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# Nursing Home Liability Insurance: An Overview

**by**

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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.

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## Contents

## Executive Summary

### Background

Liability insurance has become an important issue for nursing home providers, consumer advocates, and regulators. As in any business, maintaining liability insurance is an important part of the responsible operation of a nursing home. The Insurance Information Institute defines liability insurance as "Insurance for what the policyholder is legally obligated to pay because of bodily injury or property damage caused to another person."[1] Liability insurance helps to cover the cost of lawsuits, enabling a business to defend itself and pay any awarded damages without threatening its financial stability.[2] In recent years, nursing homes in some states have experienced dramatic increases in the cost of liability insurance. In addition, many insurers have stopped offering policies altogether in some states, making coverage difficult to obtain. Policy proposals to address these problems include limits on litigation, improved state oversight of nursing homes, risk management programs in nursing homes, experience ratings, alternatives to commercial insurance, and strengthened regulation of the insurance industry.

### Purpose

AARP undertook this study to provide information about issues related to nursing home liability insurance. The study reviews the nature and extent of problems with the cost and availability of nursing home liability insurance, the causes of the problems, and their proposed solutions.

### Methodology

AARP searched and reviewed the related literature from a variety of sources, most dating from between 2001 and 2003. Key sources are summarized in Appendix 1. In addition, we commissioned Weiss Ratings, Inc., an independent insurance company rating agency, to contact companies that sell nursing home liability insurance, brokers who participate in the nursing home liability insurance market, and two state departments of insurance, to ask about their experiences and opinions. Because of the low sample size, however, their responses cannot be generalized. Appendix 2 includes a more detailed description of Weiss's methodology and a discussion of the limitations of its results.

### Principal Findings

Below are the key findings pertaining to the nature and extent of the problems, the causes of the problems, and their proposed solutions.

Nature and extent of the problems

Research on the nature and extent of the problems with the cost and availability of nursing home liability insurance is limited. Results show that, in some states, many nursing homes have experienced dramatic increases in the cost of liability insurance. However, the studies are generally limited to a particular segment of the nursing home industry, such as for-profit providers, or to a particular state, and their results may not apply to all nursing homes. In some

states, particularly in the South, many insurers have stopped selling nursing home liability insurance at any price, making coverage difficult to obtain.

Causes of the problems

Many factors have contributed to current problems with the cost and availability of nursing home liability insurance. Current problems are a result of both increased litigation and a number of other factors affecting insurance markets, such as:

- the property/casualty insurance cycle;
- premium cuts during the 1990s;
- lower returns on investment income;
- more claims and payouts and the perceived variability and unpredictability of claims;
- losses from claims resulting from the September 11, 2001 terrorist attacks; and
- insurers' business decisions.

Proposed solutions

This paper examines the six major solutions that have been proposed.

(1) *Limits on residents' ability to sue*. Nursing homes and insurance companies have lobbied for laws, referred to as tort reform,[3] that limit the ability of residents and their families to sue and collect claims. Opponents of restrictions on lawsuits, primarily consumer advocates and plaintiffs' attorneys, have expressed concern that these laws would weaken an important incentive that motivates nursing homes to provide quality care and would erode individuals' rights.

Some studies suggests that certain types of tort reform, such as a cap on damages, can improve the cost and availability of liability insurance, while other studies suggest that tort reforms are not effective. No studies have assessed the effects that limits on the ability to sue may have on quality of care or access to compensation for injured residents. In addition, state courts have found some tort reform laws to be unconstitutional.

(2) *Improved enforcement of nursing home quality standards.* Another possible solution is to improve government oversight of nursing homes and enforcement of quality standards. Strengthened oversight and enforcement may help to improve quality and thus reduce bad outcomes that may lead to litigation and higher liability insurance premiums. Because the right to sue is often seen as an important supplement to the regulatory system, some tort reform proponents have said that when such reforms make it more difficult to bring lawsuits, enforcement should be strengthened to fill in that gap.

(3) *Risk management*. Risk management refers to efforts to avoid quality problems that could lead to litigation and otherwise reduce the risk of litigation and claims. Reports from nursing home liability insurance companies and nursing homes suggest that risk management could make liability insurance more available and affordable. One drawback of risk management programs is that some of them can be expensive for nursing homes to implement.

(4) *Experience ratings.* An experience rating system rates nursing homes' insurability, including whether it has a strong risk management program, and is used by insurers to base premiums on a facility's risk. Experience rating systems ensure that nursing homes that provide quality care have reduced premiums compared to nursing homes with poor care histories, just as individuals with good driving records pay lower automobile insurance premiums than drivers with histories of unsafe driving. An example is the nursing home tier-rating system created by the Texas Department of Insurance, which currently applies only to nursing homes in Texas's Joint Underwriting Association. The Texas state insurance commissioner also established best practices for risk management for nursing homes, which insurers may consider when determining a facility's insurance rate.

(5) *Alternative forms of insurance*. Alternatives to commercial insurance include:

- self-insurance,
- group self-insurance, and
- joint underwriting agreements (JUAs) and other state-sponsored insurance pools.

Alternatives to traditional insurance have made insurance more available and affordable for many nursing homes; however, such alternatives may not be able to provide affordable coverage for all nursing homes.

(6) *Strengthened regulation of the insurance industry.* Several consumer groups have advocated for stronger regulation of the insurance industry as a solution to the cost and availability problems of liability insurance.[4]

## Conclusions

Two of the proposed solutions, namely risk management and increased oversight of nursing homes, may improve quality of care for nursing home residents. In addition, experience rating systems reward good providers with lower premiums and hold providers with a history of poor care accountable by charging them higher premiums. These merit attention as first steps in making liability insurance more affordable and available. Alternative forms of insurance may also offer solutions for many, if not all, nursing homes. These solutions should be given priority over litigation limits, which may have harmful consequences on quality of care and access to compensation for injured residents and their families.

Additional, rigorous research would be useful to better understand the effects of the proposed solutions on availability and affordability of long-term care liability insurance, as well as their effects on quality of care and access to compensation.

## Background

Liability insurance has become an important issue for nursing home providers, consumer advocates, and regulators. As in any business, maintaining liability insurance is an important part of the responsible operation of a nursing home. The Insurance Information Institute defines liability insurance as "Insurance for what the policyholder is legally obligated to pay because of bodily injury or property damage caused to another person."[5] Liability insurance helps to cover the cost of lawsuits, enabling a business to defend itself and pay any awarded damages without threatening its financial stability.[6]

The nursing home liability insurance market differs from personal insurance markets (e.g., automobile insurance) in that relatively few insurers have been active in the market at any particular time, and long-term care coverage accounts for only a small portion of income for the companies that provide this insurance.[7] Because the long-term care liability insurance market is relatively small compared to other markets, such as homeowners' or car insurance, insurers have tended not to develop expertise in the factors affecting a nursing home's liability risks. As a result, factors such as a provider's liability loss history, quality, and financial stability have had little impact on the provider's premiums or access to liability insurance.

In recent years, nursing homes have experienced a dramatically increased cost of and reduced access to liability insurance. No consensus exists on the causes of these problems. Nursing home providers and insurance companies have focused on a rise in the frequency and *severity* (total dollar amount of claim, including compensation to the plaintiff and defense costs[8]) of lawsuits. Plaintiffs' lawyers and consumer advocates, on the other hand, are likely to attribute rising liability insurance premiums to a number of other factors affecting insurance markets.

These different explanations of the causes of the problem lead to different proposed solutions. Policy proposals to address these problems include limits on litigation, strengthened state oversight of nursing homes, risk management, experience ratings, alternatives to commercial insurance, and strengthened regulation of the insurance industry.

## Purpose

AARP's Public Policy Institute undertook this study to provide information about issues related to nursing home liability insurance. The study reviews the nature and extent of problems with the cost and availability of nursing home liability insurance, the causes of the problems, and their proposed solutions.

## Methodology

AARP reviewed the following literature sources dated from 1993 to 2003, with most sources dated between 2001 and 2003:

- law review articles;
- scholarly journal articles;

- publications on the websites of organizations that analyze the insurance industry, including the Insurance Information Institute, A.M. Best, and Insurance Services Office, Inc. (ISO);
- news articles;
- studies conducted for state and federal policymakers;
- studies conducted for advocates with varying perspectives (nursing home providers, consumer advocates, attorneys representing nursing home residents, and attorneys representing nursing homes); and
- testimony from a congressional hearing.

Many of the studies are based on small samples that are not representative of the entire industry or have other methodological problems. In addition, many of the studies were conducted for long-term care provider or consumer organizations with particular political perspectives or a financial stake in the issue; these studies were not peer-reviewed before publication. Where applicable, the paper analyzes the strengths and limitations of these sources, summarizes their findings and implications for policy development, and identifies unanswered questions or areas where further research is needed.

Appendix 1 includes the following information for the key studies discussed in this paper:

- the short name used to describe the study in this paper and the year of publication;
- the issues addressed;
- the scope and sample of the research; and
- comments, such as who funded the study and limitations of the results.

In addition to reviewing the literature, AARP commissioned Weiss Ratings, Inc., an independent insurance company rating agency, to contact a sample of members of the nursing home liability insurance market—liability insurance companies, brokers, and state regulators—and ask about their experiences and opinions. Weiss conducted this research during fall 2001. The results are summarized in the text, but because of low sample size, the results cannot be generalized. Appendix 2 provides a more detailed description of Weiss's methodology and the limitations of its results.

## Nature and Extent of the Problems

Research about the nature and extent of the problems suggests that liability insurance has become significantly more costly and less available for many nursing homes in recent years. At the same time, large differences in cost and availability exist among states and among facilities within a state. As noted in the methodology discussion, the results of many of the studies should be interpreted with caution because of their limited sample size and scope and potential bias.

### Increased Cost

The few studies that have measured changes in the cost of nursing home liability insurance coverage are based on a small, unrepresentative sample or on a particular state. Thus, their findings may not represent the experience of all nursing homes. Their results suggest that premiums have increased dramatically in some states.

Increased premiums

The few studies that examined trends in premiums over time have found large increases in the average premium paid for liability insurance among those providers included in the studies. One such study was funded by American Health Care Association (AHCA), a long-term care provider association representing primarily for-profit nursing homes.[9] The study was conducted in February, 2002 and repeated in March, 2003 by Aon Risk Consultants, Inc, the risk management arm of Aon Corporation, which also provides retail, reinsurance and wholesale brokerage, claims management, specialty services, and human capital consulting services.[10] Respondents operated primarily nursing home beds, but also operated an unspecified number of assisted living, home health care, and rehabilitation beds. The 2002 study included information on insurance premiums and coverage for policy years 2000 and 2001 reported by 29 commercially insured long-term care providers nationwide. The 2003 study included insurance information from policy years 2001 and 2002 from 56 providers.[*] In both studies, respondents to the questions on insurance premiums were primarily smaller, independent, and regional providers, both for-profit and not-for-profit.

In the 2002 study, respondents to the questions about insurance information operated an average of fewer than 3,000 beds and a median of approximately 1,000 beds.[11] Respondents to the 2003 study were, on average, much smaller than respondents to the 2002 study, operating an average of 1,240 licensed beds, with half the respondents operating 61 or fewer beds.[12] (The reports did not include the total number of beds operated by respondents.) Research participants for each study were recruited through an "AHCA data call." The reports did not specify the nature of the call, how providers were selected to receive it, or how many providers received it. Hence, the response rates for the studies are unknown. Providers who were most affected by increased premiums may have been more motivated to respond. Another limitation to the study is that it relied on self-reported information supplied by nursing home providers, without detailed verification or audit. To the extent that these providers were aware of the purpose of the report (to support efforts at tort reform), they had a financial incentive to overstate or mischaracterize their costs. Because of the small sample size and other limitations, results cannot be generalized to all nursing homes.

In the 2002 study, the responding providers reported an average increase in premiums of $240,352, or 130 percent, between 2000 and 2001. In the 2003 study, respondents reported an average increase of $130,086, or 143 percent, between 2001 and 2002. Actual premium amounts were not reported, but could be calculated from the amount and percentage increases, as shown in the table below.

[*] Both studies also surveyed long-term care providers about their litigation experiences, discussed below, to which greater number of providers responded. Respondents to the questions on litigation were primarily large, for-profit national chains. For the most part, these large chains were self-insured and did not report commercial insurance coverage information but did respond to questions about their litigation experiences.

**Table 1: Changes in average insurance premiums, 2000 - 2002**

| | Aon 2002 study | Aon 2003 study |
|---|---|---|
| Ave. Premium in 2000 | $184,886 | -- |
| Ave. Premium in 2001 | $425,238 | $90,969 |
| Ave. Premium in 2002 | -- | $221,055 |

Calculated from Bourdon and Dubin, 2002 and 2003.

As the table shows, respondents to the 2002 study reported paying an average of $425,238 for liability insurance in 2001, while respondents to the 2003 study reported paying an average of $90,969 for coverage the same year. A likely explanation for this discrepancy is that respondents to the 2003 study had, on average, far fewer beds than respondents to the 2002 study and thus would be charged lower total premiums. Because of the great difference in number of beds operated by respondents, and because the studies did not provide information on premiums per bed, information is not comparable across the two studies. The median percentage increases were not reported.

A few studies examined trends in a particular state and also found large increases in the average premium. In January 2001, the Texas Department of Human Services surveyed all certified nursing homes in the state of Texas about their nursing home liability insurance costs and coverage.[13] Among the 935 homes that responded (88 percent of all certified nursing homes in the state), premiums had more than doubled since the previous year, with the average premium per bed jumping from $447 for the previous year to $973 for the current premium, an increase of 118 percent. The median premium per bed had risen from $300 to $661, an increase of 120 percent.

A February 2001 study by the Texas Senate Research Center also found dramatic premium increases for Texas nursing homes.[14] The study reported that nursing home liability insurance premiums charged by state-regulated insurers had increased from $200 per bed in 1998 to $900 per bed in 2000. Premiums charged by surplus-line insurance companies (whose rates are not regulated by the state) increased from $2,500 per bed to $5,000 per bed.[*] Results were based on Texas Department of Insurance data and interviews with Texas Department of Insurance staff.

A 2002 study in Mississippi, partially funded by a law firm representing nursing homes, addressed both litigation and liability insurance.[15†] The study's analysis of insurance costs included the results of a survey of 22 of Mississippi's approximately 200 nursing homes conducted by the Mississippi Health Care Insurance Services Corporation. For the 22 homes that responded, the cost of liability insurance rose from an average of $115 per bed to $855 per bed, an increase of 643 percent between 1998 and 2001. The median premium rose from $17,993 in 1998 to $59,569 in 2001, an increase of 231 percent. In the same study, an analysis of data from Medicaid cost reports from 167 facilities found much lower increases in premiums.

[*] In order to insure a nursing home in Texas, surplus line companies must show proof that the home was unable to secure regulated insurance rates. The Texas Department of Insurance commented that the higher rates charged by surplus line companies were partially a result of the selective policy writing of regulated insurance companies that forces nursing homes seen as riskier by insurance companies into the surplus-line market.

[†] The study's methodology and results related to insurance are discussed here. The methodology and results related to litigation are discussed later in this paper.

Among nonhospital nursing facilities, liability insurance expenses increased from $3,335,660 in 1998 to $5,621,021 in 2000, an increase of 69 percent (data were not available for 2001). The cost of liability insurance premiums represented 1.27 percent of nursing homes' average total expenses in 2000, up from 0.86 percent in 1998. The study did not offer an explanation for the variation in reported premium increases.

According to a study by the Texas Senate Research Center, as of February 2001, nursing home liability insurance was an issue in several states and was not an issue in several others.[16] The Senate Research Center conducted a state-by-state survey of state insurance personnel, legislative staff, long-term care agency personnel, and nursing home interest groups to assess whether nursing home liability insurance was a problem in their state. Respondents from eight states (Florida, New York, Pennsylvania, Iowa, Indiana, Missouri, Washington, and Kentucky) said that nursing home liability insurance premiums were a problem in their state. Respondents from the remaining five states (California, Ohio, Michigan, Arizona, and Arkansas) said that nursing home liability insurance had not been identified as an issue in their state. The situation may have since changed in some states. For example, problems have recently been reported in Arkansas (see below).

Decreased coverage

Research on coverage is limited, but suggests that the majority of commercially insured nursing homes have *not* experienced decreased coverage, that is, reductions in the limits of liability or increased deductibles. It is not clear from the literature whether, when coverage is reduced, nursing homes are paying the same amount for less coverage or whether these more restrictive insurance plans cost less, but require the insured to absorb more of the costs. Information on coverage is limited, because many of the data come from Aon's 2002 and 2003 studies, the findings from which, as noted above, cannot be generalized to all nursing homes. Other data come from one state, where conditions may be different from other states.

*Reduced limits of liability.* One way of decreasing coverage is by reducing the limits of liability, that is, the maximum amount of coverage provided by an insurance transaction.[17] The insured is responsible for any losses above the limit of liability. Limits of liability may be on a per occurrence basis or an annual aggregate basis.

Aon's 2002 and 2003 studies both found that the *average* per occurrence limit for respondents was reduced by nearly half a million dollars ($488,679 between 2000 and 2001 and $474,074 between 2001 and 2002).[18] The studies did not report the per occurrence limits before or after the decreases or the percentage of the decreases. However, in both studies, the majority of providers—20 of the 27 respondents in 2002 and 50 of 53 respondents in 2003—reported no change in their per occurrence limit of liability. Thus, a few providers accounted for most of the decrease in coverage. Five respondents to the 2002 study and three respondents to the 2003 study reported having had coverage reduced by half a million dollars or more per claim.

In addition to per occurrence reductions, annual aggregate limits of liability were also unchanged for the majority of respondents to both Aon studies.[19] In the 2002 study, annual aggregate limits of liability declined by an average of $2.3 million between 2000 and 2001, with the majority of this reduction experienced by three of the 27 respondents. Similarly, in the 2003 study, annual

aggregate limits of liability were reduced by an average of $624,000 between 2001 and 2002, with a majority of the increase experienced by seven of the 56 respondents.

*Increased Deductibles.* A second way of reducing coverage is by raising deductibles. Two studies asked providers about deductibles and had contrasting results. In a 2001 survey by the Texas Department of Human Services, 452 of the state's 1,061 certified nursing homes reported their current deductibles, while 378 reported their previous period's deductibles.[20] Between the previous and current coverage periods, the median deductible for long-term care liability insurance in the state increased tenfold, from $25,000 to $250,000, while the average deductible rose from $327,726 to $373,191. As in the Aon study, it was not clear how this decreased coverage affected a facility's premiums.

In contrast, Aon's 2002 and 2003 nationwide surveys of providers found that the majority of respondents reported little or no change in their per occurrence deductibles.[21] In the 2002 study, all 15 respondents who provided information on their annual aggregate deductibles said that their deductibles either increased slightly or were unchanged between policy years 2000 and 2001. In the 2003 study, 31 of the 33 respondents said that their deductibles were unchanged between 2001 and 2002.

## Insurers Leaving the Market

In addition to increasing premiums, several insurers have discontinued offering nursing home liability insurance altogether, particularly in southern states. Because relatively few insurers have offered long-term care liability insurance at any time, when insurers discontinue offering coverage in a state, nursing homes may be left with very few, if any, insurance companies from which to buy coverage. The scarcity of data on the topic and rapid changes in the insurance industry make it difficult to assess the extent of the problem of insurers leaving the market. Highlights from the few studies that examined the issue are discussed below.

In the Weiss survey, six of the nine insurers that responded reported they had discontinued offering nursing home liability insurance in one or more states within the past three years. None of these insurers said it anticipated that its company would stop offering coverage in any more states in the near future. Eight of the 14 brokers surveyed said they had worked with at least one insurer that had discontinued coverage in a state within the past three years. When asked in what states insurers had stopped offering coverage, insurers and brokers most frequently mentioned Florida, Alabama, and Texas.

Reports from Florida, Arkansas, and Texas show that few insurers currently provide coverage in these states.

- In its October 2001 study conducted for a trade association representing Florida long-term care providers, the University of South Florida reported that, since February 2001, no admitted insurance carriers (those regulated by the state Department of Insurance) had offered nursing home liability coverage in Florida.[22] The study also said that excess and surplus insurance carriers, whose rates are not regulated by the state, had "effectively stopped writing policies in the state." This was a dramatic change from a 2000 Florida Department of

Insurance study, which found 22 insurance companies that were writing or renewing policies for nursing homes in the state, including 17 that were writing policies and five that were renewing only.[23]

- An Arkansas news report said that, as of September 2001, 80 insurers were able to write long-term care liability coverage in Arkansas, but only five had products registered with the state insurance department.[24] Only two of those five were selling policies, however, and one of those two would not renew policies, while the other was renewing policies selectively.
- A February 2001 report by Texas's Senate Research Center said that the number of state-regulated nursing home liability insurance carriers in the state decreased from eight in 1996 to two in 2001.[25] Also, the report noted, few surplus-line carriers were willing to write nursing home liability coverage.

## The Effect of Quality of Care on Insurance Cost and Availability

In the past, quality of care had little or no effect on premiums for nursing home liability insurance, and premiums were based on the number of beds. One reason for this unselective underwriting is that the nursing home industry was poorly understood by insurers. In May 2000, the Florida legislature passed legislation to create a Task Force on the Availability and Affordability of Long-Term Care, to study and make recommendations on issues related to long-term care, including liability insurance and litigation.[26] The legislation named the University of South Florida's Florida Policy Exchange Center on Aging (which also conducted the study of Florida nursing homes funded by a long-term care provider association referred to in this study) to provide staff support to the Task Force. An Informational Report released in February 2001 presents the results of the Task Force's study. The Florida Task Force study gave several reasons why insurers tended not to develop expertise in nursing homes:[27]

- Relatively few have been active in this market at any point in time.
- Nursing home liability insurance constitutes a small portion of income of the companies that provide the insurance; the long-term care liability insurance market is relatively small compared to other markets, such as homeowners' or car insurance.
- Many insurers that left the market had been in it for only a short period and left after sustaining losses.

Besides lack of knowledge of the nursing home industry, another reason why insurers were unselective in underwriting liability insurance for nursing homes is that, in the past, insurers considered nursing homes to be good liability risks. This was because before 1995 it was relatively more difficult for a nursing home resident to sue and collect compensation than for a hospital resident (see below).[28] During this time, nursing home liability insurers lowered premiums to attract more customers. Rates were based on the number of occupied beds, and nursing home rates were typically far less than rates for hospital beds.

The research suggests that companies that provide long-term care liability insurance have become more selective in underwriting. For example, insurers often offer better rates to, or are more likely to insure, facilities with higher quality, more financial stability, or a more favorable liability history. In some states, however, premiums are increasing even for nursing homes that provide good quality care and have no history of claims.

The Weiss survey also found a trend toward more selective underwriting. The few insurers that responded reported more selective underwriting, with increased attention paid to various predictors of liability losses. Among the six insurers that responded, most said they considered only two factors in underwriting decisions three years prior to the survey: a nursing home's financial stability and its liability claim history. At the time of the survey, during fall 2001, most of the respondents said they also provided lower premiums to, or are more likely to insure, nursing homes with the following characteristics:

- not-for-profit (all six respondents);
- full-time risk manager (all six respondents);
- strong financial stability (all six respondents);
- favorable liability claim history (five respondents);
- laws limiting liability awards (five respondents);
- rural location (four respondents);
- fewer than five facilities (four respondents); and
- privately, not publicly, held (four respondents).

Three insurers that responded to the Weiss survey said their companies would decrease premiums for some facilities. Three years prior to the survey, the only quality-of-care factor for which all three insurers reported they would have decreased premiums was positive results from the insurance company's own facility inspection. At the time of the survey, there were seven quality-of-care factors for which all three insurers would "somewhat" or "greatly" decrease premiums (the dollar amounts by which they would reduce the premium were not reported):

- minimum deficiencies on state survey;
- low number of residents with pressure sores;
- low number of resident elopements (residents with cognitive impairments wandering away);
- low number of resident abuse incidences;
- low number of resident falls;
- positive results of the insurance company's own inspections; and
- thorough resident care policies and procedures.

The University of South Florida's December 2001 study, conducted for a long-term care provider association, found that the factors considered explained little of the difference in facilities' liability insurance premiums. Results were based on a survey of 422 Florida nursing homes, representing 65 percent of all nursing homes in the state.[29] The study reviewed the correlation between premiums and the following facility characteristics: profit/not-for-profit, national or regional chain, independent, affiliation with a continuing care retirement community (CCRC), faith-based, number of beds, region of the state, number of lawsuits filed in 2001, and whether the facility was uninsured. All the variables in the model combined explained only five percent of variance in premium amounts. Average annual premiums were highest for regional chains, which paid $180,210, compared to $91,108 for a national chain and $164,816 for independent facilities. These figures included payments for self-insurance as well as commercial insurance.[30] The analysis did not include any indicators of quality or the number of lawsuits filed in previous years. Data were based on survey questions about litigation activity during the study period of January 1, 2001 through October 5, 2001 and about liability insurance cost data

from the facility's July 1, 2001 Medicaid Rate Computation Letter.[31] Thus, the lack of a relationship between lawsuits and premiums is likely because insurers had not had time to adjust their rates in response to lawsuits that occurred that year.

The 2001 Florida Task Force study suggests that, in that state, premiums are increasing even for good providers with no history of claims. According to the insurers interviewed: "Insurance companies explained that premiums are high primarily because losses in the Florida nursing home industry are high and unpredictable. Even facilities that have no paid claims history are reportedly being charged higher insurance rates."[32]

## Implications of these Trends

The high cost and lack of availability of liability insurance have raised concerns about uninsured nursing homes, about Medicare and Medicaid reimbursements to nursing homes for higher insurance costs, and about access to quality care.

### Uninsured nursing homes

Problems with the cost and availability of liability insurance have raised concerns that some nursing homes may operate without insurance. Reports from Texas, Florida, and Washington say that between 11 and 20 percent of nursing homes in those states are uninsured.

- The 2001 Texas Department of Human Services study found that, of the state's 935 nursing homes (88 percent of all certified homes) that responded, 66 percent said they had commercial liability insurance coverage, and another 18 percent said they were self-insured.[33] Fifteen percent said they were uninsured.
- In the December 2001 University of South Florida study, one in five Florida nursing homes surveyed said they were uninsured.[34] Another 36 percent of facilities said they were self-insured, although it was not known whether their self-insurance met state standards. More than one in four facilities (28 percent) said they did not expect to renew their coverage, although the report did not say whether or not they intended to self-insure.
- In March 2003, the president of the Washington Health Care Association, which represents most of Washington State's 270 nursing homes, said that at least 30 nursing homes in the state (11 percent) were operating without liability insurance.[35]

In 2001, both Florida and Texas enacted laws requiring nursing homes to maintain liability insurance.[36] As of March 2003, Washington State did not require nursing homes to have insurance.[37]

As in any business, liability insurance is an important part of the responsible operation of a nursing home, because it provides a way for a facility to pay for any claims against it without jeopardizing its solvency. Uninsured nursing homes are a concern to consumers, because liability insurance ensures that injured residents will be able to collect any compensation awarded by the courts. According to the president of a nursing home association in Washington, uninsured nursing home owners do not want residents or their families to know they are uninsured, for fear of losing business.[38] The state long-term care ombudsman advised consumers to ask to see the facility's policy.

However, in the 2001 University of South Florida study, some of the managers surveyed believed there were positive outcomes for the facility of being uninsured: "They stated that they were more directly involved in lawsuits against them and were able to refuse to proceed to court or refuse to settle for what they thought were unrealistic monetary damages. When insured, many of these facilities were left out of the litigation process, with their insurance carriers settling the majority of lawsuits without any input from them at all—even when the facility felt that the plaintiff attorney's demands were unreasonable."[39] The nursing homes surveyed also reported a decrease in lawsuits against them, because having no insurance meant it was harder for plaintiffs to collect settlements.[40] Some said that staff were more watchful about situations that could lead to a lawsuit, because they believed a lawsuit could force a facility to close.

Medicaid and Medicare reimbursements

Because Medicare and Medicaid pay a large portion of the cost of nursing home care, increases in liability insurance could lead to greater Medicare and Medicaid expenditures. Of the total amount spent on nursing homes, the federally and state-funded Medicaid program pays approximately 49 percent, the federal Medicare program pays 10 percent, and private sources pay 41 percent.[41]

Although supporters of tort reform frequently refer to increased costs to Medicare and Medicaid due to litigation and liability insurance, there is a lack of data on the actual impact on these programs. For example, a 2002 policy paper by the Department of Health and Human Services (HHS), which supported the President's proposals for tort reform, stated, "Since the costs of nursing home care are mainly paid by Medicaid and Medicare, these increased costs [of nursing home liability insurance and the costs of claims] are borne by taxpayers, and consume resources that could otherwise be used to expand health (or other) programs."[42] However, the report provided neither the amount of liability costs and insurance premiums that are paid by Medicare and Medicaid nor the amount by which Medicare and Medicaid reimbursements to nursing homes have actually increased as a result of increased liability insurance premiums or increased claims. Reimbursement for nursing homes' liability expenses varies from state to state.

The 2002 and 2003 Aon studies, conducted for a long-term care provider association primarily representing for-profit facilities, presented data for "per diem loss cost [the cost of settling and defending claims] versus Medicaid reimbursement."[43] The reports stated, "In many states, the increase in liability costs is largely offsetting annual increases in Medicaid reimbursements."[44] This implies that all of the "loss costs" are being born by Medicaid. However, the reports provided no information on the amount of increases in Medicaid reimbursement that are used to reimburse for liability losses. Presenting liability loss data as percentage of Medicaid reimbursements may be misleading, because private pay and Medicare, taken together, pay about half the costs of nursing home care and almost always pay nursing homes a higher rate than does Medicaid.

Access to quality care

A point made by proponents of limits on nursing home litigation is that increases in liability insurance premiums may threaten the ability of nursing homes to provide quality care.[45] For example, a 2003 Harvard survey of attorneys who bring or defend claims against nursing homes concluded, "The diversion of substantial resources now required to defend and pay nursing home

lawsuits is likely to have an independent, negative impact on quality."[46] However, the authors did not actually measure the effect of litigation on quality of care. Charles Roadman, president and chief executive officer of the American Health Care Association, warned that increases in liability insurance premiums could "mean the difference between hiring or laying off more nurse assistants" for providers with limited resources.[47]

Such statements may be true for nursing homes that have no reserve financial resources with which to pay settled claims and are unwilling or unable to institute cost-effective quality improvements that will reduce lawsuits. However, many nursing homes, especially the larger chains, have resources that allow them to absorb losses in some years that are offset by gains in past and future years, and many are developing quality improvement programs.

Some studies cast doubt on the premise that the money nursing homes spend to defend claims or pay for liability insurance would otherwise have gone towards improving resident care. Two studies by the General Accounting Office (GAO) (see below) suggest that there is little relationship between the amount of money available to nursing homes and their spending on staffing.[48] A 2002 *U.S. News and World Report* investigative report examined nursing home financial statements and concluded, "The nursing home industry's cries of poverty don't add up."[49] The findings showed that, "The nursing home industry is profitable and growing, with operators spinning a far brighter tale for Wall Street than for Capitol Hill. Many nursing homes are earning exceptionally healthy profit margins, often 20 and 30 percent." The investigation also found that substandard care could not always be blamed on lack of funds. *U.S. News* described one nursing home where "the home's operator has reaped millions to furnish an affluent lifestyle that has included a small fleet of luxury cars, a million-dollar mini-mansion, and trips to Hawaii and Lake Tahoe." Despite these profits, state inspectors had found "patients unclothed, with no privacy during intimate treatments; assembly-line feeding by aides so harried they jammed food into patients' mouths; residents failing to receive pain medication; uncovered garbage; unchecked and untreated wounds; uncertified nurse aides; and the risk of death or injury from inattention or unsafe equipment."

Another point made by proponents of tort reform is that the higher costs of liability insurance and litigation may cause nursing homes to go bankrupt or sell their facilities. The 2002 Mississippi study reported that these costs drove Beverly Enterprises, Extendicare, and National Health Care Corporation to sell their nursing facilities in Florida.[50] The study did not report any effects on quality of care or access to care related to these changes in ownership.

## Causes of the Problems

There is much disagreement about the causes of the current problems with the cost and availability of nursing home liability insurance. Nursing homes and insurers have focused on litigation as the cause of the problems.[51] Consumer advocates and residents' attorneys have attributed the current problems to the property/casualty insurance cycle and other factors affecting the insurance market. The research suggests that the problems have multiple causes, and that both litigation and other conditions affecting insurance markets play a role.

## Litigation

Because the amount of litigation appears to be increasing, several studies assume this increase is the cause of problems with the cost and availability of nursing home liability insurance. For example, Aon's 2002 and 2003 studies stated that increases in premiums "are the result of an explosion in litigation."[52] Although Aon documented increases in frequency and severity of claims among some providers, these increases did not appear to amount to an "explosion in litigation" (see below). Moreover, the study did not address factors other than litigation that may have contributed to premium increases and reductions in coverage. Few studies have systematically assessed the relationship between litigation and problems with nursing home liability insurance, and the results of those few studies have been mixed.

The Weiss study suggests that litigation has contributed to problems with the availability of insurance in some states. Among the six insurers that said they had left the market in one or more states, four said that "increased frequency and severity of claims" was a factor in their decision to leave.

On the other hand, Americans for Insurance Reform, an organization of more than 100 public interest groups formed in 2002 to strengthen regulation of the insurance industry and prevent what they consider price gouging,[53] conducted an analysis in 2002 of the outcomes of medical malpractice tort reform laws in three states and found no relationship between litigation and medical malpractice insurance premiums.[54] The study found that over the past 30 years, insurance premium rates had been unrelated to payouts for lawsuits, but instead, had followed the ups and downs of the economy.

Because lawsuits are frequently identified as a cause of problems with the cost and availability of nursing home liability insurance, the remainder of this section examines the nature and causes of nursing home litigation.

### Trends in nursing home litigation and the nature of claims

Following are some of the key findings from the literature on trends in litigation and the nature of claims.

*Lawsuits do not appear to be frivolous.* The 2001 Florida Task Force study examined the claims in residents' rights lawsuits against nursing homes in Hillsborough County, Florida.[55] The researchers concluded that, of the 225 cases for which court files were available, none appeared to meet the legal definition of "frivolous," that is, clearly devoid of merit. The primary cause of action in all the cases was the right to receive "adequate and appropriate health care." (The analysis included lawsuits brought under residents' rights statutes only.) Nearly all (95 percent) of the cases involved one or more of the following harmful incidents: pressure sores, falls, dehydration and malnutrition, or weight loss. The details of the cases were not disclosed, because 98 to 99 percent of them were settled out of court.

Consistent with this study, the 2003 Harvard study surveyed 278 attorneys that bring or defend claims against nursing homes and found that more than half of claims nationally involved

deaths.[56] The next most frequently alleged harms were pressure ulcers or bed sores, dehydration or weight loss, and emotional distress—all serious allegations.

In 2001, the Sun-Sentinel and Orlando Sentinel reviewed 924 lawsuits filed against nursing homes in South and Central Florida during the previous five years and concluded that "the vast majority of the lawsuits are anything but frivolous."[57] Many of the lawsuits alleged rape, physically abusive staff, poor medical decisions, or neglect. Almost half the suits involved a resident's death. Half of the 924 lawsuits alleged bedsores, one-third claimed infections, and one-quarter mentioned falls. Many of the suits accused nursing homes of causing more than one injury.

*Most but not all lawsuits against nursing homes claim harm to residents as a result of the care and treatment they received (or did not receive).* In 2001, Jury Verdicts Research, a research firm that provides reports to plaintiff and defense attorneys on verdicts and settlements resulting from personal injury claims, examined the most frequently occurring types of lawsuits against nursing homes nationwide during "the most recent 10-year period."[58] The exact dates were not reported. Jury Verdicts Research estimated that a total of 77 percent of cases were related to the care and treatment of residents. Specifically:

- 36 percent were related to treatment,
- 35 percent claimed negligent supervision of residents, and
- 6 percent claimed physical/sexual abuse.

The remainder of cases were related to business/employee negligence (11 percent), premises liability (11 percent), or other (1 percent). These results may not represent all claims.

*Liability claims are not widespread.* According to Aon's 2003 report, the annual number of claims per 100 occupied beds in 2002 was 1.45.[59] Data on claims were based on reports from 79 providers, primarily nursing home operators. While this is three times the level for 1991 claims, it is still small and not indicative of an "explosion in litigation." Since the starting numbers were small, any increase would result in a dramatic increase in percentages.

*Lawsuits have grown in both frequency and severity, at least in some sectors of the nursing home industry.* Prior to the mid-1990s, it was difficult for nursing home residents and their families to sue and obtain compensation, even when substandard care caused death or serious injury to a resident.[60] A 2001 review in *The Actuarial Digest* by Richard S. Biondi, a consulting actuary specializing in property and casualty insurance, cites the following reasons why it was more difficult for a nursing home resident to sue, compared to a hospital patient:

- Most nursing home residents could not claim lost earnings, but many injured hospital patients could.
- Reduction of an injured nursing home resident's life expectancy was typically small compared to that of a younger hospital patient with the same injury.
- Nursing homes did not perform hazardous operations on residents, which could potentially result in lawsuits.

- Because nursing home residents were expected to die within a few years of entering a facility, if a resident died as a result of the facility's negligence, it was difficult to prove the death would not have occurred anyway.

In the late 1990s, large awards for pain and suffering, previously more common in medical malpractice claims against physicians, began to be awarded more frequently to injured nursing home residents as well.[61] Punitive damage awards against nursing homes also became more common.

Although several recent studies have documented large increases in the frequency and severity of lawsuits against some nursing homes, several of these studies are based on a particular state or sector (e.g., large, for-profit chains) of the nursing home industry, and results cannot be generalized to all nursing homes:

- In the 2003 Harvard survey, attorneys reported that the number of nursing home claims they handled and the average size of recoveries had increased over the past five years.[62] On a scale of 1 to 5 (1 = decreased substantially; 3 = stayed about the same; 5 = increased substantially), the average rating for number of claims handled was 4.2 and the average score for size of recovery was 4.0. Among cases that resulted in compensation to the plaintiff, attorneys reported an average recovery amount of $406,000, approximately 18 percent of which was for punitive damages. Of the total claims, 7.9 percent went to trial, 74.5 percent were settled in mediation, and 2.3 percent were settled in arbitration.

  A limitation of the study is that it does not validate attorneys' reports of awards, and attorneys may have had problems remembering and estimating details of their cases such as average payment amounts and percent of cases won. Also, information from the litigants' attorneys is often of limited value because in tort cases there is often no clear-cut winner. First, if a plaintiff's case involves many claims, if he or she loses most of them, the nursing home may claim it won. Yet the plaintiff's attorney will also claim victory because it got some money for his or her client. Second, cases that do not go to trial are usually settled for significantly less than the amount requested. If a million dollar case is settled for $50,000, both sides may consider this a won. These factors may explain the discrepancies in reports by the plaintiff and defense attorneys in the study. Plaintiff attorneys estimated winning 61 percent of their cases, while defense attorneys estimated winning 68 percent of their cases. Plaintiff attorneys reported an average recovery of $436,000, while defense attorneys reported an average of $384,000, a $52,000 per case difference.

  A further limitation is that the study does not distinguish between jury verdicts, settlements, and amounts actually paid. There is no evidence that the amounts reported were those actually paid. For example, jury verdicts can be set aside by a judge, compromised by settlement pending appeal, or reduced on appeal.
- In the section of Aon's 2002 nationwide study addressing long-term care facilities' litigation experiences, 60 long-term care providers responded, representing 440,000 nursing home beds and 32,000 assisted or independent living beds, which Aon estimated at approximately 26 percent of all U.S. beds.[63] Other sources indicate that the number of beds operated by respondents was somewhat less than 26 percent of nursing home beds, and considerably less

than 26 percent of all U.S. assisted and independent living beds.[*] Respondents were primarily large, for-profit chains, and facilities in states with high liability losses were overrepresented. Because results are based on a small, unrepresentative sample, and because of other methodological problems previously noted, the findings from this study cannot be generalized. Respondents to the 2002 study reported a total of 20,539 non-zero claims occurring over the past twelve years.

Among survey respondents, claims were increasing in both frequency and severity. Average liability losses increased from $240 per occupied bed in 1990 to $2,360 per occupied bed in 2001; the average claim tripled from $67,000 in 1990 to $219,000 in 2001; and the number of claims per 100 beds increased from 0.36 in 1990 to 1.08 in 2001. Inflation-adjusted amounts were not provided. These losses represented all non-zero general and professional liability losses, including: amounts paid to plaintiffs; defense costs, such as investigation and defense attorney fees; and plaintiff attorney fees. The portion of the claims awarded for economic, non-economic, and punitive damages were not specified. The data included jury awards as well as claim settlements.

- Similarly, in Aon's 2003 study, 79 respondents, which Aon again estimated as representing 26 percent of U.S. beds, provided information on their litigation experiences.[64] Respondents operated approximately 480,000 long-term care beds, primarily nursing home beds but also including an unspecified number of independent living, assisted living, home health care, and rehabilitation beds. As in the 2002 study, respondents included several large for-profit chains, which may have skewed the sample. This study also found increases in frequency and severity of claims among survey respondents. Among respondents to this study, average liability losses increased from $290 per occupied bed in 1990 to $2,340 per occupied bed in 2001 and $2,880 per occupied bed in 2002. The average claim increased from $63,000 in 1990 to $182,000 in 2001 and $198,000 in 2002. The number of claims per 100 beds increased from 0.46 in 1991 to 1.28 in 2001 and 1.45 in 2002. Respondents reported a total of 26,173 non-zero claims over the twelve years prior to the study.
- In April 2000, the Florida Department of Insurance sent a survey to all 515 insurers that were authorized to sell any type of liability insurance in the state to determine which insurers were writing long-term care liability insurance. Based on the responses and additional information obtained from brokers, agents, trade associations, and others, a second survey was sent to 79 insurance companies. All 79 responded. Nursing home claims data were based on claims reported by insurers who wrote long-term care liability insurance during the last three years. These included 17 companies that were currently providing such coverage and 23 that had provided such coverage during the last three years and were no longer providing it, and two insurers who did not write any coverage during the last 3 years. The number and size of claims reported by these companies were fairly stable for claims with closed indemnity payments ranging from $1 to $250,000 (161 claims totaling $7.8 million in 1997; 162 claims totaling $6.8 million in 1999). However, there was a sharp increase in claims above

[*] As of 1999, the National Investment Center estimated 1,928,714 skilled nursing beds, 585,735 assisted living beds, and 11,726 independent living seniors apartments (excluding active adult communities) in the United States (National Investment Center for the Seniors Housing & Care Industries (NIC), *NIC National Supply Estimate of Seniors Housing and Care Properties*, Annapolis, MD: NIC, 2000). According to these estimates, respondents to Aon's 2002 survey represented 23 percent of nursing home beds and five percent of assisted and independent living beds.

$250,000 (36 claims totaling $17.0 million in 1997; 61 claims totaling $29.3 million in 1999).[65]

- The 2001 Florida Task Force study included an in-depth review of liability issues in the 35 nursing homes in Hillsborough County, Florida. It found that, among these 35 homes, the proportion of nursing homes with one or more suits climbed from 41 percent in 1995 to 87 percent in both 1998 and 1999, and then dropped to 71 percent in 2000.[66] Although lawsuits declined in Hillsborough in 2000, the key informants interviewed—including corporate risk managers, a prominent defense attorney, and nursing home association representatives—said that nursing home litigation had been increasing in the state as a whole. Six of the 31 (19 percent) homes operating in Hillsborough at the time the report was written were not-for-profit, similar to the proportion statewide, where 21 percent of nursing homes were not-for-profit. The data included cases that went to court as well as cases that were settled out-of-court. The study noted that over 95 percent of nursing home lawsuits in Florida are settled out of court, similar to the rate of settlement of other types of liability cases in Florida, according to the Florida Department of Insurance.
- The 2002 Mississippi study, in the section of the study addressing litigation, cited a separate report, by the Mississippi Health Care Association, that between 1997 and 2001, lawsuits against nursing homes in the state reportedly increased by 190 percent.[67] (The total number of lawsuits was not reported.) The study did not measure the severity of those claims.
- A 2001 investigation by the Sun-Sentinel and Orlando Sentinel found that the number of lawsuits filed against nursing homes in South and Central Florida had tripled from 90 suits filed in 1996 to 270 in 1999.[68] In 2000, 231 suits were filed.

*The rate of increase in severity in claims appears to be slowing in some states.* Using Aon's data on severity of claims nationwide from 1991 to 2002,[69] assuming annual compounding, an annual rate of increase of 11.0 percent can be calculated. However, the rate of increase for the most recent five years is 4.9 percent. Adjusting for inflation would lower it even more. This suggests that the rate of increase in severity of claims may be slowing.

Rates of increase or decrease in severity of claims vary from state to state. According to Aon's 2003 study, the average non-inflation-adjusted severity of claim increased modestly in Florida during the five-year period from 1998 to 2002.[70] In Texas, Mississippi, and Arkansas the average severity of claim actually decreased, and it remained about the same in Alabama. It increased in California and in the remaining states combined.

*The frequency and severity of claims are driven by a small number of facilities with multiple claims and a few extraordinarily large awards.* The research suggests that much of the average increase in frequency and severity of claims is driven by a small number of facilities with extraordinarily large numbers of lawsuits and a few extraordinarily large claims:

- Aon's 2002 nationwide study, based on its survey of primarily nursing homes but also including other types of long-term care and independent living facilities, found that, although the average claim was $219,000, this average was driven by a few exceptionally large claims.[71] Of the approximately 200,000 claims examined, 68 percent were for $50,000 or less. A total of 211 claims were for $1 million or more, and 10 of these were for $5 million or more. These represented only currently reported claims, not final amounts paid.

- Similarly, in Aon's 2003 study, of the 26,000 non-zero claims reported, over 70 percent were for $50,000 or less.[72] A total of 317 were $1 million or greater, and 14 were $5 million or greater.
- The 2001 University of South Florida study found that, while the majority of facilities had been sued at least once during the first nine months of 2001, a smaller number of facilities had been sued many times. Among the 422 facilities surveyed, 38 percent had not been sued, 22 percent had been sued once, 17 percent had been sued twice, and 23 percent had been sued three or more times.[73]
- The 2001 Florida Task Force study found that, between 1990 and 2001, nursing homes in Hillsborough County experienced a median of 10 lawsuits, while one nursing home experienced 35 lawsuits.[74] No studies were found that addressed the distribution of lawsuits for other states or for the nation as a whole.

Although a few large claims may affect the cost and availability of liability insurance for all nursing homes,[75] it is not clear whether they constitute an "explosion in litigation."

*Litigation costs are significantly higher in some states than in others.* Aon's 2002 and 2003 studies both found large variation in liability losses among states, with losses particularly high in Florida and Texas. Their 2002 study found that, among facilities surveyed, average liability losses per nursing home bed in 2001 were $11,000 in Florida and $5,500 in Texas, compared to $2,400 nationwide.[76] Similarly, the 2003 study found average losses per nursing home bed of $10,500 in 2001 and $11,800 in 2002 for Florida; $4,900 in 2001 and $6,300 in 2002 for Texas; and $2,300 in 2001 and $2,900 in 2002 nationwide.[77]

Possible causes of lawsuits

Much disagreement exists about the causes of increased litigation against nursing homes. Consumer groups and plaintiff attorneys view litigation as resulting from quality-of-care problems in nursing homes, weak oversight and enforcement, and lack of risk management. In contrast, nursing home providers and insurers see litigation and claims increasing as a result of: inadequate public reimbursement, which makes it difficult to provide adequate care; residents' rights laws, which make litigation easier for plaintiffs; and growth in the number of law firms specializing in the representation of nursing home residents. Although several studies have suggested possible causes of litigation, the evidence has been inconclusive.

*Residents' rights laws and growing intolerance of poor care.* One reason for the increase in lawsuits against nursing homes may be that society has grown less tolerant of poor quality nursing home care. These changing views may affect nursing home litigation in two ways: the passage of residents' rights laws that provide a basis for residents to sue, and jurors' changing expectations for nursing home quality. The need for lawsuits may be reduced as nursing homes respond to society's increased concern about resident care by taking steps to improve quality.

In addition to the federal rights granted under the 1987 Nursing Home Reform Law (part of OBRA 1987), several states have enacted additional rights to provide further protections for nursing home residents. State residents' rights laws sometimes include a private right of action, which allows residents and their families to sue when a nursing home violates the residents' rights specified by the law. These rights include the right to receive "adequate and appropriate

health care," the primary cause of action in most lawsuits against nursing homes included in the 2001 Florida Task Force study.[78] Violations of residents' rights laws are one of several claims in lawsuits filed against nursing homes.*

Several observers have commented that residents' rights laws are a cause of increased litigation. For example, in a 2001 article in *Chartered Property and Casualty Underwriters (CPCU) Journal*, William J. Warfel, a professor of insurance and risk management at Indiana State University, contends that that strengthened residents' rights laws are a factor affecting the cost and availability of nursing home liability insurance.[79] He notes that federal and state monitoring and enforcement of nursing home quality standards are often inadequate to protect residents. As a result, several states have passed residents' rights statutes, providing residents with the right to sue when nursing homes violate the law.

Consulting actuary Richard S. Biondi agrees, pointing out that some states enacted legislation to protect nursing home residents from abuse and to establish residents' rights and minimum standards of care.[80] These new laws have provided additional grounds for injured residents' claims.

Only one study was found that examined the relationship between states' residents' rights laws and litigation, and no clear link was found. Aon's 2002 study reported that the two states with the highest reported liability losses, Florida and Texas, both had strong residents' rights laws.[81] These laws guaranteed nursing home residents such rights as to be provided adequate care, to be treated with dignity, and to "a safe and decent living environment." Information about liability losses was based on Aon's survey, mentioned earlier, of 60 long-term care providers. Some other states with higher than average liability losses also had long-term care residents' rights statutes; these included Arkansas, California, and Georgia. On the other hand, the report also noted that more than half the states in the United States have a residents' bill of rights, and not all of them have experienced higher than average liability losses. Moreover, some states that have had particularly high liability losses do not have a residents' bill of rights; these include Alabama, Mississippi, and West Virginia. The researchers did not control for other factors that may have affected the amount of liability losses for nursing homes. The study was repeated in 2003 with similar results.[82]

*Poor quality.* In several recent studies, GAO and the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) confirmed problems of substandard quality of care in nursing homes nationwide. These findings provide evidence that many resident injuries occur as a result of substandard care and are not unavoidable results of aging and illness. Following are some highlights of these findings:[83]

- Between 1995 and 1998, state surveyors cited nearly one in three (30 percent) nursing homes

* Other claims include: violations of state consumer protection statutes; tort claims including battery, infliction of emotional distress, and false imprisonment; breach of contract (based on the facility admission agreement and/or contract with Medicare or Medicaid); fraudulent misrepresentation; contract formation defenses; unconscionability; the federal False Claims Act; Racketeer Influenced and Corrupt Organizations (RICO); and federal and state civil rights laws (National Consumer Law Center, Inc. *When You Can't Go Home Again: Using Consumer Law to Protect Nursing Facility Residents,* (Boston: National Consumer Law Center, Inc.), 2000.).

in California for violations that caused or put residents at risk of death or serious harm. Another 33 percent of facilities were cited for substandard conditions that caused less serious harm, and an additional 35 percent were cited for violations that had not caused actual harm but could cause more than minimal harm to residents if not corrected. Only 2 percent of California nursing homes were found to have no or only minimal deficiencies.

- Another study, also based on state survey findings, examined nursing home quality nationwide. From 1997 to 1998, one percent of nursing homes in the sample were cited for violations that caused or put residents at risk of death or serious injury, and 26 percent were found to have caused other actual harm. Another 43 percent were cited for violations that created a potential for more than minimal harm, and 31 percent had no or only minimal deficiencies.
- As of 2001, more than 90 percent of nursing homes were at risk of harming residents because of inadequate staffing levels.

Four studies have examined the relationship between quality and other facility characteristics and the likelihood of being sued, with results suggesting that better-quality facilities are less likely to be sued.[84]

Of the three studies that included indicators of quality,[85] two found a relationship between the probability of being sued and indicators of quality.[86] The first study, completed in 2001 by economist Hank Fishkind, was commissioned by a Florida law firm representing nursing home residents and was based on data for 1998 to 2001 from 98 nursing homes in central Florida, as well as information from the Centers for Medicare and Medicaid Services, GAO, the Florida Department of Insurance, Fishkind and Associates, a Senate Interim Report, and the *Orlando Sentinel*.[87] The study found that the frequency of lawsuits against nursing homes correlated with the following factors:

- larger number of beds,
- higher number of deficiencies,
- being a for-profit facility, and
- low staffing ratios.

Other sources suggest that the number of deficiencies and low staffing ratios can be considered proxies for quality. State regulators cite nursing homes for deficiencies when they are found to be in violation of quality-of-care standards. However, GAO found that deficiencies understate the extent of serious care problems, because state surveyors often miss significant care problems due to weaknesses in state survey methods and the predictable timing of surveys (see below).[88] On the other hand, nursing home operators contend that surveys may overstate quality of care problems, due to surveyors citing facilities for preexisting resident injuries that were not caused by the facility.[89] However, resident advocates note that facilities should make note of any preexisting conditions when a resident is admitted. The Centers for Medicare and Medicaid Services found a clear link between inadequate staffing levels and quality problems.[90] A study by Charlene Harrington, a University of California researcher, and colleagues, found that for-profit nursing homes had lower staffing ratios and averaged more deficiencies per home than did nonprofit or public facilities.[91]

The second study that found a relationship between being sued and quality, an investigation by Florida's *Sun-Sentinel* and *Orlando Sentinel*, examined nursing home lawsuits filed in Central and South Florida between 1996 and 2000. The review found that the one commonality among infrequently sued nursing homes was that they had few violations on their inspection reports; facilities with many violations were three times more likely to be sued.[92] No correlation was found between the number of lawsuits filed against a nursing home and its average rate or its staffing ratio. In addition to having few violations cited against them, visits to some of the infrequently or never sued nursing homes suggested that these homes were well-managed and provided good quality care. For example, in one home that had never been sued most of the managers had been there 10 years or more and staff turnover was less than one percent a year. A resident commented, "It's a fun place. Anyone who is unhappy here is an unhappy person."

The third study that examined the relationship between probability of being sued and indicators of quality, part of the 2001 Florida Task Force study, was based on data from 28 nursing homes in Hillsborough County, Florida. The study did not find a relationship between probability of being sued and indicators of quality among nursing homes in that county.[93] A multivariate analysis examined the relationship between the number of lawsuits and the following facility characteristics: number of beds, not-for-profit status, Medicaid ratio, indicators of case mix, survey deficiencies, and other quality measures. The number of beds was the only significant predictor of number of lawsuits. It was not clear whether or not facility size had any relationship to the number of lawsuits per resident.

A fourth study, the 2001 University of South Florida study mentioned above, did not examine the relationship between indicators of quality and being sued but noted that, among the 422 Florida facilities surveyed, nonprofits had significantly fewer lawsuits filed against them than for-profits.[94] However, this difference became insignificant when the analysis controlled for other facility characteristics. When other factors were taken into account, the only significant predictor of lawsuits was number of beds. For-profit status, facility type, affiliation with a continuing care retirement community (CCRC), faith-based, region of state, whether the facility was uninsured, and the amount of the insurance premium were not found to be significant predictors of number of lawsuits. The analysis did not include quality measures, such as staffing ratios and number of deficiencies. As in the 2001 Florida Task Force study, it was not clear whether or not there was any correlation between facility size and frequency of lawsuits per resident.

*Weak survey procedures and ineffective enforcement.* Another factor that may have contributed to lawsuits is weak government enforcement of nursing home quality standards. The 1987 Nursing Home Reform Act requires state regulators to conduct unannounced surveys of each nursing home at least once every 15 months to monitor compliance with federal quality standards. A series of recent GAO studies documented weaknesses in survey procedures and substandard enforcement:[95]

- During annual surveys, state surveyors often missed significant care problems, such as pressure sores, malnutrition, and dehydration.
- Complaints made by residents, family members, or nursing home staff often went uninvestigated for weeks or months. In addition, states frequently had procedures that

discouraged the filing of complaints.
- When serious quality deficiencies were detected, enforcement mechanisms frequently failed to ensure that the problems were corrected and remained corrected.

When enforcement of standards is weak, residents may be more likely to turn to litigation to resolve quality problems.

*Lack of risk management.* Lack of risk management is one possible contributor to poor quality, lawsuits, and, ultimately, higher insurance premiums. Risk management refers to programs and procedures aimed at minimizing liability losses. These include efforts to reduce the need for lawsuits by improving quality of care and efforts to improve a facility's ability to defend itself by clearly documenting care provided. According to the 2001 Florida Task Force study, "Insurers familiar with the broader health care market find it vexing that few long-term care providers have facility-based risk management programs that are standard in the acute care setting."[96]

*Public reimbursement.* Some observers have suggested that poor quality, and thus lawsuits and liability insurance problems, are partly a result of inadequate public reimbursement to nursing homes that serve residents covered by Medicare or Medicaid. For instance, Biondi contended that one major change during the mid-1990s that may have led to increased claims against nursing homes is that Medicaid and Medicare reimbursement rates dropped as reimbursement rules changed.[97] Many nursing homes, which were accustomed to more generous government reimbursement, experienced financial problems that may have affected quality of care, he said.

A look at inflation-adjusted reimbursement rates, however, shows a long-term trend of increased reimbursement rates (see Table 2).

**Table 2: Average Skilled Nursing Facility Reimbursement per Resident per Day**

| | 1992 | 1994 | 1998 | 1999 | 2000 | 2001 |
|---|---|---|---|---|---|---|
| Medicare rates (2001 inflation-adjusted dollars) | $157 | $195 | | $237 | $243 | $266 |
| Medicaid rates (1998 inflation-adjusted dollars) | $ 87 | $ 91 | $ 96 | | | |

Sources: Medicaid rates and Medicare rates for 1992 and 1994 are from AARP Public Policy Institute, *Across the States 2000: Profiles of Long-Term Care Systems,* 2002; 1996; 1994. Refers to the average payment per day by Medicare Part A to skilled nursing facilities in the United States; does not include territories.

Medicare rates for 1999 to 2001 are from CMS, http://www.cms.hhs.gov/statistics/feeforservice/NationalSummary.pdf, November 2002, accessed April 11, 2003. Data include Puerto Rice, Virgin Islands, and unknown. Data does not include swing beds.

Adjustments for inflation calculated by AARP Public Policy Institute based on the Consumer Price Index for All Urban Consumers (CPI-U).

In his 2001 article, Warfel also cited inadequate government reimbursement as one cause of the current nursing home liability insurance problems. He argued, "Medicare and Medicaid reimbursements oftentimes do not cover adequately the full costs of providing quality, long-term care services."[98]

The nursing home industry has frequently lobbied for increased reimbursements, saying that current reimbursements are insufficient to provide adequate care. For example, in November 2002, the American Health Care Association (AHCA), the trade association of primarily for-profit long-term care facilities, issued a press release asking Congress to restore a temporary $1.8 billion increase in Medicare payments that had been canceled October 1.[99] AHCA President Dr. Charles Roadman said the Medicare cuts "threaten essential caregiver jobs, quality patient care, and seniors' access to it." He added, "The government cannot, on the one hand, demand higher quality patient care and, on the other, cut the financial resources necessary to achieve this important public policy objective."

In contrast, two recent GAO studies suggest that increased reimbursement does not necessarily lead to better quality. In one study, GAO examined the relationship among nursing home expenditures, staffing levels, and quality-of-care deficiencies cited by state regulators in three states.[100] Although the findings cannot be generalized to all nursing homes in the country, they do provide insight into nursing home spending patterns. Overall, the researchers found no clear relationship between a nursing home's total spending or spending and the proportion of money it spent on nursing care or its quality-of-care deficiencies. In Ohio and Washington, nursing homes with higher spending spent a higher proportion of total spending on capital, operations, and administrative expenses, not on nursing care. In Mississippi, the share of total spending devoted to nursing was the same in the highest-spending and lowest-spending nursing homes. More important than spending was the number of nursing hours provided to residents. Nursing homes in Ohio and Washington that provided more nursing staff hours per day were less likely than nursing homes with fewer hours to be cited for serious quality problems.

The second study included more than one-third of all skilled nursing facilities nationwide.[101] GAO assessed the impact of the temporary Medicare reimbursement increase intended to encourage nursing homes to increase their nursing staff, one of several such increases since 1998. The results showed that average nursing time changed little after the increase in Medicare payment for staffing. Although the payment change could have paid for about 10 added minutes of nursing time per resident per day, average nursing time increased by less than two minutes per resident per day over the average of three and one-half hours per resident per day in 2000. Furthermore, the portion of residents covered by Medicare was not a factor in whether nursing homes increased their nursing time.

In December 2002, the Medicare Payment Advisory Commission (MedPAC) met to discuss recommendations for Medicare policy and concluded that "overall Medicare payments to SNFs [skilled nursing facilities] are more than adequate to cover SNFs' costs" for caring for Medicare residents.[102]

In lobbying for more Medicare funds, the nursing home industry has argued that Medicaid payments are inadequate to cover the cost of care and thus nursing homes must use Medicare rates to offset money lost on residents receiving Medicaid. Studies have shown that, for many nursing homes, Medicaid reimbursements fall short of Medicaid allowable costs. For example, a 2002 report conducted for American Health Care Association by BDO Siedman, LLP found that the average unreimbursed allowable Medicaid cost was $10 per resident per day, based on data

from 30 states.[103]

However, this Medicaid shortfall does not necessarily have an adverse effect on nursing homes' overall financial well-being. A *U.S. News and World Report* analysis found no relationship between a nursing home's profits or losses and the portion of its residents covered by Medicaid.[104]

*Growth in the number of law firms specializing in representing nursing home residents.* Some observers have attributed the growth in the frequency and severity of claims against nursing homes to the proliferation of law firms specializing in representing nursing home residents. The 2003 Harvard survey of 278 attorneys that brought or defended claims against nursing homes found that respondents had been practicing law for an average of seventeen years but had been involved in nursing home litigation for only eight, suggesting "a mobilization of attorneys into this area in the mid-1990s."[105] Attorneys specializing in nursing home litigation were particularly prevalent in Florida and Texas. According to the study, the numbers of nursing home lawyers per 1,000 residents were 1.5 in Florida and 0.8 in Texas, compared to 0.3 nationally.

No studies were found that examined the impact of the growth of such law firms on the frequency and severity of claims. It is possible that advertising by law firms may lead to more litigation as residents and their families become more aware of the availability of counsel to take their cases. In addition, law firm advertising could raise jurors' awareness of nursing homes' legal obligations to provide adequate care, which might cause jurors' to have greater expectations of nursing homes. The 2003 Harvard study suggested that both poor quality care and growth in the number of law firms specializing in nursing home cases have contributed to the increase in nursing home litigation, referring to "plaintiff attorneys' gaining ground on a reservoir of substandard care."[106]

## Factors in the Broader Insurance Market

In addition to nursing home litigation, a number of other factors affecting insurance markets have contributed to current problems surrounding the cost and availability of nursing home liability insurance. These factors have affected not only nursing home liability insurance, but a broad range of insurance markets as well. For example, one 2002 article by A.M. Best, a company that provides insurance company ratings and information about the insurance industry, described skyrocketing premiums affecting the entire professional liability insurance market, with insurers scrutinizing insured companies more closely.[107] Professional liability insurance includes errors and omissions insurance, which covers service professionals' liability for financial loss due to negligence, and directors and officers insurance, which protects a company's board of directors against claims of mismanagement from employees and shareholders. Another A.M. Best article in 2000 reported that golf courses had also recently experienced premium increases and difficulty obtaining insurance, after nearly a decade of insurers' competing intensely for new policies.[108] An April 2002 *Wall Street Journal* article reported increased premiums and decreased coverage for all types of business insurance policies, including medical malpractice, workers' compensation insurance, and directors and officers insurance.[109]

Because companies that sell long-term care liability insurance generally sell other types of insurance as well, the long-term care liability insurance market is affected by conditions in the broader insurance market. These conditions affect the various long-term care liability insurance companies differently, depending on what other types of insurance the company provides. The literature suggests six potential factors affecting the cost and availability of many types of insurance policies:

- the property/casualty insurance cycle;
- severe premium cuts during the 1990s;
- lower returns on investment income;
- more claims and payouts and perceived variability and unpredictability of claims;
- losses from claims resulting from the September 11, 2001 terrorist attacks; and
- insurers' business decisions.

Property/casualty insurance cycle

Like most industries, the property/casualty insurance industry goes through cycles, alternating between "hard" and "soft" markets.[110] During a soft market, insurers' investment income grows more quickly than losses. Consequently, more insurers enter the market, and insurance companies reduce premium rates to attract new customers. For customers, insurance premiums are lower, and coverage is easier to obtain. During a hard market, insurers' investment income grows more slowly, and losses increase more quickly. Premiums are inadequate to cover losses. As a result, many insurance companies increase premiums, reduce coverage, or leave the market altogether. For the customer, insurance premiums are high, and coverage is less available. Figure 1 describes these insurance cycle stages.

**Figure 1: The Property/Casualty Insurance Cycle**

**Soft market**

Insurers' investment income grows more quickly than losses.

↓

More insurers enter the market, and insurance companies reduce premium rates in competition to attract new customers.

↓

Insurance premiums are lower, and coverage is easier to obtain.

**Hard market**

Insurers' investment income declines and losses increase. Premiums are inadequate to cover losses.

↓

Insurance companies increase premiums, reduce coverage, and leave the market.

↓

Insurance premiums are high, and coverage is more difficult to obtain.

For most of the 1990s, the property/casualty insurance industry was in a soft market, with affordable premiums and easy-to-obtain coverage. During this time, insurers cut premiums to compete for customers. The property/casualty insurance industry is currently in a hard market, with sharply increased premiums and coverage more difficult to obtain. In addition to the two Aon studies cited earlier, Aon also wrote a white paper for an association of non-profit long-term care providers in 2002. The paper predicted, "The insurance market is at the beginning of the hard market meaning that insurance premiums will continue to rise and coverage will continue to be reduced for the next several years."[111] This hard market began with lowered rates of return on insurers' investments, combined with increased claims and payouts and perceived variability and unpredictability of claims. The September 11, 2001 terrorist attacks impacted insurers' losses, as well. Some analysts have called for an investigation into whether insurers' poor business decisions contributed to current problems, because, if they did, limiting litigation may not solve the problems.

Severe cuts in premiums

During the soft market of the 1990s, the insurance industry enacted severe premium cuts as insurers competed for customers. An April 2002 *Wall Street Journal* article reported that insurers cut rates sharply and loosened terms in a wide range of insurance policies, from directors and officers liability coverage to medical malpractice to workers' compensation.[112] By 1999, insurers were paying an average of $1.07 in claims and related expenses for every dollar of premium received for business coverage. During this soft market, insurers' gains in investment income compensated for these underwriting losses. Current premium increases in nursing home liability and other lines of insurance reflect in part the need to compensate for the severe cuts in premiums that took place during the soft market.

Lower returns on investment income

Another factor affecting insurance markets is that insurers' investment income declined significantly in the early 2000s. A December 2001 article by Insurance Services Office, Inc. (ISO), a company that provides information about the insurance industry, reported that the property/casualty insurance industry experienced a 5.7 percent decline in net investment income between the first nine months of 2000 and the same period in 2001, from $29.2 million to $27.5 million.[113] During this time, the industry also had a 45.7 percent drop in realized capital gains, from $12.8 billion to $6.9 billion. ISO vice president John J. Kollar commented, "Insurers must focus on fundamentals such as underwriting and pricing as they cannot count on investment gains to offset poor underwriting results."

More claims and payouts and perceived variability and unpredictability of claims

Another factor contributing to premium increases is that growth in the frequency and severity of claims in a variety of areas has made it more difficult for insurance companies to predict future claims. Thus, insurance companies must raise premiums to cover uncertain future losses. A 2002 study by Insurance Information Institute, a company that provides information on insurance topics, analyzed insurance industry data from A.M. Best, Insurance Services Office, Insurance Information Institute, and several other sources. The results showed that litigation has become more frequent in a wide range of areas, including asbestos, so-called toxic mold, diminished value, after-market parts, lead, construction defects, guns, genetically modified foods,

pharmaceuticals, directors and officers (e.g., Enron), and professional liability (e.g., Arthur Anderson), as well as nursing homes and medical malpractice.[114]

Claims have also become more severe. Between 1993 and 1999, average jury awards greatly increased in the areas of product liability, medical malpractice, personal negligence, premises liability, vehicular liability, business negligence, and overall. According to the Institute, jury awards have been particularly large in Texas, Mississippi, Alabama, California, New York, Florida, Illinois, and Louisiana.[115] These losses affect the various nursing home liability insurers differently, depending on what other types of coverage they provide.

September 11, 2001

Although not all nursing home liability insurance providers may have been affected, the September 11, 2001 terrorist attacks resulted in severe losses for some segments of the liability insurance market. In its December 2001 article, Insurance Services Office, Inc. (ISO) reported that the U.S. property/casualty industry posted a $3.1 billion net loss during the first nine months of 2001—its first-ever net loss after taxes through nine months.[116] According to ISO, the net loss was primarily a result of losses from claims resulting from the September 11 terrorist attacks. The industry's underwriting losses increased by 80 percent between the first nine months of 2000 and the first nine months of 2001. The 2001 University of South Florida study also mentions the attacks of September 11, 2001 as a factor affecting nursing home liability insurance costs.[117] The report said that the attacks seriously affected the reinsurance industry and resulted in higher premiums, higher deductibles, and lower available policy limits in many liability insurance markets.

Business decisions of insurers

The *Wall Street Journal* article mentioned earlier suggested that the recent increases in medical malpractice insurance premiums were due in part to poor business decisions by insurers. The article described the 1990s as "a decade of imprudence among insurers—a period that combined a relentless price war with aggressive risk-taking."[118] Another *Wall Street Journal* article, titled "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" said, "While malpractice litigation has a big effect on premiums, insurers' pricing and accounting practices have played an equally important role."[119] In at least one case, the article reported, a state charged an insurance company with fraud, alleging that some company executives and board members misled the company's board about the adequacy of premium rates and funds set aside to pay claims. The company had provided insurance to nursing homes as well as medical offices.

At the July 2002 House Energy and Commerce Committee hearing on medical malpractice insurance, representatives of consumer advocacy groups testified that increases in premiums were due, in part, to poor business decisions of insurers.[120] In response, Rep. John Dingell (D-Michigan) and other members of Congress have argued that a search for solutions should not address tort laws alone, but should also investigate the role of insurers' business practices. To do this, several Committee members requested that the General Accounting Office examine the role the insurance industry has played. "Are medical malpractice insurers properly pricing their product?" Dingell asked.[121]

## Proposed Solutions

Several solutions have been proposed for making nursing home liability insurance more available and affordable. The six major proposed solutions are limits on residents' ability to sue, strengthened enforcement of nursing home quality standards, risk management, experience ratings, alternatives to commercial insurance, and strengthened regulation of the insurance industry. The research relevant to each approach is described below.

### Limits on Residents' Ability to Sue

Much attention has focused on legislative proposals to limit the ability of residents harmed by negligence to sue and collect compensation, referred to as "tort reform."[122] Proponents of tort reform contend that such laws would lower liability insurance premiums by making liability losses more limited and more predictable.

Nursing home provider groups have been strong supporters of limits on litigation. A September 2002 press release by the American Health Care Association (AHCA) supported proposed federal legislation H.R. 4600, designed to restrict lawsuits. The American Association of Homes and Services for the Aging (AAHSA), which represents nonprofit providers, also strongly supported the bill. A statement by AAHSA said, "Nursing homes urgently need the relief this bill would provide from the growing volume of often baseless litigation that has resulted in sharp increases in their medical liability insurance premiums."[123] However, no studies have addressed the validity of lawsuits against nursing homes or presented evidence that these lawsuits are "often baseless."

In his 2001 article in *Property and Casualty Underwriters (CPCU) Journal*, Warfel recommended limiting nursing home liability losses, for example by capping noneconomic and punitive damages.[124] He contended that these measures would make costs more predictable and alleviate the price and availability problems that some states are experiencing with nursing home liability insurance.

On the other hand, consumer advocates have argued that the right to sue is needed to compensate injured residents and to improve quality by supplementing traditional government regulatory enforcement with private oversight and enforcement. Facilities with the largest number of and the most severe claims have frequently been cited by state regulators for multiple deficiencies.[125] Thus, the regulatory system and tort litigation are two separate systems for addressing poorly performing nursing homes. For example, lawsuits have brought about quasi-regulatory results in some facilities, such as change of ownership or closure of a nursing home that has provided exceptionally poor care. The 2001 Florida Task Force study noted that the three most frequently sued facilities in Hillsborough County had each "subsequently undergone transformation: two properties have changed ownership and the third has permanently closed."[126]

#### Research on the effects of limits on the right to sue

No studies were found that specifically examined the effects of tort reform aimed at nursing home liability. The empirical evidence of the impact of existing state tort reform laws affecting other industries is limited, and results have been mixed. One study conducted by a consumer group found no link between passage of tort reform and premiums for various types of insurance.

Two studies related to medical malpractice suggest that certain limits on litigation can help lower insurance premiums, while a third study related to medical malpractice found that premiums continued to increase, regardless of caps.

A 1999 study by the consumer advocacy group, Center for Justice and Democracy (then known as the Citizens for Corporate Accountability and Individual Rights), examined the impact of existing limits on litigation and refuted the claim that tort reform lowers insurance costs.[127] The study analyzed data from the Insurance Services Office on insurance premiums and loss costs (the portion of premiums paid that insurance companies use to pay for claims and to adjust claims) in every state over a 14-year period, from 1985 through 1998. The researchers categorized the states into three groups by the number of "major tort law limits" (that is, major restrictions on the ability to sue and collect claims) enacted by the state and weighted by the number of years the laws had been in effect. Decisions as to what constituted a "major tort law limit" were based on information provided by the American Tort Reform Association (ATRA) and the Association of Trial Lawyers of America (ATLA) and additional legal research and consultation with lawyers or lobbyists in every state. A limitation of this method is that it treats all types of restrictions on the right to sue as equal and does not allow for assessing whether some are more effective in lowering insurance premiums than others. Another limitation of the study is that states with zero limits on the right to sue were placed in the same category as states that passed only one limit. For example, the following states were all placed in category "1": Massachusetts, which passed no tort limits; Mississippi, which enacted a law affecting joint and several liability only; Nebraska, which addressed collateral source offset only; and North Carolina, which enacted a punitive cap only. Trends in insurance rates and loss costs were examined separately for lines of insurance covering general tort, product liability, and medical malpractice insurance, since state tort restrictions often targeted one of these areas.

The study found no consistent relationship between insurance premiums and state-enacted restrictions on the right to sue. Some states with little or no change in tort law had low liability insurance premium increases and fewer loss cost increases, while some states in the group that had enacted the most tort restrictions experienced large increases in premiums rates and loss costs. A possible explanation for this finding is that states experiencing large insurance premium increases may be more likely to enact tort limits, while states experiencing little or no increases in premiums may be less likely to see a need for such laws.

An American Insurance Association (AIA) press release criticized the Center for Justice and Democracy study, saying that it used an "incorrect time period analysis," and an "irrational method of classifying states." At the same time, the AIA supported the study's conclusion that limits on the right to sue do not necessarily lower insurance rates. "Insurers never promised that tort reform would achieve specific savings, but rather focused on the benefits of fairness and predictability," the AIA said.[128] The AIA also noted that restrictions on lawsuits are just one factor determining the cost of insurance and that other factors include accident frequency, population density, medical inflation, underlying economic conditions, state taxes, and the degree of market competition.

Weiss Ratings' research suggests that limits on litigation may not increase the availability of insurance in the short term. Among the four insurers interviewed, three specifically said that

state laws limiting litigation, in and of themselves, would not bring them back to the states they had left anytime soon. Instead, insurers said they would wait to see the longer-term effects of the laws on insurers' losses.

In contrast, two studies related to medical malpractice found that certain limits on lawsuits had reduced insurance and liability costs, but the studies differed as to which types of limits were identified as being effective. A 1996 actuarial analysis by the American Academy of Actuaries examined the outcomes of medical malpractice tort reform in California, New York, and Ohio.[129] The study concluded that a package of reforms, including a cap on noneconomic awards (often referred to as damages for "pain and suffering") and a mandatory collateral-source offset rule (a rule requiring each suit to consider damages already paid from other sources), were most likely to reduce liability insurance premiums.

In 1993, the U.S. Congress's Office of Technology Assessment (OTA) analyzed the results from six earlier studies on the effects of legal changes that limit the number of suits or amount of compensation in medical malpractice cases. The OTA analysis found that the only changes shown to reduce malpractice insurance premiums were a cap on total damages and a law shortening the extension of statute of limitations from the date of discovery.[130] Other types of limits—including laws that impose caps on noneconomic or punitive damages only, require or allow collateral source payments to be deducted from the plaintiff's malpractice award, establish pretrial screening panels, restrict the statute of limitations in other ways, limit contingent attorney fees, require or allow periodic payment of awards, or modify the standard of care—showed conflicting results or no statistically significant effect on insurance premiums. OTA's conclusions were tentative, however, in part because of methodological flaws in the studies, differing definitions of the particular malpractice reforms, and different methods of categorizing the reforms.

Most recently, a June 2003 study by Weiss Ratings, Inc. (separate from the survey conducted for AARP) also found no evidence that caps on non-economic damages reduced medical malpractice premiums.[131] The researchers examined premium rates for doctors in three high-risk specialties—internal medicine, general surgery, and obstetrics/gynecology—in the 19 states that had enacted caps on non-economic damages in medical malpractice suits since 1975. The study analyzed data from the National Practitioner Data Bank and the *Medical Liability Monitor*.

Weiss found that, although states with caps experienced larger reductions in non-economic damage award payouts by medical malpractice insurance companies, premiums in these same states rose faster than in states without caps.[132] Between 1991 and 2002, "median" medical malpractice insurance premiums rose more quickly in states with caps than in those without (by 48.2 percent in states with caps vs. 35.9 percent in states without caps). Second, states without caps were more likely to experience constant or declining medical malpractice premiums than states with caps. Third, premiums in states with caps were slightly more likely to exceed the "national median" (47.4 percent of states with caps had premiums below the national median, compared to 50 percent of states without caps).

The researchers concluded that there were other, more important factors affecting medical malpractice premiums than caps or payouts for claims.[133] Until convincing evidence of a link

between caps on non-economic damages and premiums is demonstrated, they recommended that state regulators review and revise their parameters for approving insurance rate increases; that insurance companies practice more prudent actuarial analysis and planning; and that states cease licensing doctors who have lost their licenses in other states.

A June 2003 article in *Medical Liability Monitor* reported that insurers and doctors have criticized Weiss's methodology.[134] Limitations of the study cited include not differentiating between states by level of cap or when the cap was implemented, not weighting premiums according to market share when calculating average and median premiums, and not accounting for premium discounts or surcharges. In addition, the *Medical Liability Monitor* itself cautioned readers about the use of their data by Weiss to calculate state averages and medians.

A limitation of all the above studies is that none of them examined the impact of tort restrictions on quality of care or on access to compensation for injured individuals. OTA reported that the vast majority of injuries resulting from medical negligence do not result in lawsuits. Discussion of ways to help patients, such as increasing access to the courts for the many valid claims that are never filed and reducing the incidence of malpractice, has been "conspicuously absent" from arguments supporting restrictions on medical malpractice lawsuits, the OTA said.[135] Another OTA report noted that medical malpractice tort restrictions might have important unintended consequences, including impacts on the quality of care, the physician-patient relationship, access to the legal system, and the adequacy of compensation for patients injured by negligent care.[136] The American Academy of Actuaries also cautioned that the full impacts of tort reform must be considered:

> Although these reforms have been successful in reducing the cost of medical malpractice insurance, elected officials and regulators must still consider the effects of medical malpractice reform on physicians, consumers, health plans, and other interested parties. When considering medical malpractice reform, state and federal officials should weigh the impact on society as a whole and strive for a balanced, comprehensive solution.[137]

States must also consider the constitutionality of any limit on the right to sue, as several such limits have been declared unconstitutional. Appendix 3 lists the state tort reform laws that have been enacted from 1985 through 1997 and were subsequently declared unconstitutional.[138] A wide range of provisions in state constitutions have been used to overturn state tort reform laws. A 2001 article in *Rutgers Law Journal* noted that tort reform provisions have been successfully challenged on the bases of state constitutional provisions on: open courts and right to remedy, civil jury trial, due process and equal protection, and separation of powers.[139] Tort reform measures have also been overturned on the basis of process restrictions in state constitutions, such as single-subject limits, which require that state laws address one subject only. Also, some state constitutions have provisions that specifically protect tort remedies. For example, the Arizona Constitution includes the provision, "no law shall be enacted in this State limiting the amount of damages to be recovered for causing the death or injury of any person." The article also noted that, because there are no federal constitutional claims that could realistically be used to challenge state tort reform laws, state constitutions provide the only available basis for challenging these laws. A 1997 article in the *American Bar Association Journal* identified the

constitutional right of plaintiffs to trial by jury and to remedies in the courts for civil damages as the most common basis for overturning restrictions on tort suits.[140]

**Strengthened Enforcement of Nursing Home Quality Standards**

Because the ability to bring lawsuits is often seen as an important supplement to the regulatory system, tort reform proponents have often proposed that when legislative changes make bringing lawsuits more difficult, enforcement should be strengthened to fill in that void.

In addition to limits on litigation, Warfel's 2001 article recommended more effective state oversight of nursing homes, increased Medicare and Medicaid funding, and strengthened risk management programs. These changes, he said, would help to make reliance on lawsuits less necessary to ensure quality.[141]

The Mississippi study also recommended strengthened state oversight, in addition to tort reform.[142] The study cited literature showing that quality of care is a serious problem in nursing homes. The authors contended that these quality problems would be addressed more effectively through strengthened enforcement of the regulatory system, rather than litigation. Litigation, they said, is less effective because juries and attorneys lack the training and expertise needed to evaluate the quality of care provided and because large awards may actually harm the quality of care and increase costs. The study called for limitations on the ability to sue, combined with increased regulatory enforcement through the Medicare and Medicaid survey and certification process and use of the 1998 False Claims Act.[143] The False Claims Act makes it illegal to submit a false claim for payment to the United States government. The government has used the False Claims Act to enforce quality in nursing homes that are reimbursed through Medicare, Medicaid, and other federal health care programs.[144]

In his study for a law firm representing nursing home residents, Fishkind also identified improving quality of care as the solution to Florida's nursing home liability insurance crisis.[145] Specifically, he proposed:

- fostering competition among nursing homes by repealing the certificate of need process;
- fostering competition by establishing a voucher system for state-funded nursing home care, whereby instead of paying nursing homes, the state would give residents or their legal representatives a voucher for use at licensed facilities or for home care;
- mandating increased staffing; and
- strengthening state sanctions for violations of quality standards.

No studies were found that measured the effect of strengthened regulation and oversight on the cost and availability of liability insurance.

**Risk Management**

As the Florida Task Force commented in its 2001 report, the nursing home industry's failure to conduct risk management may be one factor contributing to current problems with the cost and availability of nursing home liability insurance.[146] This is changing, as nursing home providers, insurers, and consumer groups alike have called for more widespread use of risk management in

nursing homes. Risk management is intended to reduce the frequency and severity of claims and thereby lower the cost and improve the availability of liability insurance. Reports from long-term care providers and liability insurers suggest that risk management efforts can reduce liability insurance costs, in addition to improving quality. Florida has adopted a statute requiring nursing homes to have risk management and quality assurance programs.[147]

Several studies have recommended risk management as a solution to the long-term care liability insurance problem:

- Warfel, in his 2001 article, recommended that nursing homes invest greater resources in risk management, or loss control, to reduce the number of lawsuits resulting from inadequate care, as part of the solution to problems with the cost and availability of nursing home liability insurance.[148]
- The 2002 Aon white paper also recommended that nursing homes improve their risk management and loss control programs.[149]
- The 2001 Florida Task Force report just mentioned above said that risk management is essential to reduce insurance premiums.[150]
- An article in *Provider* magazine also highlighted the importance of risk management: "Both state regulators and attorneys specializing in long term care litigation recognize that the delivery of quality care and solid risk management practices will minimize potential liability exposures for long term care facilities."[151] According to the article, risk management programs should reduce malpractice lawsuits and moderate further increases in liability insurance premiums.

Reports from liability insurance companies and nursing homes suggest that risk management programs can improve quality and reduce liability insurance premiums. In the Weiss study, all six insurers that responded said they offer lower premiums to, or are more likely to insure, nursing homes with a full-time risk manager.

Below are four examples of risk management efforts that aim to lower liability insurance premiums for long-term care providers:

- Some nursing homes have begun using a new type of mattress that nearly eliminates pressure sores, which are caused when bed-bound persons are not moved frequently enough. According to the chief administrator of Provider Alliance, an insurance company, facilities may qualify for discounts of 5 to 12 percent on their liability insurance premiums by using these mattresses.[152] In addition, the company that manufactures these mattresses will indemnify nursing homes for $250,000 of liability for pressure sore lawsuits.
- In response to the increase in litigation and growing liability insurance premiums, one chain of long-term care facilities developed an electronic system to document care provided.[153] According to the chain's president, complete and accurate care records can provide a defense when a facility is sued: "You can give the best care, but if you didn't document it, it didn't happen," he said.
- Fall prevention programs have reduced premiums in assisted living. One chain of assisted living facilities lowered its liability insurance costs by instituting a fall reduction program, in

which residents who were at risk of falls were encouraged to wear a shoe and insert designed to improve gait and stability and reduce falls.[154]

- An assisted living company with more than 150 facilities found that, since instituting the company's risk management program in August 2001, facilities were able to cut liability claims in half and reduce workers' compensation claims by 30 percent.[155] As of December 2002, the program had not resulted in lowered premiums, though it appeared likely that premiums would be lowered after sufficient time had passed to show credible results. The company's risk manager said insurers were "impressed that we have committed these resources to risk management. However it takes time to show results." An insurance agency vice-president commented, "By monitoring risk management, [the company] is doing the best it can to reduce premiums—or at least keep them from going any higher. Do risk management voluntarily and being able [sic] to show reductions in claims. I can't overstate the importance of that."[156]

One potential drawback of risk management is that certain risk management programs are expensive for nursing homes to implement. Nonetheless, the 2001 Florida Task Force study concluded that the benefits outweigh the costs: "Aggressive risk management programs are expensive to implement, but it's difficult to imagine how the long-term care industry can afford to be without them any longer."[157]

**Experience Ratings**

An experience rating system is a system of rating nursing homes' insurability, including whether it has a strong risk management program, used by insurers to base premiums on a nursing homes' risk.[158] An experience rating system ensures that nursing homes that provide quality care have reduced premiums compared to nursing homes with poor care histories, just as individuals with good driving records pay lower automobile insurance premiums than drivers with histories of unsafe driving.

An example is the nursing home tier-rating system created by the Texas Department of Insurance, which currently applies only to nursing homes in Texas's Joint Underwriting Association.[159] Criteria used in assessing a nursing home's risk include:

- Past claims experience;
- Quality of care rating;
- Staff ratios;
- Tenure and credentials of key personnel;
- Risk management, loss control, and general safety; and
- Evaluation by the ombudsman program.

Texas Watch, a consumer advocacy organization, said that the tiered ratings were an important start in providing a public rating system of the nursing home industry.[160] The organization recommended expanding the rating system to all nursing homes operating in the state, to protect good quality nursing homes from undue premium increases and hold nursing homes accountable when they provide poor care. Similarly, the Foundation for Taxpayer & Consumer Rights recommended mandating that medical malpractice insurers use experience rating systems to

ensure that "physicians with histories of negligence or incompetence pay more, and doctors with clean records would be rewarded with lower rates."[161]

In another measure to link liability premiums to quality of care, Texas enacted a law in June 2001 that directs the state insurance commissioner to develop best practices for risk management for nursing homes, which the commissioner did in late 2001.[162] Texas insurers are authorized, but not required, to take into consideration whether a nursing home has adopted such practices in determining the facility's liability insurance rate.

In a March 2002 hearing on nursing home liability insurance in California, the Senate Office of Research recommended that California require nursing homes to meet best practices and require liability insurers to take nursing homes' compliance with best practices into account when setting premiums.[163] These best practices were unspecified by the California Senate Office of Research.

## Alternatives to Commercial Insurance

Some long-term care providers and states have responded to the nursing home liability insurance problem by developing alternatives to traditional insurance. Three alternatives to commercial insurance are self-insurance, group self-insurance, and joint underwriting agreements (JUAs) and other state-sponsored insurance pools. Although these options may help to improve the availability and affordability of insurance for some facilities, the 2001 Florida Task Force study cautioned that premiums would likely be as high as those charged by commercial insurance.[164] The Florida Task Force, in its 2001 study, consulted J. Sterling Shuttleworth, chief executive officer of Uni-Ter Underwriting Management Corp., for information on alternatives to competitive private insurance. Shuttleworth cautioned that the alternatives require careful review, may not be feasible in Florida, and would not be easy to implement if feasible. He also noted that it might be necessary to combine options.

### Self-insurance

Some nursing home providers are "self-insuring" by putting aside money designated for that purpose or by establishing an insurance company owned by the provider (called a "captive" insurance company).[165] These providers are not affected by the cost of commercial liability insurance.

### Group self-insurance

Some facilities are joining with other facilities to form companies that operate as insurance pools to cover lawsuit claims of their members (similar to self-insurance). A group of Florida nursing home operators have formed their own insurance company, the Long Term Care Risk Retention Group (LTCRRG).[166] The group will offer liability insurance to nursing homes that meet its quality standards. As of April 2002, the group was working to raise the $9 million in capital needed before the state's Department of Insurance will allow them to issue policies.[167] The group, which wants to have at least 125 high-quality skilled nursing facilities and assisted living facilities participating, plans to offer premiums at less than half the current rate and keep the rate flat for the next three years. Participating facilities are required to have a risk management program.[168] According to the LTCRRG's president, the company hopes to keep premiums more

affordable through "sound underwriting, quality measures, good risk management, and good review of an organization's policies."

Joint underwriting agreements and other state-sponsored insurance pools

A joint underwriting agreement (JUA) is an unincorporated association of insurance companies formed to provide a particular form of insurance to the public. It is one of several types of shared market mechanisms used to make insurance available to policy holders who are unable to obtain such insurance in the regular market. JUAs have been created in some states to ensure the availability of medical malpractice, auto, property, and commercial insurance coverage. JUAs are initiated by a state's department of insurance, and premiums and policies are subject to approval by the state. In 2002, Texas expanded its medical malpractice JUA to include nursing homes. That state's new JUA is beginning with coverage for nonprofit facilities only and covering medical (professional) liability only. Pennsylvania and Wisconsin also have medical malpractice JUAs that cover some nursing homes.[169]

Similar to a JUA, an insurance pool is a group of insurance companies that pool assets, enabling them to provide substantially more insurance than can be provided by individual companies.[170] Pools may be formed voluntarily or mandated by the state to cover nursing homes that cannot obtain coverage in the voluntary market. In April 2001, Arkansas passed legislation directing the state insurance commissioner to study whether liability insurance was "readily available" in the state and to establish a risk pool if a lack of available coverage was found.[171] The insurance commissioner subsequently determined the availability of insurance in the state to be a problem. As of February 2002, the state's Department of Insurance was proceeding with plans to create a voluntary liability insurance pool for nursing homes.

## Strengthened Regulation of the Insurance Industry

Insurance companies are regulated and monitored primarily by state governments, and regulation varies from state to state. State departments of insurance are responsible for protecting consumers by regulating premiums, ensuring the safety and soundness of companies operating in the state, and ensuring that companies treat potential and current policy holders fairly.

Americans for Insurance Reform, a coalition of more than 100 public interest organizations, has urged regulators to investigate the rise in insurance premiums and to freeze prices on homeowners and medical malpractice insurance.[172] Americans for Insurance Reform is a project of the Center for Justice and Democracy. The organization contends that insurers are increasing premiums at a rate far higher than needed to compensate for losses. On the other side, insurers responded that price increases are needed because of losses and increased risks.

In a July 2002 congressional hearing on medical malpractice litigation, representatives of several consumer groups testified in favor of five specific steps government could take to increase oversight of the insurance industry to lower medical malpractice insurance costs:[173]

- Repeal the McCarran Ferguson Act of 1945, which exempts insurance companies from federal antitrust laws. As a result of the Act, the federal government does not get involved if

insurance companies should engage in collusion, price-fixing, and other anticompetitive practices.
- Create a federal system of reinsurance, since private reinsurers can influence the prices charged and policies offered by primary insurers.
- Adopt federal legislation requiring insurance companies to disclose financial data, including the bases for their price changes.
- Investigate insurance industry practices and pricing and look for ways the federal government and state insurance departments can ensure that responsible pricing is enforced.
- Regulate insurers' pricing and accounting practices.

The effect of state oversight of the insurance industry on liability insurance premiums is unclear. In 1988, California voters passed an initiative instituting a set of insurance reforms that made California one of the strongest regulators of the insurance industry.[174] Advocates of insurance reform credited these reforms for California's low medical malpractice premiums, while proponents of tort limits credited California's limits on awards.

## Summary

Problems vary from state to state.
In recent years, many nursing homes have experienced greatly increased liability insurance premiums. In some states, many insurers have stopped selling nursing home liability insurance at any price. Although some studies show a trend toward more selective underwriting, other studies suggest that, in some states, premiums are increasing even for nursing homes that provide good quality of care and have no history of claims against them. The problems in obtaining nursing home liability insurance have been most prevalent in a few southern states, including Arkansas, Florida, Mississippi, Texas, and Virginia.

Many factors affect the cost and availability of nursing home liability insurance.
Increased nursing home litigation and a number of factors affecting the broader insurance market have affected the cost and availability of liability insurance. These factors include:

- the property/casualty insurance cycle;
- severe premium cuts during the 1990s;
- lower returns on investment income;
- more claims and payouts and perceived variability and unpredictability of claims;
- losses from claims resulting from the September 11, 2001 terrorist attacks; and
- insurers' business decisions.

Several solutions have been proposed.
The paper reviewed the research related to the six major policy proposals. To review briefly:
- *Tort reform*—Some studies suggests that certain types of tort reform may improve the availability and affordability of liability insurance, while other studies suggest that tort reforms are not effective. Additional research is needed to assess the impact of tort reforms on quality of care and access to compensation for residents who are harmed. Moreover, state courts have found some tort reform laws to be unconstitutional.

- *Strengthened enforcement of nursing home quality standards*—Some studies suggest that nursing homes that deliver poorer quality of care are more likely to be sued and are likely to pay higher premiums for liability insurance. Strengthened enforcement may improve quality of care and reduce the need for lawsuits, thereby potentially lowering insurance premiums. Proposals for strengthening enforcement include improving the Medicare and Medicaid survey and certification process and increasing the use of the False Claims Act.
- *Experience ratings*—An experience rating system would rate nursing homes' insurability on such factors as past claims experience, quality of care, staff ratios, and use of risk management. Nursing homes that provide quality care would have reduced premiums compared to nursing homes with poor care histories, just as individuals with good driving records pay lower automobile insurance premiums than drivers with histories of unsafe driving. An example is the nursing home tier-rating system created by the Texas Department of Insurance, which currently applies only to nursing homes in Texas's Joint Underwriting Association. The state insurance commissioner also established best practices for risk management in nursing homes, which insurers may consider when determining a facility's premiums.
- *Risk management*—Reports from nursing home liability insurance companies and nursing homes indicate that risk management can make liability insurance more available and affordable. However, implementing risk management programs can be expensive.
- *Alternatives to traditional insurance*—Alternatives to traditional insurance have made insurance more available and affordable for some nursing homes. However, such alternatives may not be able to provide affordable coverage for all nursing homes.
- *Strengthened regulation of the insurance industry*—The lack of any federal regulation or oversight of the insurance industry and the variability of state oversight make it difficult to determine the extent to which more oversight would increase the availability of affordable liability insurance.

## Conclusions

Two of the proposed solutions, namely risk management and increased oversight of nursing homes, may improve quality of care for nursing home residents. In addition, experience rating systems reward good providers with lower premiums and hold providers with a history of poor care accountable by charging them higher premiums. These merit attention as first steps in making liability insurance more affordable and available. Alternative forms of insurance may also offer solutions for many, if not all, nursing homes. These solutions should be given priority over litigation limits, which may have harmful consequences on quality of care and access to compensation for injured residents and their families.

Additional, rigorous research would be useful to better understand the effects of the proposed solutions on availability and affordability of long-term care liability insurance, as well as their effects on quality of care and access to compensation.

## Appendix 1: Summary of Key Sources

This appendix briefly describes the major sources cited in this paper, listed alphabetically by short name used in this paper.

**A.M. Best articles, May 2002**
Issues addressed: Cost and availability of insurance in various industries.
Scope and sample: News articles.
Comments: Articles published by A.M. Best, a company that provides insurance company ratings and information about the insurance industry.

**American Academy of Actuaries study, 1996**
Issues addressed: Impact of tort reform on medical malpractice insurance and liability costs.
Scope and sample: Analyzed outcomes of medical malpractice tort reform laws in three states.
Comments: Actuarial analysis.

**Americans for Insurance Reform study, 2002**
Issues addressed: Trends in medical malpractice payouts and factors affecting medical malpractice insurance premiums.
Scope and sample: Used A.M. Best data to compare medical malpractice payouts with premiums charged and the economic cycle of the insurance industry.
Comments: Study conducted by Americans for Insurance Reform, a consumer advocacy group promoting increased regulation of the insurance industry.

**Aon's 2002 and 2003 studies**
Issues addressed: Long-term care litigation and long-term care liability insurance cost and availability in the U.S.
Scope and sample: Respondents operated primarily nursing home beds, but also operated a number of assisted living, assisted living, home health care, and rehabilitation beds.

*Insurance data:* The 2002 study was based on a survey about insurance premiums and coverage for policy years 2000 and 2001 for 29 commercially insured long-term care providers nationwide. The 2003 study was based on insurance information from policy years 2001 and 2002 from 56 providers. In both studies, respondents to the questions on insurance premiums were primarily smaller, independent, and regional providers, both for-profit and not-for-profit. In the 2002 study, respondents operated an average of fewer than 3,000 beds and a median of approximately 1,000 beds. Respondents to the 2003 study were, on average, much smaller than respondents to the 2002 study, operating an average of 1,240 licensed beds, with half the respondents operating 61 or fewer beds. (The reports did not include the total number of beds operated by respondents.)

*Litigation data:* In the section of Aon's 2002 nationwide study addressing long-term care facilities' litigation experiences, 60 long-term care providers responded, representing 440,000 nursing home beds and 32,000 assisted or independent living beds, which Aon estimated at approximately 26 percent of all U.S. beds. Other sources indicate that the number of beds operated by respondents was somewhat less than 26 percent of nursing home beds, and

considerably less than 26 percent of all U.S. assisted and independent living beds.[††] Respondents were primarily large, for-profit chains, and facilities in states with high liability losses were overrepresented. Similarly, in Aon's 2003 study, 79 respondents, which Aon again estimated as representing 26 percent of U.S. beds, provided information on their litigation experiences. Respondents operated approximately 480,000 long-term care beds, primarily nursing home beds but also including an unspecified number of independent living, assisted living, home health care, and rehabilitation beds. As in the 2002 study, respondents were primarily large, for-profit chains.
Comments: Study funded by a long-term care provider trade association representing primarily for-profit providers. Conducted by Aon Risk Consultants, Inc., the risk management arm of Aon Corporation, which also provides retail, reinsurance and wholesale brokerage, claims management, specialty services, and human capital consulting services.[175]

With respect to the *litigation data*, for-profit facilities, large chains, and facilities in states with extraordinarily high liability losses are overrepresented. In contrast, *insurance premium data* are based primarily on responses from smaller, independent, and regional operators, both for-profit and not-for-profit. The large national chains were predominantly self-insured and did not report commercial insurance coverage information. Because results are based on a small, unrepresentative sample, and because of other methodological problems previous noted, the findings from this study cannot be generalized.

Research participants for each study were recruited by AHCA, a trade association representing primarily for-profit long-term care providers, through an "AHCA data call." The reports did not specify the nature of the "call," how providers were selected to receive it, or how many providers received it. Hence, the response rates for the studies are unknown. Providers who were most affected by increased premiums may have been more motivated to respond. Another limitation to the study is that it relied on self-reported information supplied by nursing home providers, without detailed verification or audit. To the extent that these providers were aware of the purpose of the report (to support efforts at tort reform), they had a financial incentive to overstate or mischaracterize their costs. Because of the small sample size and other limitations, results cannot be generalized to all nursing homes. Because of the great difference in number of beds operated by respondents, and because the studies did not provide information on premiums per bed, information is not comparable across the two studies.

**Aon white paper, 2002**
Issues addressed: Factors affecting the long-term care liability insurance market.
Scope and sample: Expert commentary and summary of research.
Comments: White paper written for long-term care providers representing non-profit providers.

[††] As of 1999, the National Investment Center estimated 1,928,714 skilled nursing beds, 585,735 assisted living beds, and 11,726 independent living seniors apartments (excluding active adult communities) in the United States (National Investment Center for the Seniors Housing & Care Industries (NIC), *NIC National Supply Estimate of Seniors Housing and Care Properties*, Annapolis, MD: NIC, 2000). According to these estimates, respondents to Aon's 2002 survey represented 23 percent of nursing home beds and five percent of assisted and independent living beds.

**Biondi article, 2001**
Issues addressed: Nursing home litigation; factors affecting nursing home liability insurance.
Scope and sample: Expert commentary.
Comments: Article in *The Actuarial Digest*, an actuarial journal, by Richard S. Biondi, a consulting actuary specializing in property and casualty insurance.

**Center for Justice and Democracy study, 1999**
Issues addressed: The impact of tort reform on the cost of liability insurance.
Scope and sample: Analyzed data from Insurance Services Office, Inc., in every state over a 14-year period, from 1985 to 1998.
Comments: Study conducted by a consumer advocacy organization. The study analyzed data from the Insurance Services Office on insurance premiums and loss costs (the portion of premiums paid that insurance companies use to pay for claims and to adjust claims) in every state over a 14-year period, from 1985 through 1998. The researchers categorized the states into three groups by the number of "major tort law limits" (major restrictions on the right to sue) enacted by the state and weighted by the number of years the laws had been in effect. Decisions as to what constituted a "major tort law limit" were based on information provided by the American Tort Reform Association (ATRA) and the Association of Trial Lawyers of America (ATLA) and additional legal research and consultation with lawyers or lobbyists in every state. A limitation of this method is that it treats all types of restrictions on the right to sue as equal and does not allow for assessing whether some are more effective in lowering insurance premiums than others. Another limitation of the study is that states with zero limits on the right to sue were placed in the same category as states that passed only one limit. For example, the following states were all placed in category "1": Massachusetts, which passed no tort limits; Mississippi, which enacted a law affecting joint and several liability only; Nebraska, which addressed collateral source offset only; and North Carolina, which enacted a punitive cap only. Trends in insurance rates and loss costs were examined separately for lines of insurance covering general tort, product liability, and medical malpractice insurance, since state tort restrictions often targeted one of these areas.

**Fishkind study, 2001**
Issues addressed: Factors affecting the cost and availability of long-term care liability insurance in central Florida.
Scope and sample: The study was based on data for 1998 to 2001 from 98 nursing homes in central Florida, as well as information from the Centers for Medicare and Medicaid Services, GAO, the Florida Department of Insurance, Fishkind and Associates, a Senate Interim Report, and the *Orlando Sentinel*.
Comments: Study conducted by economist Hank Fishkind and commissioned by a Florida law firm representing nursing home residents.

**Florida Department of Insurance report, 2000**
Issues addressed: Availability of long-term care liability insurance in Florida.
Scope and sample: The Florida Department of Insurance sent a survey to all 515 insurers that were authorized to sell any type of liability insurance in the state to determine which insurers were writing long-term care liability insurance. Based on the responses and additional information obtained from brokers, agents, trade associations, and others, a second survey was

sent to 79 insurance companies. All 79 responded. Nursing home claims data were based on claims reported by insurers who wrote long-term care liability insurance during the last three years, including 17 companies that were currently providing such coverage and 23 that had provided such coverage during the last three years and were no longer providing it, and two insurers who did not write any coverage during the last 3 years.
Comments: Report by Florida Department of Insurance.

**Florida Task Force study, 2001**
Issues addressed: Issues related to long-term care in Florida, including liability insurance and litigation.
Scope and sample: Analyzed nursing home residents' rights lawsuits in Florida over 10 years; interviewed individuals with knowledge of nursing home liability insurance and litigation; reviewed earlier research on cost of and access to nursing home liability insurance in Florida; reviewed in-depth these issues in Hillsborough County, Florida based on data from 28 nursing homes in Hillsborough County, Florida.
Comments: In May 2000, the Florida legislature passed legislation to create a Task Force on the Availability and Affordability of Long-Term Care, to study and make recommendations on issues related to long-term care, including liability insurance and litigation. The legislation named the University of South Florida's Florida Policy Exchange Center on Aging (which also conducted the study of Florida nursing homes funded by a long-term care provider association referred to in this study) to provide staff support to the Task Force. An Informational Report released in February 2001 presents the results of the Task Force's study.

**Harvard study, 2003**
Issues addressed: Litigation against nursing homes.
Scope and sample: Survey of 278 attorneys that bring or defend claims against nursing homes.
Comments: A limitation of the study is that it does not validate attorneys' reports of awards, and attorneys may have had problems remembering and estimating details of their cases such as average payment amounts and percent of cases won. Also, information from the litigants' attorneys is often of limited value because in tort cases there is often no clear-cut winner. First, if a plaintiff's case involves many claims, if he or she loses most of them, the nursing home may claim it won. Yet the plaintiff's attorney will also claim victory because it got some money for his or her client. Second, cases that do not go to trial are usually settled for significantly less than the amount requested. If a million dollar case is settled for $50,000, both sides may consider this a won. These factors may explain the discrepancies in reports by the plaintiff and defense attorneys in the study. Plaintiff attorneys estimated winning 61 percent of their cases, while defense attorneys estimated winning 68 percent of their cases. Plaintiff attorneys reported an average recovery of $436,000, while defense attorneys reported an average of $384,000, a $52,000 per case difference.

A further limitation is that the study does not distinguish between jury verdicts, settlements, and amounts actually paid. There is no evidence that the amounts reported were ever actually paid—verdicts can be set aside by a judge, compromise by settlement pending appeal, or reduced on appeal.

**HHS paper, 2002**
Issues addressed: Tort reform in the medical liability system.
Scope and sample: Policy report.
Comments: Paper by the U.S. Department of Health and Human Services (HHS); supports the President's proposals for restrictions on litigation.

**Insurance Information Institute (III) report, 2002**
Issues addressed: Litigation and liability insurance markets.
Scope and sample: Analyzed insurance industry data from A.M. Best, ISO, III, and several other sources.
Comments: Presentation by III, a company that provides information on insurance topics.

**Insurance Services Office article, December 2001**
Issues addressed: The property/ casualty insurance industry.
Scope and sample: News article.
Comments: News article by Insurance Services Office, Inc., a company that provides information about the insurance industry.

**Jury Verdicts Research study, 2001**
Issues addressed: Nursing home litigation.
Scope and sample: Using Jury Verdict Research's database of plaintiff and defense verdicts and settlements**,** the study examined the most frequently occurring types of lawsuits against nursing homes nationwide during "the most recent 10-year period." The exact dates were not reported.
Comments: Report by Jury Verdicts Research, a research firm that provides reports to plaintiff and defense attorneys on verdicts and settlements resulting from personal injury claims. Sample of cases may not be representative.

**Mississippi study, 2002**
Issues addressed: Topics related to the long-term care industry in Mississippi, including the tort system and nursing homes and the cost of nursing home liability insurance.
Scope and sample: The study's analysis of insurance costs included the results of a survey of 22 of Mississippi's approximately 200 nursing homes conducted by the Mississippi Health Care Insurance Services Corporation. The study also included an analysis of data from Medicaid cost reports from 167 facilities. In the section of the study addressing litigation, the study cited a separate report, by the Mississippi Health Care Association.
Comments: Study partially funded by a law firm representing nursing home providers. Literature review includes survey of 22 of Mississippi's approximately 200 nursing homes conducted by the Mississippi Health Care Insurance Services Corporation. Because of the small sample size, results cannot be generalized to all nursing homes in the state. Also includes discussion of the results from a report by the Mississippi Health Care Association; does not describe the methodology of this report.

**Office of Technology Assessment (OTA) study, 1993**
Issues addressed: Effect of restrictions on medical malpractice suits on medical malpractice insurance premiums.
Scope and sample: Analyzed results from six previous studies.

Comments: Study conducted by the federal government. OTA's conclusions were tentative, because "All of the studies had serious methodological flaws."

**Texas Department of Human Services study, 2001**
Issues addressed: Nursing home liability insurance cost and coverage in Texas.
Scope and sample: Surveyed all certified nursing homes in Texas and asked if they had liability insurance and what the costs were for the coverage; 935 homes (88 percent of all certified homes in Texas) responded.
Comments: Study by the Texas Department of Human Services.

**Texas Senate Research Center study, 2001**
Issues addressed: Nursing home liability insurance premiums in Texas.
Scope and sample: Information on nursing home liability insurance premiums were based on Texas Department of Insurance data and interviews with Texas Department of Insurance staff.
Comments: Study by the Texas Senate Research Center.

**University of South Florida study, 2001**
Issues addressed: Nursing home litigation; liability insurance cost and availability in Florida.
Scope and sample: Survey of 422 Florida nursing homes, representing 65 percent of all Florida nursing homes.
Comments: Study funded by a provider association representing Florida long-term care facilities.

**Warfel article, 2001**
Issues addressed: The price and availability of nursing home liability insurance; tort reform.
Scope and sample: Expert commentary.
Comments: Article in insurance journal by William J. Warfel, a professor of insurance and risk management at Indiana State University.

**Weiss Ratings, Inc. study, 2003** (a separate study from the survey conducted for AARP)
Issues addressed: The effect on non-economic damage caps on medical malpractice insurance
Scope and sample: National data from the National Practitioner Data Bank and the *Medical Liability Monitor*.
Comments: Study by Weiss Ratings, Inc., a company that rates insurance companies and other financial institutions. Weiss Ratings is the only major ratings agency that receives no compensation from the companies it rates.

## Appendix 2: Weiss Ratings' Methodology

### Contacting the Insurers

Using its financial database, Weiss identified 1,024 insurance companies that might write nursing home liability insurance. Then, using information provided by Marsh USA Inc., an international risk management and insurance brokering firm, and the Florida Department of Insurance, Weiss narrowed the universe of current or former nursing home liability insurers to 66.

Weiss mailed (or in some instances, faxed) surveys to these 66 insurance companies in October 2001. Weiss then contacted all nonrespondents via telephone and faxed additional copies of the survey to them. This follow-up continued for the duration of the project.

Of the 66 insurance companies contacted, 20 indicated that they no longer write nursing home liability insurance and were unwilling to participate in the survey, and 37 did not respond to either the survey or the follow-up phone calls. Of the nine companies that returned completed survey responses, six currently write this coverage.

The six respondents to the Weiss survey reported an aggregate 2001 premium of $400 million, which Weiss estimates to represent approximately 40 percent of the total market underwriting nursing home liability insurance.

Once the surveys were returned, Weiss contacted the six respondents to schedule face-to-face interviews for additional insight. Two responding companies agreed to on-site interviews; two others preferred to conduct phone interviews. Two of these were with representatives of large insurers currently writing business in most markets; one interview was with a small insurer no longer writing this line of business, and one was with a company that entered this market only recently. The remaining two survey respondents declined to participate in a follow-up interview.

### Contacting Insurance Brokers

Using its own subscriber list and other sources, Weiss compiled a list of 139 U.S. insurance brokers participating in the market for nursing home liability insurance. Surveys were mailed to all 139 firms in October 2001.

Weiss contacted all nonrespondents via telephone and faxed additional copies of the survey. This follow-up continued for the duration of the project.

Of the 139 brokers contacted, four said they were unwilling to participate in the survey or no longer worked with nursing homes, and 125 did not respond to the survey or the follow-up phone calls. Of the 10 completed survey responses, eight respondents currently work with nursing homes.

### Contacting State Regulators

In addition, Weiss's staff visited the Departments of Insurance (DOIs) in Florida and Pennsylvania in November 2001. The Florida DOI was chosen because of that state's recent

regulatory activity. The Pennsylvania DOI was chosen because that state has eliminated its approval process for long-term care liability rate increases.

**Limitations**

Few insurers or brokers responded to the survey or to requests for interviews, and some of the survey respondents did not answer all of the questions. Hence, the opinions of those who chose to respond cannot represent of the views of all insurers, brokers, or state Departments of Insurance. Another limitation is that respondents' statements may reflect inaccurate information. Respondents may have particular political points of view, and their opinions may have been influenced by various media stories or advocacy studies of the issue. Although one cannot generalize based on this limited sample, the responses did provide some insight into the attitudes, opinions, and beliefs of some members of the nursing home liability insurance industry.

## Appendix 3: General, Products Liability, and Medical Malpractice Tort Reforms that Have Been Declared Unconstitutional, 1985 – 1997[176]

### General Tort Reforms

| State | Year Enacted | Type | Year Declared Unconstitutional |
|---|---|---|---|
| Alabama | 1987 | Punitive cap | 1993 |
| | 1987 | Collateral source | 1996, declared unconstitutional in part |
| Florida | 1988 | Cap, noneconomic | 1991 |
| Illinois | 1995 | Cap, noneconomic | 1997 |
| | 1995 | Joint and several liability | 1997 |
| | 1995 | Punitive cap | 1997 |
| Kansas | 1986 | Structured settlements | 1988 |
| | 1988 | Collateral source | 1993 |
| Kentucky | 1988 | Collateral source | 1995 |
| Montana | 1987 | Joint and several liability | 1994 |
| New Hampshire | 1986 | Cap, noneconomic | 1991 |
| Washington | 1986 | Cap, all damages | 1989 |

### Products Liability Tort Reforms

| State | Year Enacted | Type | Year Declared Unconstitutional |
|---|---|---|---|
| Alabama | 1987 | Punitive cap | 1993 |
| | 1987 | Collateral source | 1996, declared unconstitutional in part |
| Florida | 1988 | Cap, noneconomic | 1991 |
| Georgia | 1987 | Punitive, one per product | 1990 |
| Illinois | 1995 | Cap, noneconomic | 1997 |
| | 1995 | Joint and several liability | 1997 |
| | 1995 | Punitive cap | 1997 |
| | 1995 | Products statute of repose | 1997 |
| | 1995 | Products liability defenses | 1997 |
| Kansas | 1986 | Structured settlements | 1988 |
| | 1988 | Collateral source | 1993 |
| Kentucky | 1988 | Collateral source | 1995 |
| Montana | 1987 | Joint and several liability | 1994 |
| N. Hampshire | 1986 | Cap, noneconomic | 1991 |
| Washington | 1986 | Cap, all damages | 1988 |

**Medical Malpractice Tort Reforms**

| State | Year Enacted | Type | Year Declared Unconstitutional |
|---|---|---|---|
| Alabama | 1987 | Med mal cap | 1991 |
| | 1987 | Punitive cap | 1993 |
| | 1987 | Collateral source | 1996, declared unconstitutional in part |
| Arizona | 1989 | Med mal structured settlements | 1994 |
| Florida | 1988 | Cap, noneconomic | 1991 |
| Illinois | 1995 | Cap, noneconomic | 1997 |
| | 1995 | Joint and several liability | 1997 |
| | 1995 | Punitive cap | 1997 |
| Kansas | 1986 | Med mal cap | 1988 |
| | 1986 | Med mal structured settlements | 1988 |
| | 1988 | Collateral source | 1993 |
| Kentucky | 1988 | Collateral source | 1995 |
| Montana | 1987 | Joint and several liability | 1994 |
| N. Hampshire | 1986 | Cap, noneconomic | 1991 |
| S. Dakota | 1986 | Med mal cap, economic | 1996 |
| Texas | 1987 | Med mal cap | 1988 |
| Washington | 1986 | Cap, all damages | 1988 |

## References

[1] Insurance Information Institute, http://www.iii.org/media/glossary/alfa.L/, accessed December 18, 2002.
[2] Insurance Information Institute. "The Liability System," http://www.iii.org/media/hottopics/insurance/liability/, accessed December 18, 2002.
[3] Some consumer advocates and attorneys object to this term. See, for example, J. Robert Hunter and Joanne Doroshow. "Premium Deceit: The Failure of 'Tort Reform' to Cut Insurance Prices." New York: Citizens for Corporate Accountability and Individual Rights, 1999;" Mark Thompson, "Letting the Air out of Tort Reform: After making inroads in state legislatures, proponents of restrictions on tort suits now are fighting in the courts to protect their gains," *ABA Journal*, May 1997, 83, 64; The Foundation for taxpayer & Consumer Rights, "Comparing Consumer-Backed Reforms to 'Tort Reform,'" Factsheet, http://www.consumerwatchdog.org/insurance/fs/fs002635.php3, accessed April 4, 2003.
[4] The Committee on Energy and Commerce. Harming Patient Access to Care: The Impact of Excessive Litigation. July 17, 2002; "California Cited on Both Sides of Liability Reform Debate." Older Americans Report (June 21 2002); Treaster, Joseph B.; "Consumer Groups Unite to Track Insurance Prices: Organization Wants to Investigate Increases," *The New York Times*, July 30, 2002, C2.
[5] Insurance Information Institute, http://www.iii.org/media/glossary/alfa.L/, accessed December 18, 2002.
[6] Insurance Information Institute. "The Liability System," 2002, op. cit.
[7] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993." Tampa, FL: Florida Policy Exchange Center on Aging, University of South Florida, 2001, p. 630.
[8] Bourdon, Theresa W. and Sharon C. Dubin, *Long Term Care General Liability and Professional Liability Actuarial Analysis*, Aon Risk Consultants, Inc., March 3, 2003.
[9] Theresa W. Bourdon and Sharon C. Dubin. "Long Term Care: General Liability and Professional Liability Actuarial Analysis." Aon Risk Consultants, Inc., 2002; Bourdon and Dubin, 2003, op. cit..
[10] "Aon Corporation," http://www.aon.com/about/aon_corporation/default.jsp, accessed December 27, 2002.
[11] Bourdon and Dubin, 2002.
[12] Bourdon and Dubin, 2003, op. cit.
[13] Texas Department of Human Services. "Nursing Home Liability Insurance Survey," January 31, 2001.
[14] David Thomason, "Nursing Home Liability Insurance Rates: Factors Contributing to the Rate Increases in Texas," *In Brief,* (Austin, TX: Texas Senate, Senate Research Center), February 2001.
[15] Charles A. Campbell et al. "An Independent Study of the Long-Term Care Industry in Mississippi." The John C. Stennis Institute of Government, 2002.
[16] Thomason, 2001, op. cit.
[17] Bourdon and Dubin, 2002, op. cit.
[18] Bourdon and Dubin, 2002; 2003.
[19] Ibid.
[20] Texas Department of Human Services, 2001, op. cit.
[21] Bourdon and Dubin, 2002; 2003, op. cit.
[22] Deborah Hedgecock and Jennifer R. Salmon. "Lawsuits and Liability Insurance Experience of Florida Nursing Facilities, January-October 5, 2001." Tampa, FL: Florida Policy Exchange Center on Aging, University of South Florida, 2001.
[23] Florida Department of Insurance, *Revised Liability Data Call Results,* September 21, 2000.
[24] Associated Press Newswires. "Lawyers Critical of Insurance Department Proposal on Nursing Home Coverage," October 9, 2001.
[25] Thomason, 2001, op. cit.
[26] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[27] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit., p. 630.
[28] Richard. S. Biondi. "Nursing Home Liability Insurance," *The Actuarial Digest* 20 (4) (2001).
[29]Hedgecock and Salmon, 2001, op. cit., p. 20.
[30] Personal communication with Deborah Hedgecock, April 11, 2003.
[31] Hedgecock and Salmon, 2001, op. cit., p. 20.

[32] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit., p. 48.
[33] Texas Department of Human Services, 2001, op. cit.
[34] Hedgecock and Salmon, 2001, op. cit.
[35] Doughton, Sandi, "High insurance rates have nursing homes 'going bare,' The Seattle Times, March 30, 2003. http://seattletimes.nwsource.com/html/localnews/134665122_noinsure30m.html
[36] California Senate, Senate Office of Research, "Overview of States' Efforts to Address Nursing Home Liability Insurance Problems," March 2002.
[37] Doughton, 2003, op. cit.
[38] Ibid.
[39] Hedgecock and Salmon, 2001, op. cit., 18-19.
[40] Ibid.
[41] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. "National Health Expenditures," 2000.
[42] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System." Washington, DC: HHS, 2002, p. 13.
[43] Bourdon and Dubin, op. cit. 2002; 2003.
[44] Ibid, p. 3.
[45] See, for example, Nathan Childs. "The Lingering Insurance Question," *Provider* (American Health Care Association) (April 2002), 29-36.
[46] Stevenson, David G. and David M. Studdert, "Trends: The Rise of Nursing Home Litigation: Findings from a National Survey of Attorneys," *Health Affairs*, 22, no. 2 (March/April 2003).
[47] Childs, 2002, op. cit.
[48] GAO. "Nursing Home Expenditures and Quality," June 2002. GAO-02-431R; GAO. "Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase," November 2002. GAO-03-176.
[49] Schmitt, Christopher H. "The New Math of Old Age: Why the nursing home industry's cries of poverty don't add up," *U.S. News and World Report,* September 30, 2002, 67-74.
[50] Campbell et al., 2002, op. cit., p. 24.
[51] See, for example, Theresa W. Bourdon and Sharon C. Budin. "Florida Long Term Care General Liability and Professional Liability Actuarial Analysis." Aon Worldwide Actuarial Solutions, 2000; Theresa W. Bourdon and Sharon C. Dubin. "Florida Long Term Care General Liability and Professional Liability Actuarial Analysis." Aon Risk Consultants, Inc., 2001; Bourdon and Dubin, 2002; 2003, op. cit.; Energy and Commerce Committee. "Harming Patient Access to Care: The Impact of Excessive Litigation." Testimony by Richard Anderson, on behalf of the Physician Insurers Association of America, July 17, 2002.
[52] Bourdon and Dubin, 2002, op. cit., p.3; Bourdon and Dubin, 2003, op. cit., p. 3.
[53] Joseph B. Treaster. "Consumer Groups Unite to Track Insurance Prices: Organization Wants to Investigate Increases." *New York Times* (July 30, 2002); http://www.insurance-reform.org/list.html, accessed April 21, 2003.
[54] Americans for Insurance Reform. "Medical Malpractice Insurance: Stable Losses/Unstable Rates." New York: Author, 2002.
[55] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[56] Stevenson and Studdert, 2003, op. cit.
[57] Groeller, Greg, and Bob LaMendola, "Skyrocketing Suits Spur Crisis in Care Residences Plagued with Financial Dilemmas," *South Florida Sun-Sentinel*, Fort Lauderdale, FL, March 4, 2001.
[58] Jury Verdicts Research. *The 5 Myths of Nursing Home Litigation*. Horsham, PA: LRP Publications, 2001.
[59] Bourdon and Dubin, 2003, op. cit.
[60] Biondi, 2001, op. cit.
[61] Ibid.
[62] Stevenson and Studdert, 2003, op. cit.
[63] Bourdon and Dubin, 2002, op. cit.
[64] Bourdon and Dubin, 2003, op. cit.
[65] Florida Department of Insurance, 2000, op. cit.; Pilla David, "Long Term-Care Liability Market Continues to Shrink," *Best's Insurance News*, September 25, 2000.

[66] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[67] Campbell et al., 2002, op. cit.
[68] Groeller and LaMendola, "Skyrocketing Suits Spur Crisis in Care," 2001, op. cit.
[69] Bourdon and Dubin, 2003, op. cit., 7.
[70] Ibid.
[71] Bourdon and Dubin, 2002, op. cit.
[72] Bourdon and Dubin, 2003, op. cit.
[73] Hedgecock and Salmon, 2001, op. cit.
[74] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[75] Randall R. Bovbjerg, Principal Research Associate, Health Policy Center, The Urban Institute, Washington, D.C. Personal communication.
[76] Bourdon and Dubin, 2002, op. cit.
[77] Bourdon and Dubin, 2003, op. cit.
[78] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[79] William J. Warfel. "Nursing Home Litigation—A Case for Reform." *CPCU (Chartered Property and Casualty Underwriters) Journal* 54 (4) (2001): 2.
[80] Biondi, 2001, op. cit.
[81] Bourdon and Dubin, 2002, op. cit.
[82] Bourdon and Dubin, 2003, op. cit.
[83] U.S. General Accounting Office. "California Nursing Homes: Care Problems Persist Despite Federal and State Oversight," 1998; Centers for Medicare and Medicaid Services. "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II Final Report." Baltimore, MD: Author, 2001; Bernadette Wright. "Federal and State Enforcement of the 1987 Nursing Home Reform Act." Washington, DC: AARP, 2001.
[84] Hank Fishkind. "Economic Analysis of the Liability Insurance Crisis Facing Florida's Nursing Homes." Fishkind & Associates, Inc., 2001; Lade, Diane C. "Some well-kept nursing homes have never been sued," *Sun-Sentinel* (Mar. 5, 2001); "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.; Hedgecock and Salmon, 2001, op. cit.
[85] Fishkind. 2001, op. cit.; Lade, 2001, op. cit.; "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[86] Fishkind, 2001, op. cit; Lade, 2001, op. cit.
[87] Fishkind, 2001, op. cit.
[88] U.S. General Accounting Office. "Nursing Homes: Success of Quality Initiatives Requires Sustained Federal and State Commitment." Washington, DC: Author, 2000.
[89] Thomason, 2001, op. cit.
[90] Centers for Medicare and Medicaid Services, 2001, op. cit.
[91] Charlene Harrington et al. "Does Investor Ownership of Nursing Homes Compromise the Quality of Care?" *American Journal of Public Health* 91 (9) (2001).
[92] Lade, 2001, op. cit.
[93] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[94] Hedgecock and Salmon, 2001, op. cit.
[95] GAO. "Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards," 1999; GAO. "Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents," 1999; GAO. "Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality," 1999; GAO. HCFA "Initiatives to Improve Care Are Under Way but Will Require Continued Commitment," 1999; GAO. "Nursing Homes: Efforts Are Essential to Realize Potential of the Quality Initiatives," 2000.
[96] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[97] Biondi, 2001, op. cit.
[98] Warfel, 2001, op. cit., 2.
[99] AHCA. "AHCA: Restoration of Medicare Cuts Must Be Top Priority on January Congressional Docket." Press release, November 22, 2002. Available at http://www.ahca.org/brief/nr021122.htm, accessed January 7, 2002.

[100] GAO. "Nursing Home Expenditures and Quality," 2002, op. cit.
[101] GAO. "Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase," 2002, op. cit.
[102] Snalfnews.com. LTC Daily Analysis Briefs. "Medicare Payments to SNFs 'Adequate,' MedPAC Says," December 17, 2002.
[103] BDO Seidman, LLP, "A Briefing Chartbook on Shortfalls in Medicaid Funding for Nursing Home Care," prepared for American Health Care Association, July 11, 2002.
[104] Schmitt, 2002, op. cit.
[105] Stevenson and Studdert, 2003, op. cit.
[106] Ibid.
[107] Lynna Goch. "Cover Charge." A.M. Best, accessed May 17 2002. Available from http://www.bestreview.com/2002-05/pc_charge.html/
[108] Ron Panko. "Hard Market Hits Fairway." A.M. Best, accessed May 17 2002. Available from http://www.bestreview.com/2002-05/pc_hits.html/
[109] Christopher Oster. "Businesses' Insurance Costs Surge, but They Shouldn't Blame Sept. 11." *Wall Street Journal* (April 1, 2002).
[110] William H. Panning. "Laws and Profits." *Best's Review* (May 2002).
[111] Sharon Fine. "State of the Insurance Market for Long-Term Care Providers." Washington, DC: American Association of Homes and Services for the Aging, 2002.
[112] Christopher Oster, April 11, 2002, op. cit.
[113] Insurance Services Office, Inc. "First-Ever Nine-Month Net Loss for Property/Casualty Industry in Wake of September 11 Attack and Deterioration in Investment Results," 2001 (accessed May 2, 2002). Available from http://www.iso.com/docs/pres260.htm
[114] Robert P. Hartwig. "Liability Trends, Issues and Jury Verdicts: Impact on Insurance Liability and Excess Casualty Markets." New York: Insurance Information Institute, 2002.
[115] Robert P. Hartwig. "Liability Trends, Issues and Jury Verdicts: Impact on Insurance Liability and Excess Casualty Markets." New York: Insurance Information Institute, 2002.
[116] Insurance Services Office, Inc. 2001, op. cit.
[117] Hedgecock and Salmon, 2001, op. cit.
[118] Christopher Oster, April 11, 2002, op. cit.
[119] Rachel Zimmerman and Christopher Oster. "Insurers' Missteps Helped Provoke Malpractice 'Crisis'." *The Wall Street Journal* (June 24, 2002).
[120] Jeff Smokler. "Lawmakers Argue against Tort Reform." *Provider* (September 2002); Jamie Court, Foundation for Taxpayer and Consumer Rights, testimony, "Harming Patient Access to Care: The Impact of Excessive Litigation," House Energy and Commerce Committee, Subcommittee on Health, July 17, 2002; Travis Plunket, Consumer Federation of America, testimony; Lauren Townsend, Coalition for Consumer Justice, testimony.
[121] Smokler, 2002, op. cit.
[122] Some consumer advocates and attorneys object to this term. See, for example, Hunter and Doroshow, 1999, op. cit.; Thompson, 1997, op. cit.; The Foundation for Taxpayer & Consumer Rights, accessed 2003, op. cit.
[123] "AAHSA Applauds House Passage of Medical Liability Reform." Statement by Jennifer Hilliard, Public Policy Attorney, AAHSA, September 26, 2002.
[124] William J. Warfel, 2001, op. cit.
[125] Lade, 2001, op. cit.; Correspondence with Toby Edelman of Center for Medicare Advocacy, December 11, 2002.
[126] Florida Task Force on the Availability and Affordability of Long-Term Care, 350 (Dec. 1, 2000, Second Draft Report), cited in correspondence with Toby Edelman of Center for Medicare Advocacy, December 11, 2002.
[127] Hunter and Doroshow, 1999, op. cit.
[128] American Insurance Association. "AIA Cites Flaws in Critic's Report on Tort Reform." Washington, DC: Author, 2002; House Committee on Energy and Commerce. "Harming Patient Access to Care: The Impact of Excessive Litigation." Testimony by Lauren Townsend, Coalition for Consumer Justice, July 17, 2002.
[129] "Medical Malpractice Tort Reform: Lessons from the States." Washington, DC: American Academy of Actuaries, 1996.
[130] U.S. Congress, Office of Technology Assessment. "Impact of Legal Reforms on Medical Malpractice Costs." Washington, DC: U.S. Government Printing Office, 1993.

[131] Weiss, Martin D., Melissa Gannon, and Stephanie Eakins, *Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage.* Palm Beach Gardens, Florida: June 2, 2003 (Revised), Weiss Ratings, Inc.
[132] Ibid.
[133] Ibid.
[134] "Weiss study says caps not the answer; methodology disputed by insurers," *Medical Liability Monitor*, Vol. 28, No. 6, June 2003, 1.
[135] U.S. Congress, Office of Technology Assessment. "Impact of Legal Reforms on Medical Malpractice Costs."
[136] U.S. Congress, Office of Technology Assessment. "Defensive Medicine and Medical Malpractice." Washington, DC: U.S. Government Printing Office, 1994.
[137] "Medical Malpractice Tort Reform: Lessons from the States," 1996, op. cit.
[138] Hunter and Doroshow, 1999, op. cit.
[139] Williams, Robert F. "Forward: Tort Reform and State Constitutional Law," 32 *Rutgers Law Journal*, 897, Summer 2001.
[140] Thompson, 1997, op. cit.
[141] Warfel, 2001, op. cit.
[142] Campbell et al., 2002, op. cit.
[143] Title 31, Chapter 37 – the False Claims Act. .U.S.C. §§ 3729 – 3733.
[144] Snalfnews.com. "Whistleblowers Continue to Target Health Care," December 18, 2002, http://www.snalfnews.com/AnalystNews.cfm?id=259, accessed December 23, 2002.
[145] Fishkind, 2001, op. cit.
[146] Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993, 2001, op. cit.
[147] California Senate, Senate Office of Research, "Overview of States' Efforts to Address Nursing Home Liability Insurance Problems," 2002, op. cit.
[148] Warfel, 2001, op. cit.
[149] Fine, 2002, op. cit.
[150] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[151] June E. Leigh. "Assisted Living: A Risky Business." *Provider* (August 2002), 49.
[152] "Mattress Manufacturer Softens Costs of Florida Liability Insurance for LTC." *Housing the Elderly Report* (April 2002).
[153] Lyn Wagner. "Regional Provider Seizes Technology: Rise in Litigation Impacts Decision." *Provider* (September 2002).
[154] Arthur Seifert. "Chipping Away at Insurance Costs." *Assisted Living Today* (August 2002).
[155] "Emeritus stresses risk management." *Briefings on Assisted Living* 8 (12) (December 2002).
[156] "An insider's tips on finding the best insurance package." *Briefings on Assisted Living* 8 (12) (December 2002).
[157] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[158] Thomason, 2001, op. cit.
[159] Ibid.
[160] Thomason, 2001, op. cit.
[161] The Foundation for Taxpayer & Consumer Rights, "How to Address the Insurance and Malpractice Crises Facing the Nation," Factsheet, http://www.consumerwatchdog.org/healthcare/fs/fs003112.php3, accessed April 4, 2003.
[162] Devore, Elizabeth. "Nursing Homes: The Escalating Crisis," National Conference of State Legislatures, Health Policy Tracking Service, February 2002.
[163] March 6, 2002, "Nursing Home Closures, Bankruptcies, and Liability Insurance: Is there a Crisis?" Testimony of Peter Hansel, Hearing of Senate Health and Human Services Committee and Senate Subcommittee on Aging and Long-Term Care, California.
[164] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[165] Hedgecock and Salmon, 2001, op. cit.
[166] Carrie Brown. "Florida Nursing-Home Operators Form Own Liability-Insurance Company." *Housing the Elderly Report* (April 2002).
[167] "Providers Form Their Own Liability Insurance Company in Florida." *BAL (Briefings on Assisted Living)*

*Weekly* (January 30, 2002).
[168] Lyn Wagner. "Florida Long Term Care Facilities Launch Self-Insurance Plan," *Provider* (American Health Care Association) (2002).
[169] "Informational Report of the Task Force on Availability and Affordability of Long-Term Care for the Florida Legislature in Response to House Bill 1993," 2001, op. cit.
[170] Insurance Information Institute, "Glossary of insurance terms," http://www.iii.org/media/glossary/, accessed April 3, 2003.
[171] Devore, op. cit.
[172] Treaster, op. cit.
[173] The Committee on Energy and Commerce. *Harming Patient Access to Care: The Impact of Excessive Litigation*. July 17, 2002.
[174] "California Cited on Both Sides of Liability Reform Debate." *Older Americans Report* (June 21 2002).
[175] "Aon Corporation," http://www.aon.com/about/aon_corporation/default.jsp, accessed December 27, 2002.
[176] Hunter and Doroshow, 1999, op. cit.