleged criminal acts?

Let’s start with the bad news first: All the polices we researched for this paper contain insuring agreements that state that the coverage is triggered only when there is a claim for **Damages**. Since a criminal proceeding does **NOT** demand damages, this can, and likely will, be a basis for denying the policyholder any advancement of defense costs. Furthermore, the ever-present conduct exclusion generally results in no coverage for claims alleging criminal acts, whether intentional or not.

**TIP:** A fix to this, adapted from Miscellaneous Professional Liability policy drafting, might involve:

- Modification of the **Claim Definition** to include not only claims for damages, but criminal proceedings arising out of evacuation conduct **AND**
- A parallel carve-back to the **Conduct Exclusion** to afford coverage when the crime alleged arises from evacuation conduct or a carve-back to the Conduct Exclusion that defends until there is a final adjudication of intentionally criminal conduct.

Often, when an insured’s employees are charged with both civil and criminal allegations in LTC, senior housing or hospitals, carriers realize the benefit of providing a criminal defense to the wrongdoer, so the civil action can be minimized and/or eliminated. Even apart from offering the language modifications above, carriers have been willing to assist on a case-by-case basis in cases with criminal allegations. Whether the insurer’s claims and underwriting departments will consider providing a criminal defense depends on:

1. Number of claims
2. Severity of claim(s)
3. Media attention on claim(s)
4. Loyalty and relationship between carrier and policyholder
5. Jurisdiction of claim(s)

As a matter of public policy, the carriers cannot insure direct liability for finally adjudicated intentionally criminal acts. However, policyholders need to be ready to ask their carriers for assistance with criminal defense costs for their employees in order to minimize potential high exposure claims.

**CONCLUSION**

The questions posed above have no clear answers yet certainly are cause for candid discussions with underwriters and policyholders regarding policy intent in these scenarios. Undoubtedly, the impact of natural and man-made disasters is not only catastrophic in terms of loss of life and property, but could change the insurance industry and coverages for health care facilities, as evacuation tragedies inform our coverage expectations. As your health care risk adviser, Willis strives to achieve with underwriters the broadest coverage and, equally important, no surprises for our health care clients.

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