U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

THE NURSING HOME LIABILITY INSURANCE MARKET:

A CASE STUDY OF CALIFORNIA

June 2006

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract #HHS-100-97-0019 between HHS's ASPE/DALTCP and Medstat. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Susan Polniaszek, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Susan.Polniaszek@hhs.gov.

THE NURSING HOME LIABILITY INSURANCE MARKET:
A Case Study of California

Brian Burwell
Eileen Tell

Thomson Medstat

June 1, 2006

Prepared for
Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHS-100-97-0019

The opinions and views expressed in this report are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services, the contractor or any other funding organization.

TABLE OF CONTENTS

INTRODUCTION 1

STATE ENVIRONMENT 2
- California Nursing Home Industry 2
- Nursing Home Quality and Oversight in California 3
- Nursing Home Litigation and Liability Insurance Trends in California 3
- Nursing Home Liability Insurance Market in California 5
- Legal and Legislative Environment in California 7

SUMMARY 13

APPENDIX A: EXAMPLE OF THE PROCESS BY WHICH AN EADACPA CASE MIGHT BE LITIGATED 14

REFERENCES 19

GLOSSARY 21

TABLES 25
- TABLE 1: Aon Estimates of Nursing Home Liability Costs--California vs. U.S.

INTRODUCTION

The market for professional liability insurance for nursing home operators has been in a state of flux in recent years, beginning in the late 1990s. The cost of professional liability insurance has increased dramatically in all areas of the country, though much higher increases have occurred in some regions than in others. Concurrently, the availability of insurance coverage has decreased, as many admitted insurance carriers incurred significant losses in this product line, and decided to exit the market altogether. Those carriers that decided to stay in the market have changed the terms and conditions of liability coverage, taking on less risk at higher prices.[a] The high cost and limited availability of professional liability insurance has resulted in a growing number of nursing home operators being forced to operate without any professional liability insurance coverage whatsoever.

A major factor contributing to the recent turbulence in the nursing home liability insurance market is increased litigation activity against nursing home operators. However, the nature of the link between nursing home litigation and the cost and availability of professional liability insurance is a matter of considerable debate in the policy arena.

This report is one of five case studies prepared as part of a larger study sponsored by the Office of the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services on trends and issues in the nursing home liability insurance market. Additional case studies are being conducted of the nursing home liability insurance market in the states of Ohio, Florida, Georgia, and Texas. The case studies are designed to provide greater insight into the dynamics of the problem by examining the experiences of states with differing long-term care, economic, political, legal, and insurance landscapes. This report presents the case study on nursing home litigation and insurance issues in the State of California.

The case study was conducted through in-person and telephone interviews, and a literature review specific to the experience in California. In-person interviews took place during a site visit conducted in June 2003. Telephone interviews with key stakeholders preceded and followed the on-site meeting. Interviews included a broad range of stakeholders including consumer advocacy organizations, insurers, brokers, plaintiff attorneys, defense attorneys, representatives of both the for-profit and not-for-profit nursing home industry, assisted living facilities and nursing home medical directors and physicians. Meetings were also convened with individuals representing the Department of Health Services, the Licensing and Certification Program, and legislative staff.

---

a. For a more extensive discussion of recent trends in the nursing home liability insurance market, see Burwell, B., Stevenson, D., Tell, E., and Schaefer, M. *Recent Trends in the Nursing Home Liability Insurance Market*. Report prepared for the Office of the Assistant Secretary for Planning and Evaluation HHS, June 2006. [http://aspe.hhs.gov/daltcp/reports/2006/NHliab.htm]

STATE ENVIRONMENT

California was selected as a case study because, from a distance, it appeared to be a state of contradictions. On the one hand, California is considered a model state in regard to medical malpractice tort reform. In 1975, in response to a medical malpractice crisis, California enacted the Medical Injury Compensation Reform Act (MICRA) which limited medical malpractice awards brought against licensed health care providers, including nursing homes, to a $250,000 cap on non-economic damages. State and federal medical malpractice reform initiatives often use MICRA as the best legislative model for tort reform across all states. On the other hand, analytical studies conducted by Aon Risk Consultants identified California as a state with a relatively high frequency of nursing home litigation activity, and loss costs well in excess of the national average.[1] These apparent contradictions in the nursing home litigation environment led to the selection of California as one of the five case study states.

California Nursing Home Industry

California's nursing home environment is distinctive in many ways that might affect liability trends, facilities' ability to deal with them, and the reform debate more generally. First, for-profit companies and regional and national chains control a larger than average share of the state's 1,303 nursing facilities. California ranks third in the country in the percentage of nursing homes that are for-profit (79%). While the percentage of chain providers in California decreased from 63% in December 2001 to 55% in June 2005, this percentage is still above the national average (52%).[2]

Second, nursing home supply and utilization rates in California are well below the national average. The state has 123,920 certified nursing home beds, 32 for every 1,000 people age 65 or older. This ratio is well below the national average of 46. The bed supply appears just as low when considering people age 85 and older, the age group most likely to use nursing facility care. California's ratio of 241 beds per 1,000 people age 85 or older is the ninth lowest in the nation and 30% below the national average of 345.[3] California's occupancy rate is equal to the national average (86%).[4]

Third, both public and private reimbursement rates are close to the national average. In 2002, the state's Medicaid program paid an average of $114 per day. This rate was 23rd among 46 states that responded to a survey of Medicaid payment policies.[5] The 2003 average private pay rate in urban areas, $161, ranked 20th among the 50 states and DC.[6]

Fourth, nursing facilities in California are not more dependent on Medicaid than in other states. Medicaid is the primary payer for 66% of residents in certified facilities, the same as the national average (66%). Medicare is the primary payer for 11% of residents, slightly below the national average of 12%.[7]

Fifth, California saw an increase in Medicaid-certified beds since 2001, while the percentage of these beds remained constant in most of the country. Medicaid-certified beds increased from 87% in December 2001 to 91% in June 2005. Nationally, 91% of nursing facilities were Medicaid-certified at both dates. The percentage of Medicare-certified beds, most of which are also Medicaid-certified, increased from 58% in December 2001 to 81% in June 2005. This increase reflected the national pattern during the same time after changes in Medicare reimbursement. The national average increased from 60% to 82%. California also matches the national average for the proportion of non-certified beds (5%).

Nursing Home Quality and Oversight in California

Data from Medicare and Medicaid certification surveys indicate California has more deficiencies than nursing facilities across the country. In 2004, surveys identified 15.6 deficiencies per California facility, which ranked second in the nation to the District of Columbia. A small portion of these quality concerns led to actual harm to residents or put residents at risk of death or serious injury (i.e., immediate jeopardy). While California facilities had more overall deficiencies than most places, they had *fewer* of the most serious deficiencies. California ranked fourth-to-last in the percentage of facilities with actual harm or immediate jeopardy problems (7%, compared to the national average of 15.5%).[8]

Survey data may understate quality problems, however. A 1999 U.S. Government Accounting Office (GAO) Report offered strong criticism of the nursing facility enforcement system, and noted large variations among states in the survey process.[9] Although a more recent GAO report noted improvements, it identified continued nursing home oversight shortcomings in several states, including underreporting of actual harm in California surveys.[10]

California's nursing home staffing is consistent with at the national average. California facilities employed 3.7 licensed nurse and certified nursing assistant staff per resident day in 2004.[11]

Nursing Home Litigation and Liability Insurance Trends in California

Recent studies on lawsuits against nursing homes in California report contradictory results. A 2005 actuarial analysis conducted by Aon Risk Consultants reported rapidly rising liability costs among California nursing homes, as shown in Table 1.[12] Prior to the year 2000, claim frequency and severity in California, and therefore total loss costs, were below the national average. However, beginning in the year 2000, claim frequency increased significantly. Claim severity also increased continuously from 1999 to the year 2004. By 2004, according to Aon, claim frequency in California was 15% higher than the national average, while claim severity was 48% higher. The analysis conducted by Aon was based on data representing 27,000 nursing home beds in

California, approximately 20% of all nursing home beds in the state. The nursing homes represented in the study are generally from large, self-insured, multi-regional chains.

A second study by the Insurance Services Office (ISO) in 2002 also found that California nursing homes experienced higher loss costs than the national average, although total loss costs were much lower than reported in the Aon study.[13] The ISO study, conducted on a database of commercially-insured nursing homes representing about 400,000 occupied beds--about 27% of the nursing home market--estimated claim frequency, claim severity, and average loss costs over the three-year period from 1998 to 2000. For California, ISO estimated average claim severity of about $155,000 over this three-year period, relatively close to the Aon estimates presented in Table 1. Average claim frequency in California, however, as estimated by ISO, was only about 2.0 claims per 1,000 beds--much lower than the Aon estimates--although higher than the national average of all beds included in the ISO study. Estimates of claim frequency in the 2005 Aon study for the 1998-2000 time period were five times higher than the estimates generated by ISO.

Two other recent studies attempted to measure litigation activity in California and found no increases in nursing home lawsuits in recent years. A study conducted by the University of California, San Francisco and the Hastings College of Law in 2003 for the California Senate Office of Research identified only 118 cases in California nursing home lawsuits between the years of 1993 and 2001, with the number of lawsuits peaking in 1997, at 14 cases.[14] The researchers on the study identified nursing home cases through on-line searches of 14 public and private legal databases.

In a second study conducted in 2003, the California Advocates for Nursing Home Reform (CANHR) reviewed California Superior Court civil indices in 16 California counties, representing 50% of all freestanding nursing homes in the state, for the three-year period of January 1, 2000 through December 31, 2002.[15] During this three-year period, CANHR identified a total of 501 lawsuits against nursing homes for negligent care--157 in the year 2000, 180 in 2001, and 164 in 2002. With these findings, CANHR argued that the number of lawsuits filed against California nursing homes was neither excessive nor increasing dramatically, stating the industry's claim of an explosion of nursing home litigation as a "myth."

The contradictory findings in the four studies cited above can be partly explained by their methodological differences. The Aon and ISO studies are based on liability claims reported by insurers and providers. The liability claims reported include both *general* and *professional* claims. Thus, not all liability claims relate to incidents of patient negligence or abuse. For example, these studies also include liability claims that involve employees of nursing homes as plaintiffs, or other non-resident litigation. Neither the Aon nor the ISO study differentiates between these types of liability claims. The samples of nursing facilities represented in the Aon and ISO studies also differ markedly from one another. The Aon study is largely based upon the liability experience of large, self-insured, multi-regional chains, while the ISO study is based

solely on the experience of nursing homes that had insurance coverage through admitted commercial insurers.

The Hastings and CANHR studies tried to measure nursing home litigation through records maintained by the California judicial system. In that regard, they only identified liability claims that had proceeded to the point of entering the court system. Liability claims that were settled between the plaintiff and the insurer/defendant prior to entering the judicial system were not included in the Hastings and CANHR studies. Also, the Hastings and CAHNR studies only attempted to measure the frequency of nursing home litigation, and did not address the severity of nursing home claims (either settlement amounts or trial awards) and therefore provide no data on total liability costs incurred by the industry. An internal report by NORCAL, a mutual insurance company in California, reported that punitive damages were allowed in 46% of their elder abuse cases in 1999 and 2000, compared to less than 1% of their traditional medical malpractice cases.[16]

Nursing Home Liability Insurance Market in California

As recently as 1999, there were as many as 18 companies writing nursing home liability coverage in California. By 2003, most carriers, both admitted and non-admitted, had left the market. Unlike admitted carriers that adhere to state insurance regulation, non-admitted carriers do not follow state regulations. In 2003, insurance brokers reported that there were only three insurers still writing coverage in California: AIG, CAN, and American Empire. Farmers Insurance and St. Paul are two of the more notable carriers that left the California market altogether. One factor for the exit of carriers in the "retail" insurance market was reportedly the decision by most of the traditional reinsurers to get out of the long-term care business altogether.[b] Specifically, one insurance industry spokesperson indicated that the number of reinsurers writing reinsurance for the nursing home product line in 2003 worldwide had declined from about 50 companies to only about eight companies.

One insurance representative who had worked in the long-term care market in California for over 15 years stated that 1999 was a watershed year because the California Supreme Court decision in *Delaney v. Baker* broadened the criteria for bringing a nursing home case under the EADACPA statute (which is described more fully in the next section). The insurance market responded to this added exposure by making coverage changes to lower risk, increasing premiums, adopting more selective underwriting criteria and, for many, exiting the market. During the time of the contractor's site visit in 2003, providers and insurance representatives pointed to the following trends and examples as illustrative of recent changes in the California marketplace:

[b.] One insurance broker reported that retail insurers in this market typically retain 25% of the risk, and sell off the remaining risk to reinsurers.

- Deductibles had increased, averaging $50,000, compared with the first-dollar coverage that was routinely available before 1999.

- Premiums had risen from around $100/bed in the mid 1990s to an average of approximately $2,300 per bed in 2003.

- Whereas the typical pre-Delaney policy might have offered $1 million of coverage, policy limits of $250,000 to $300,000 of coverage were more usual in 2003.

- Insurers were adding endorsements to existing policies to limit coverage. For example, policies might have lower coverage limits for claims based on physical or sexual abuse (e.g., $100,000-$300,000 coverage limits).

- Only one carrier was still writing coverage on an occurrence basis; the remaining carriers in the marketplace had switched to writing policies strictly on a claims-made basis (see definition below).

- For some facilities, particularly those with a poor claims history, the only coverage they could obtain were policies written on a "finite" coverage basis, where the policy may provide $250,000 in coverage for a premium cost of $275,000. In essence, these policies involve no transfer of risk between the insured and the insurer. This type of coverage is typically provided when the facility has a legal or financial requirement to obtain "insurance" but is otherwise uninsurable.

- Although some policies allow for coverage of attorney's fees, most policies do not insure for punitive damages. The California Department of Health Services observed: "Without such coverage, just one significant lawsuit could mean bankruptcy or closure."[17]

- One 160-bed church-related non-profit facility had to seek a new insurer when its existing insurer refused to renew coverage. Although the facility had a good claims history, the insurer was concerned about negative survey findings against the facility. The cost of changing insurers also meant a premium increase from $8,000 to $17,500 annually. Given the high cost, this provider decided to "go bare" once the term of the current insurance expired.

- A skilled nursing facility in Northern California went from an occurrence form policy with a $5,000 deductible, to a claims-made policy with a $100,000 deductible.

- A Northern California chain "paid $76 per bed two years ago for a policy that was occurrence based with a $0 deductible....In 2003, the chain paid $1,096/bed for a claims-made policy subject to a $100,000 deductible."[18]

- The board of a non-profit nursing home in northern California, due to a huge increase in premium costs, decided to go without liability coverage altogether.

In June 2003, almost all nursing homes in California were either uninsured, self-insured or were obtaining liability insurance in the "surplus" market (i.e. from non-admitted carriers). Policies purchased in the surplus market are not subject to regulation by state departments of insurance. Carriers in the surplus market can increase premiums, terminate coverage, and/or impose changes in the terms of coverage without state regulatory approval.

Most surplus carriers were writing policies exclusively on a "claims-made" basis, meaning that the policy only covers adverse events which both take place *and* for which claims are submitted during the term of the policy. A "claims-made" policy limits risk for the carrier, while increasing risk for the insured. For example, if a carrier decides that its exposure to future lawsuits has increased, the carrier can cancel the policy, "walk away" from the business, and not be liable for any subsequent lawsuits, *even if* the lawsuit resulted from events which took place during the term of the policy. The premium costs of policies written on a "claims-made" basis typically start at a relatively low level and then increase over time as the term of the policy expands to cover multiple years of incidents and claims.

Given the restrictions and high costs of the surplus market, some California providers were considering alternative risk retention/captive groups as potential vehicles for insuring liability risk. Captives are basically self-formed risk pools of providers that decide to share risk among the members of the captive.[19] Some captives are written on insurance paper to satisfy bond requirements to "have insurance" and some are self-insured across the members of the captive. The traditional captive has joint liability as well as shared administrative costs among its members.

In a traditional captive, members are also responsible for their own underwriting. That is, the members of a captive must decide among themselves with whom they wish to share liability risk. There must be a sufficient number of members for the captive to be adequately capitalized, while at the same time limiting membership to facilities with low liability risk. A variation on the risk retention captive is a "cell captive" in which participants share administrative expenses but not liability risk.

Although a number of providers interviewed during the California site visit were considering the formation of a captive as an alternative insurance option, the use of captives in the California market was not significant in June 2003.

Legal and Legislative Environment in California

Nursing home litigation issues in California play out in a complex legal environment. Two different statutes define and drive the basis for claims, the legal requirements for making and supporting a claim, and the criteria for determining

damage awards. Understanding these statutes, and the subsequent case law around them, is critical to understanding the dynamics of nursing home litigation and insurance issues in California. Moreover, California case law around the applicability of these two statutes to nursing home liability cases is still evolving, with a number of key issues still working their way through the California appellate courts.

The MICRA of 1975 defines criteria for civil action against any licensed health care provider. Nursing homes, but not assisted living facilities, are included in the definition of health care provider under the MICRA statute. MICRA was enacted in response to a medical malpractice insurance crisis in the mid 1970s, due to increases in the number and size of legal actions taken against physicians. Among the more significant components of MICRA were the following provisions:

- Limited awards for "pain and suffering" and other non-economic damages to $250,000.

- Reduced the time limit for filing malpractice cases to three years (from four years previously).

- Created a scale for limiting attorney's contingency fees for the highest awards.

- Imposed a notice requirement for the "intent to sue" of 90 days prior to the filing of a lawsuit. This last provision was intended to serve as a mechanism for facilitating early resolution of grievances against health care providers, possibly avoiding formal filings of lawsuits.

It is important to note that California law also did not allow a claim for pain and suffering to continue beyond the claimant's death. In brief, the right to compensation for pain and suffering died with the patient, and surviving heirs were not allowed to seek damages for their own pain and suffering. Since many nursing home claims are brought on behalf of a resident who has died, civil action on such claims was not possible within this context.

EADACPA, enacted in 1991, provides for expanded civil remedies to all elderly or disabled persons, alive or deceased, where injury or harm results from abuse or neglect.[20] EADACPA was passed in response to concerns with the treatment of nursing home residents following a series of studies on the quality of life for California's elderly, including studies by the Little Hoover Commission on California State Government Organization and Economy, an independent state oversight agency.[21] EADACPA was enacted with the specific policy intention of increasing financial incentives for plaintiff attorneys to take on elder abuse cases, since the limitations of the MICRA statute provided little financial incentive for attorneys to take on lawsuits brought by nursing home residents, or their survivors, particularly if the nursing home resident was deceased.

Key provisions of EADACPA, providing remedies barred by MICRA, are:

- It permits actions for pain and suffering to continue after the death of the claimant.

- It creates new civil remedies for elder abuse of up to $250,000 in non-economic damages (e.g., pain, suffering or disfigurement) *in addition to* MICRA provisions.

- It allows courts to award attorneys' fees and costs to successful plaintiffs, over and above compensation for damages.

- It expands the statute of limitations for taking civil action from one year (under MICRA) to two years.

While EADACPA expanded remedies available in instances of elder abuse or neglect in long-term care facilities, it also required a higher burden of proof than a medical malpractice case brought under MICRA. Under MICRA, a "preponderance of the evidence" is required to show proof of negligence. EADACPA imposes a higher standard of proof, namely "clear and convincing evidence of willful disregard" for the rights of residents. (See Appendix A for a description of the legal process for litigating an EADACPA case.)

A critical issue raised by the EADACPA legislation is the applicability of the MICRA and EADACPA statutes to lawsuits brought against nursing homes for adverse outcomes. In brief, these two statutes raise the question of which adverse events in nursing homes are considered "medical malpractice" and should be litigated under the MICRA statute, and which adverse events are considered "elder abuse" and should be litigated under EADACPA. This issue was specifically addressed by the California Supreme Court in *Delaney v. Baker* in 1999.

One key outcome of Delaney v. Baker was the Supreme Court's finding that health care providers are *not* protected from the "enhanced remedies" of EADACPA and thus, the MICRA limits on claims against health care providers do not apply if the plaintiff can meet the requirements for bringing a case under EADACPA. *Delaney v. Baker* held that "where the behavior was of an egregious nature committed with the requisite 'recklessness, oppression, fraud, or malice,' the enhanced remedies of EADAPCA Section 15657 could apply."[22] The case established EADACPA as a "separate and wholly independent basis for liability from a cause of action for 'professional negligence' as that term is applied in the context of MICRA…."[23] Thus, rather than reading EADACPA as applying to different facts than MICRA, the court interpreted it to provide an alternative route to actions that are barred by MICRA. The case clarified a distinction between acts of "custodial neglect" to be applied under EADACPA from cases of "professional negligence" as a cause of action under MICRA. The Supreme Court's ruling in *Delaney v. Baker* served to expand the exposure of nursing homes to potential legal actions. In many cases, plaintiffs filing lawsuits against nursing homes

seek remedies under both statutes, in order to increase the amount of total compensation awarded.

In July 2001, a legislatively-mandated task force was convened to study the cost and availability of nursing home liability insurance in California. Agencies participating in the study task force included the California Department of Health Services (DHS), the California Department of Insurance (CDI), the State Office of Health Planning, and the State Department of Finance. Although the task force report was originally due to the legislature in March 2002, its submission was delayed to June 2003.

The Task Force Report was released shortly after the June 2003 site visit. Constituencies on both sides of the nursing home liability and insurance debate expressed disappointment about the report. It did not report any compelling findings or make strong recommendations. The report documented what was already known--that although there was compelling anecdotal evidence of a significant crisis in this market, there was a lack of reliable and objective data to sufficiently characterize and assess the problem. The report's recommendations primarily focused on the need to collect better information about the nature of the problem, and the need for the state to study the problem further before initiating any kind of policy response.

Key recommendations to DHS in the Task Force Report included the following:[24]

- Increase DHS data collection regarding litigation and insurance claims against nursing homes and regarding the cost and availability of liability insurance. The task force believed that existing authority to collect the requisite data from both admitted and non-admitted carriers in the states already existed in the health and safety code. Non-admitted insurers would be required to submit data since the requirement pertains to every insurer providing professional liability insurance to a *licensed* health facility. Additionally, nursing homes would be required to provide information about their liability insurance as a condition for facility license renewal.

- Require nursing homes to implement an approved risk management plan as a condition of facility licensure. Elements of the plan would include having a full-time risk manager for a facility of 50 beds or more, a risk management committee, training programs for new employees, corrective action plans, and other features.

- Conduct a study to assess the relationship between the state's enforcement of nursing home quality standards and legal actions in recent elder abuse cases.

- Continue to study the effect of liability insurance issues on long-term care providers.

In addition, the Task Force Report outlined a number of additional policy initiatives that could potentially be implemented to address the liability insurance situation, without

specifically endorsing any of them. For each initiative, the report discussed the advantages and disadvantages of each but did not recommend a specific course of action:

- Facilitate captive or alternative insurance arrangements such as a Joint Underwriters Association.

- Mandate an insurance rate roll-back.

- Establish provisions related to arbitration or mediation during an initial 90-day notice to file suit period.

- Shorten the statute of limitations for MICRA.

- Specify a method for defining “reasonable” attorneys’ fees to help contain litigation costs, especially in high award cases.

- Allocate a portion of punitive damage awards to go to quality care improvements in nursing homes or place a cap on punitive damages.

- Limit the admissibility of state and federal survey documents in civil action, unless they contain information directly relevant to the specific case.

In 1997, DHS was charged with developing a standardized admission agreement for use in long-term care facilities. The goal was to have one model admissions agreement that would be used by all providers for all new admissions. The development of the model admissions agreement was stalled by a debate regarding whether providers could include binding arbitration agreements, on a voluntary basis, as part of the standardized admission agreement. Final regulations governing standardized admission agreements were published by DHS in July 2005, and took effect on January 2, 2006.

The final regulations specifically prohibit providers from presenting arbitration agreements as part of the standardized admission agreement. Specifically, the regulations state:

> “The licensee shall not present any arbitration agreements to a prospective resident as a part of the Standardized Admission Agreement. Any arbitration agreement shall be separate from the Standard Admission Agreement and shall contain the following advisory in a prominent place at the top of the proposed arbitration agreement, in bold-face type of not less than 12 point type: “Residents shall not be required to sign this arbitration agreement as a condition of admission to this facility, and cannot waive the ability to sue for violation of the Resident Bill of Rights.”[25]

Two bills were enacted in the FY 2003 legislative session that affected the nursing home liability insurance issue. First, Assembly Bill 634 made all settlements of elder abuse claims public information. Although the amount of the settlement or verdict still

remains confidential, all other details of the case would be public information. The bill also includes destruction of evidence in elder abuse actions within the definition of misuse of the discovery process and would apply penalties for such.

The second bill enacted during the FY 2003 legislative session was Senate Bill 686, which mandated that insurance companies report certain data on policies issued for all long-term care providers in California to CDI on an annual basis. The Bill also extended the notification period for an insurer who intends to withdraw from the California market from 60 days to 90 days. Finally, the Bill authorized CDI to establish a market assistance program for long-term care facilities if the Department finds that liability insurance is not readily available in the voluntary insurance market, including the formation of an unincorporated, non-profit, temporary joint underwriting association.

SUMMARY

While not at the level of severity observed in Florida and Texas, nursing home providers in California reported many of the same trends in the market for professional liability insurance: skyrocketing premiums for all providers, regardless of their claims histories; reduced coverage provided by available insurance products; increased risk shifted back to nursing home providers by insurers; market exit of most of the state's regulated insurance carriers, leaving only a few surplus line carriers in the marketplace; increased use of insurance captives; a growing number of providers deciding to forego insurance coverage altogether; and a contentious relationship between the nursing home industry and consumer advocacy groups regarding the "root causes" of the crisis.

As in other states, efforts to assess the true magnitude of the nursing home liability insurance situation in California are hindered by the absence of objective and reliable data. Reliable information on professional liability losses incurred by providers and insurers, as well as comprehensive information on changes in the cost and availability of insurance, is not available. The studies that have been conducted on the issue have been sponsored by constituencies with strong self-interests, and with clear political agendas for influencing the policy debate. The annual Aon studies have reported an increasing frequency of liability claims for nursing home providers in California. However, this increasing frequency has not been found in the other studies, such as the study conducted by CANHR.

Although mandated to collect liability claims and insurance data from long-term care facilities, CDI has, to date, not been successful in achieving that goal. The exit of admitted carriers regulated by CDI has hindered the ability of the Department to collect data. Although the state legislature has demanded the collection of better information, this outcome is not guaranteed given the current volatility in the liability insurance market.

California is an example of a state where the nursing home liability issue is linked to residents' rights statutes. The EADACPA statute, and subsequent California case law, expanded the liability exposure of health care providers to torts incurred on a special class of individuals--the elderly and disabled who are the victims of "reckless neglect." It intentionally expanded civil remedies for individuals whose opportunities for redress would otherwise be limited by the constraints imposed under the MICRA statute. The existence of two independent but inter-related statutes governing civil remedies for damages incurred by nursing home residents in California has made the legal environment in that state extremely complex. The level of resources invested by both plaintiffs and defendants in litigating individual cases was far higher than observed in other states.

APPENDIX A:
EXAMPLE OF THE PROCESS BY WHICH AN EADACPA CASE MIGHT BE LITIGATED

A lawsuit filed under the California Elder Abuse and Dependent Adult Civil Protection Act (EADACPA) generally begins with a family member of a nursing home resident approaching an attorney with a complaint about the care provided by the nursing home, and inquiring whether the complaint is worthy of filing a lawsuit. The nursing home resident may be still living or deceased. The attorney must then decide whether the facts of the case, as reported by the family member, warrant moving forward with a more complete investigation of the incident.

First, the attorney must assess whether the incident reported by the family member constitutes elder abuse as defined under the EADACPA statute, that is, “physical abuse, neglect, or financial abuse.” Further, in order to be eligible for the “enhanced remedies” under EADACPA, the plaintiff must prove by “clear and convincing” evidence” that the defendant was guilty of “recklessness, oppression, fraud, or malice” in abusing the plaintiff. California case law has clearly established that the EADACPA statute requires a higher burden of proof for proving recklessness than the evidence required to prove neglect under a standard medical malpractice (MICRA) case. This difference is often characterized as the difference between “professional negligence” and “reckless neglect.” “Professional negligence” can include incidents in which health care providers commit a medical error that, given their professional training and qualifications, should not have been made. “Reckless neglect,” on the other hand, requires a higher degree of culpability than professional negligence.

In California case law, this higher degree of culpability has often been based on the concept of “foreseeability,” that is, that the defendant knew that its policies and practices would increase the likelihood that the incident would occur. In EADACPA cases involving nursing home residents, the “foreseeability” standard is often played out in a debate about staffing levels. Plaintiffs will often make the case that the plaintiff was harmed because the nursing home employed too few staff, below recommended state standards. Thus, the argument is made that the nursing home could foresee that its staffing levels were likely to increase the likelihood of an adverse event and failed to take remedial action. This argument is often characterized as the “profits over people” approach. A survey history that demonstrates a repeated pattern of deficiencies, particularly the same types of deficiencies, is also frequently used to support the “foreseeability” standard.

Finally, in the case of a corporate employer such as a nursing home, the plaintiff must be able to prove that the recklessness, oppression, fraud or malice was done or ratified by a “managing agent” of the corporation.

If the plaintiff can make a case for "reckless neglect", then the "enhanced remedies" of EADACPA are available to the plaintiff. The "enhanced remedies" of EADACPA allow family members to sue for up to $250,000 in non-economic damages (pain and suffering) even after the person who was the victim of elder abuse dies. Under a standard medical malpractice case in California, the right to sue for pain and suffering dies with the victim. Second, EADACPA allows plaintiffs to recover attorneys' fees and costs, separate from economic and non-economic damages.

An attorney will assess the merits of a potential EADACPA case by reviewing the available evidence. The attorney will generally request a copy of the patient's medical records from the nursing home and other medical records, interview potential witnesses, such as former nursing home employees, and also review state survey and licensure data, which can serve as evidence that the negligent care alleged in the patient's case was part of a broader pattern of substandard care, previously identified by state surveyors. If the attorney believes there is sufficient evidence to move forward with a case under EADACPA, the attorney will then proceed with the filing of a formal lawsuit. Plaintiff attorneys state that there is a good deal of investigative work that must be conducted prior to ever filing a suit under EADACPA, and that there are many cases that are initially investigated, but then dropped, for lack of sufficient evidence.

As the litigation of EADACPA cases has evolved over the years, the typical EADACPA lawsuit filed today includes multiples causes of action. That is, in addition to suing the nursing home for elder abuse under the EADACPA statute, the attorney may also sue the nursing home on other legal grounds. If the negligent care of the nursing home resident is alleged to have caused the death of the nursing home resident, the attorney may file a "wrongful death" claim in addition to an elder abuse claim. The plaintiff attorney may also file a standard medical malpractice claim for professional negligence under the MICRA statute. In some cases, the attorney may also believe there is sufficient evidence to file a claim for fraudulent activity. For example, if a nursing home represented itself to the plaintiff or a plaintiff's family as providing specialized care for people with Alzheimer's disease, but failed to provide specialized training of its staff on the treatment of Alzheimer's patients, then the attorney may decide to file a cause of action that the nursing home misrepresented itself in a fraudulent manner. There may be claim made under the Business and Professions Code (Section 17200) for unlawful or unfair business practices. Defense attorneys state that this claim is often used as a discovery device, since it allows for expanded discovery of the company's business operations. There may be Breach of Contract claim, a Violation of Patients' Rights claim, and, in some cases, an Assault and Battery claim. Finally, the attorney may file additional causes of action for Negligent Infliction of Emotional Distress (NIED) and/or Intentional Infliction of Emotional Distress.

The obvious advantage to the plaintiff of filing multiple causes of action is the opportunity to receive compensation from the defendant under each cause of action. However, each cause of action must be separately litigated, greatly increasing the legal complexity of these cases. It is very easy for an EADACPA case to wrack up legal fees in the hundreds of thousands of dollars, on both sides. Given that the enhanced

remedies of EADACPA allow for the payment of attorneys' fees, in addition to direct compensation to the plaintiff, there is a clear financial incentive for plaintiff attorneys to maximize litigation costs (at least in winnable cases). On the defense side, this provision creates an additional incentive to settle cases early in the process, before legal costs on both sides get out of hand.

An EADACPA lawsuit may name more than one party as a defendant in the case. In addition to the nursing home itself, the lawsuit may name the facility's medical director, the patient's treating doctor, or others as additional defendants. This is because the court may decide that the responsibility for the incident that led to the lawsuit is shared among multiple parties. This can potentially lead to situations in which a court decides that the plaintiff is entitled to $250,000 in non-economic damages for pain and suffering, but that the nursing home corporation itself is only responsible for 50% of the damages, the medical director is responsible for 40% of the damages, and the treating doctor is responsible for 10%. If the plaintiff attorney failed to name the medical director or the treating doctor as additional defendants in the original lawsuit, then the plaintiff may recover only 50% of the damages to which he or she is otherwise entitled.

Once a lawsuit is filed, the formal process of discovery begins. Both plaintiff and defense attorneys state that the discovery process in nursing home EADACPA cases, as opposed to straight medical malpractice cases, is considerably more "massive." The patient may have been in the nursing home for years, and the alleged negligent action itself (e.g., inadequate feeding leading to weight loss and malnutrition) may have occurred over a period of many months. This means that there are many more records to review and more people to take depositions from.

The discovery process may lead to additional legal actions. If the defense believes that the plaintiff attorney is requesting information in the discovery process that is either protected information or is irrelevant to the case, the defense may object to making that information available. In response, the plaintiff attorney may file motions to compel discovery if he or she feels that the defense is not complying with proper requests for information, or is using failure to comply as a delaying tactic. A judge can also award sanctions if an attorney asks for money to compensate for the additional professional time involved in dealing with difficulties getting the opposing attorney to provide requested information during discovery. This can further add to the overall legal costs of the case.

The defense attorney in the case may elect to submit a demurrer to the court, which is a legal action requesting the court to strike one or more causes of action in a lawsuit. Importantly, the defense may argue that, even assuming that all of the alleged facts in the case filed by the plaintiff are correct, the case should be tried as a simple medical malpractice case rather than as an elder abuse case. For example, the defense may argue that the facts of the case (if true) show that the defendant may have been guilty of professional negligence (e.g., failing to prevent a resident from escaping the building and being hit by a car) but not "reckless neglect." Since proof of reckless

neglect under EADACPA often leads a case down the path towards the seeking of punitive damages, there is considerable incentive for the defense to limit the cause of action to a more simple case of professional medical malpractice. An additional incentive for the defense is that if the court agrees that the case should be tried as a general medical malpractice case and not an elder abuse case, than the enhanced remedies of the EADACPA are generally no longer available.

At some point in the litigation of an EADACPA case, the plaintiff attorney may decide whether he or she has sufficient evidence to seek punitive damages. The plaintiff attorney may sue for punitive damages if he or she can prove by clear and convincing evidence that a managing agent of the defendant has been guilty of "oppression, fraud or malice." Note that the requirements for the seeking of punitive damages are quite similar to the requirements for the award of pain and suffering damages under EADACPA, with the exception that EADACPA includes the additional concept of recklessness, or as previously discussed, "reckless neglect."

The definitions of oppression, fraud or malice necessary for the seeking of punitive damages generally require the plaintiff to prove "despicable conduct" on the part of the defendant. That is, the plaintiff must prove that the nursing home knew that what it was doing was potentially harmful to the patient and went ahead and did it anyway. For example, "despicable conduct" could apply if the nursing home was aware that an employee had prior convictions for sexual abuse, but failed to terminate that employee, or if a resident had a history of wandering from the facility and the nursing home failed to take any actions to prevent future escapes.

If a plaintiff attorney decides to seek punitive damages, he or she must file a motion to amend the original lawsuit, stating intent to seek punitive damages. This motion must be filed at least nine months prior to the scheduled trial date. The defense is provided the right to submit counter briefs and evidence opposing the motion, arguing why the case does not warrant the seeking of punitive damages. The judge assigned to the case will then make a ruling regarding whether the evidence is sufficient for the plaintiff to seek punitive damages. In addition, this ruling indicates whether economic and non-economic damages will be available under EADACPA. If the judge finds the evidence sufficient to allow the suit to be amended to include punitive damages, this alone often sends a powerful message to both parties that there is a good possibility that the plaintiff has a strong case. Conversely, if the motion is denied, it may weaken the plaintiff's case. This information, among other factors, is likely to play a role in the parties' willingness to negotiate a settlement in lieu of going to trial.

Plaintiff and defense attorneys who work on EADACPA cases state that there is currently a complex legal argument ensuing around the award of punitive damages in EADACPA cases. There are a number of unresolved issues regarding the applicability of punitive damage awards in cases involving long-term care providers. These unresolved issues are currently being considered by the California Supreme Court in the Convenant Care case, and a decision is expected in the not too distant future.

At some point during the processing of the case, one or the other side, either the attorney representing the plaintiff or the attorney representing the defendant will usually call the opposing attorney and suggest settling the case. Very few cases go to full jury trial; most cases are settled out of court. If both parties agree to discuss the possibility of a settlement, then usually a professional mediator will be brought on to facilitate the discussions between both parties. If the case is settled, the parties usually agree to keep the terms of the settlement confidential, and not make them available to the public. This makes it difficult to conduct analyses of the outcomes of EADACPA cases.

REFERENCES

1. Bourdon, T, and Dubin, S. *Long Term Care General Liability and Professional Liability Actuarial Analysis*. Aon Risk Consultants. 2003.

2. American Health Care Association, Health Services Research and Evaluation (AHCA/HSRE). *OSCAR Data Reports: Operational Characteristics June 2005*. Washington, DC: AHCA/HSRE. American Health Care Association, Health Services Research and Evaluation. *OSCAR Data Reports: Operational Characteristics December 2001*. Washington, DC: AHCA/HSRE.

3. Medstat analysis based on data from American Health Care Association, Health Services Research and Evaluation (AHCA/HSRE). *OSCAR Data Reports: Operational Characteristics June 2005*. Washington, DC: AHCA/HSRE. Medstat analysis based on data from U.S. Census Bureau. *Estimates of the Resident Population by Selected Age Groups for the United States and for Puerto Rico: July 1, 2004*. Washington, DC: U.S. Census Bureau.

4. American Health Care Association, Health Services Research and Evaluation (AHCA/HSRE). *OSCAR Data Reports: Operational Characteristics June 2005*. Washington, DC: AHCA/HSRE.

5. Grabowski, DC, Feng, Z, Intrator, O, and Mor, V. "Recent Trends in State Nursing Home Payment Policies." Health Affairs. June 16, 2004 Web Exclusive.

6. Gibson, MJ, Gregory, SR, Houser, AN, and Fox-Grage, W. *Across the States: Profiles of Long-Term Care (sixth edition)*. Washington, DC: AARP. 2004.

7. American Health Care Association, Health Services Research and Evaluation (AHCA/HSRE). *OSCAR Data Reports: Operational Characteristics June 2005*. Washington, DC: AHCA/HSRE.

8. Harrington, C, Carillo, H, Wellin, V, and Shemirani, B. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1995-2001*. San Francisco, CA: University of California at San Francisco. 2002.

9. U.S. Government Accounting Office (GAO). *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*. Washington, DC: U.S. GAO. 1999.

10. U.S. Government Accounting Office (GAO). *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*. Washington, DC: U.S. GAO. GAO-03-561, 2003.

11. Harrington, C, Carillo, H, Wellin, V, and Shemirani, B. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1995-2001*. San Francisco, CA: University of California at San Francisco. 2002.

12. Aon Risk Consultants. *Long Term Care 2005 General Liability and Professional Liability Benchmark Analysis*. March 21, 2005.

13. Insurance Services Office (ISO). *Nursing Home Liability Insurance: A Discussion of the Current Insurance Crisis*. Jersey City, NJ: ISO. 2002.

14. Weinberg, J, Brosman, D, and Goldman, J. "Institutional Elder Abuse in California: The Consequences of EADACPA." Paper prepared for the California Senate Office of Research. May 27, 2003.

15. California Advocates for Nursing Home Reform (CANHR). *Much Ado About Nothing: Debunking the Myth of Frequent and Frivolous Elder Abuse Lawsuits Against Nursing Homes*. November 2003.

16. NORCAL. "Institutional Elder Abuse: A Litigation Trend Physicians Need to Know." Claims Rx. March/April 2001.

17. California Department of Health Services. *Liability Insurance for California Long-Term Care Providers*. A report to the California Legislature. June 2003.

18. California Association of Health Facilities. *The Impact of Elder Abuse Litigation on Long-Term Care (LTC) Liability Costs*. Issue Paper. 2003.

19. "Captives--A Structured Alternative." Risk Alert. Volume II, Issue I, January 2003. Prepared by Marsh, Inc.

20. Mehta, S. "Elder Abuse Law." California Lawyer. Pp. 55-60, November 2001.

21. California Department of Health Services, op. cit.

22. California Department of Health Services, op. cit.

23. Garcia, S, and Bamberger, D. "Skilled Nursing Facilities--How Many Times Can We Tell You 'It's Not Medical Malpractice!'" Consumer Attorneys of California Forum. Volume 32, Number 5, June 2002.

24. California Department of Health Services, op. cit.

25. California Department of Health Services. *Standard Admission Agreement Regulations, Health and Safety Code, Sections 72516 and 73518*. July 6, 2005.

GLOSSARY

Admitted Carriers are commercial insurers whose nursing home liability insurance products are regulated by state departments of insurance. These carriers enjoy some advantages over non-admitted carriers. They can participate in state guaranty funds, which help protect policyholders in the case of insurer insolvency. Also, they have a marketing advantage over non-admitted carriers because some brokers, facility providers and lenders value state oversight and participation in the guaranty fund.

The **Alternative Market** to nursing home liability insurance is composed of various forms of self-insurance, meaning the risk is borne by the participants and not an insurance company. The different forms of self-insurance include risk retention and risk purchasing groups (RRGs), captives, rent-a-captives, and sponsored captives (Joint Underwriting Associations).

Arbitration Agreements are contracts, the terms of which are determined by an arbitrator, entered into by opposing parties. An arbitrator is a person or panel of people who are not judges and may be: (1) agreed to by the parties; (2) required by a provision in a contract for settling disputes; or (3) provided for under statute. Arbitration is designed to be a fair and equitable means of dispute resolution agreed to by both parties to avoid a court trial and the associated expenses and time investment.

Capitalization means funding the reserves of an insurance or self-insurance program to pay claims.

A **Cell Captive** is a captive in which member providers share administrative expenses but not risk.

A **Captive** is a self-formed pool of providers who share risk among themselves, thus acting as their own insurance company. Members do their own underwriting, meaning they decide among themselves which providers to admit to the captive. Members will share liability risk with the providers they admit.

Claims Made Policies provide coverage for insured events that both occur and *for which a claim is made* during the term of the policy. Thus, if an incident occurs, but the policy is terminated before a claim is made, liability for the incident is not insured.

Claims Occurrence Policies provide coverage for all incidents and events that occur during the term of the policy, regardless of when a liability claim is made, or when a lawsuit is settled.

Collateral Damages are damages incurred by the plaintiff that are already covered by other sources of payment. ‘‘Collateral source offset’’ rules reduce awards by denying plaintiffs compensation for losses that are recouped from other sources,

such as health insurance. These rules aim to prevent plaintiffs from ‘‘double dipping’’ by recovering for losses for which the plaintiff has already been remunerated through other sources of payment.

Deductibles are initial amounts of claims incurred by the policyholder not covered by the insurance policy. Insurance coverage begins only for losses incurred above the deductible amount.

Economic Damages in civil litigation is compensation due the plaintiff for financial losses caused by the wrongful actions of another party (e.g., awards for the medical bills of a nursing home resident caused by an abusive employee).

Estimated Liability Costs are approximate calculations of expenses for damages to which a nursing home is exposed. Because estimates are derived from information provided by nursing homes and the cost of settlements of lawsuits is confidential information known only to the insurance carrier, plaintiff's attorney and defense attorney, these calculations are only estimates and are subject to change.

General Liability Claims/Losses are amounts a nursing home liability insurer is legally obligated to pay as damages to a plaintiff due to bodily injury or property damage.

A **Joint Underwriting Association** is a state-sponsored organization that creates insurance pools and functions as an insurer in markets without a significant number of licensed insurers. It has the power to sell insurance policies, collect premiums, and purchase reinsurance and it can usually guarantee a certain level of premium rates to its members. It can also levy surcharges on policyholders and, in some cases, on licensed insurers selling liability insurance, to create reserves to pay claims.

Joint and Several Liability in civil litigation is a situation in which the concurrent acts of two or more defendants bring harm to the plaintiff. Such acts need not occur simultaneously, but must contribute to the same event. In such a case, the damages may be collected from one or more of the defendants. If the court does not apportion blame in specific shares, the damages may be collected from any and all defendants. If a defendant does not have the financial wherewithal to pay, the others must make up the difference.

Non-admitted Carriers, also called **Surplus Line Carriers**, are commercial insurers whose nursing home liability insurance products are not regulated by state departments of insurance. These insurers enjoy some advantages over admitted carriers. They have greater flexibility in designing and pricing products. Because they are not subject to state regulation, they can also change coverage forms and application protocols more quickly. However, they must pay an "excess and surplus lines" tax that is not levied on admitted carriers. They cannot participate in state guaranty funds, which help protect policyholders in the case of insurer insolvency

Non-economic Damages in civil litigation is compensation due the plaintiff for intangible harms (e.g., pain and suffering).

Nursing Home Liability Insurance is indemnification of nursing home providers against damages for negligent care and abuse.

Nursing Home Residents' Rights Statutes are state and federal laws to protect each nursing home resident's civil, religious and human rights.

Offshore Captives are captives located outside the United States. The most popular host states for offshore captives include Bermuda, Guernsey and the Cayman Islands.

Premium is the charge paid by a policyholder for insurance coverage.

Professional Liability Claims/Losses are amounts a nursing home liability insurer is legally obligated to pay as damages and associated claims and defense expenses to a plaintiff due to a negligent act, error or omission in a nursing home provider's rendering or failure to render professional services.

Punitive damages in civil litigation means monetary compensation awarded by a judge or jury which exceeds the losses suffered by the injured party in order to punish the defendant.

Regulated Insurance Carriers are admitted carriers (see definition above).

Reinsurance is the practice of insurance carriers ceding risk to other firms, called reinsurance companies, in order to limit their liability exposure. Reinsurance companies essentially provide insurance to insurance companies. Instead of assessing the risk of individual policyholders, reinsurance companies assess risk on a broader scale, such as on the basis of a particular product line (nursing home liability insurance) or a geographic region.

A **Rent-A-Captive** is a captive, usually formed by an insurance company, broker or captive manager, and rented out to users (in this case nursing home providers) who avoid the cost of funding their own captive. The user provides some form of collateral so that the rent-a-captive is not at risk from any underwriting loss suffered by the user.

Risk Management Programs are structured approaches to purposefully limit liability risk. They include systematic efforts to improve and maintain high standards for care quality, but can also include additional management techniques to minimize liability exposure, such as improving written documentation. They are often formalized within the management structure of nursing home providers in the form of Risk Management Committees, and/or a designated Director of Risk Management along with formal Risk Management plans that are implemented and monitored by senior management.

A **Risk Retention Group (RRG)** is an insurance company that is owned by its members. The members of an RRG come from the same industry. For instance, nursing home providers can form an RRG in order to obtain nursing home liability coverage.

A **Settlement** is an agreement reached between the legal counsel of the plaintiff and the defendant that terminates a civil litigation before a verdict is reached by the court.

Tort Reform generally means a movement intended to curb litigation and damages in the civil justice system. With respect to nursing home liability insurance, many states have enacted tort reform through legislation and it has changed the legal framework under which residents and/or family members can seek damages for negligent or abusive care practices. States also placed limits on the amount of damages that could be awarded to plaintiffs and/or their family members, particularly non-economic damages for pain and suffering.

Underwriting is the process by which an insurer assesses the risk of insuring a particular applicant for coverage. Risk retention groups also underwrite by assessing the risk of accepting a prospective member.

TABLES

TABLE 1: Aon Estimates of Nursing Home Liability Costs--California vs. U.S. (National Averages)									
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Claims per 1,000 Beds*									
California	3.9	8.5	9.8	8.5	12.2	14.5	13.8	14.5	15.0
U.S.	6.2	6.8	8.2	10.1	11.1	12.3	12.3	12.6	13.1
Severity ($) per Claim*									
California	110,000	142,000	145,000	160,000	180,000	210,000	200,000	240,000	260,000
U.S.	133,000	171,000	203,000	165,000	187,000	186,000	181,000	180,000	176,000
Loss Costs ($) per Occupied Bed									
California	400	970	1,200	1,460	2,210	3,030	2,710	3,540	3,990
U.S.	820	1,160	1,660	1,670	2,070	2,290	2,230	2,270	2,310
Per Diem Loss Costs as Percentage of Average Medicaid Reimbursement									
California	1.4%	3.3%	4.0%	4.5%	6.6%	7.5%	6.6%	8.6%	9.2%
U.S.	2.6%	3.5%	4.8%	4.6%	5.4%	5.6%	5.2%	5.0%	4.9%
* Estimated data based on bar chart.									

NURSING HOME LIABILITY INSURANCE MARKET

Reports Available

Recent Trends in the Nursing Home Liability Insurance Market (Main Report)
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab.pdf

Nursing Home Liability Insurance Market: A Case Study of California
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-CA.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-CA.pdf

Nursing Home Liability Insurance Market: A Case Study of Florida
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-FL.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-FL.pdf

Nursing Home Liability Insurance Market: A Case Study of Georgia
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-GA.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-GA.pdf

Nursing Home Liability Insurance Market: A Case Study of Ohio
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-OH.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-OH.pdf

Nursing Home Liability Insurance Market: A Case Study of Texas
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-TX.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-TX.pdf