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 GEORGIA

June 2006

Office of the Assistant Secretary for Planning and Evaluation

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TABLE OF CONTENTS

INTRODUCTION

The market for professional liability insurance for nursing facility operators is in a state of flux, and the cost of professional liability insurance for nursing home owners has increased substantially in all areas of the country, though much higher in some states than in others. At the same time, the number of insurance carriers offering liability coverage for nursing homes has decreased dramatically, as many admitted insurance carriers incurred substantial losses in this product line in the late 1990s, and consequently decided to get out of 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] Consequently, in some areas of the country, many nursing facility owners have been forced to operate without any professional liability insurance coverage whatsoever.

A contributing factor to increased cost and reduced availability of professional liability insurance for nursing homes has been increased litigation. 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.

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 (HHS) on trends and issues in the nursing facility liability insurance market. Additional case studies were conducted on the nursing facility liability insurance market in California, Florida, Ohio and Texas. The case studies are designed to provide greater insight into the dynamics of the liability insurance market 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 facility litigation and insurance issues in Georgia.

The case study draws largely upon a week long site visit conducted by contractor staff in January 2004. The case study offers a brief background on the Georgia nursing home industry, nursing home quality, and litigation and liability insurance trends in Georgia. The report draws on in-person, telephone, and email discussions, in addition to published and unpublished literature. Discussions were conducted with a broad range of stakeholders including consumer advocates, representatives of for-profit and non-profit nursing homes, plaintiff and defense attorneys, nursing home regulators, state Medicaid rate setting officials, nursing home ombudsmen, insurance carriers, and insurance brokers. Numerous follow-up calls were made, and additional background materials collected, during the spring of 2004 to augment the information obtained during the conduct of the site visit.

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[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

In 2002, the American Medical Association identified Georgia, as a "crisis state" based on: (1) loss of access to medical care by exceptional numbers of people; and (2) physicians making major career changes due to excessive medical liability insurance premiums.[1] That same year, an Aon Risk Consultant's liability insurance actuarial analysis reported that the frequency and severity of nursing home claims in Georgia were increasing at an "alarming" rate.[2] In addition, there were anecdotal reports that the nursing home liability crisis was spreading from Florida north into Georgia, as plaintiff attorneys with specialized expertise in nursing home litigation were looking for new markets to enter. For these reasons, Georgia was selected as one of the five case study states.

Georgia Nursing Home Industry

Georgia's nursing facility environment is distinctive in many ways that may affect liability trends, facilities' ability to respond to the insurance crisis, and the reform debate more generally. First, regional and national chains, both for-profit and non-profit, have a larger market share in Georgia than anywhere else in the country. Nearly three-fourths (73%) of the state's 361 nursing facilities are part of a chain. The percentage of for-profit providers in the state has decreased from 76% in December 2001 to 66% in June 2005. The current figure is equal to the national average.[3]

Second, the supply of nursing facilities and nursing home utilization rates are slightly above average. The state has 40,026 certified nursing facilities beds, 47 for every 1,000 people age 65 or older. This ratio is close to the national average of 46. However, the state has a relatively small population of people age 85 and older, the age group most likely to use nursing facility care. Georgia's ratio of 420 beds per 1,000 people age 85 or older is 22% above the national average of 345.[4] Georgia's occupancy rate (90%) is greater than the national average (86%).[5]

Third, both public and private reimbursement rates are among the lowest in the nation. In 2002, the state Medicaid program paid an average of $91 per day. This rate was 43rd among 46 states that responded to a survey of Medicaid payment policies.[6] The 2003 average private pay rate in urban areas, $129, ranked 39th among the 50 states and DC.[7]

Fourth, nursing facilities in Georgia are more dependent on Medicaid than in other states. Medicaid is the primary payer for 76% of all residents in certified facilities, the fourth highest rate in the country and much higher than the national average (66%). Medicare is the primary payer for 10% of residents, less than the national average of 12%.[8]

Fifth, the vast majority of Georgia's nursing facility beds are certified for Medicare, Medicaid, or both programs. Less than 0.1% of beds are non-certified, compared to the national average of 5%. The percentage of Medicare-certified beds increased from 68% in December 2001 to 90% 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% over the same time period. The percentage of Medicaid-certified beds remained constant during this time (99%, most of which are also Medicare-certified). Nationally, 91% of nursing facilities are Medicaid-certified.[9]

Nursing Home Quality and Oversight in Georgia

Data from Medicare and Medicaid certification surveys indicate Georgia facilities have more deficiencies, on average, than nursing facilities across the country. In 2004, surveys identified 10.0 deficiencies per Georgia facility, compared to the national average, 9.2. A small proportion of these quality concerns led to actual harm to residents or put residents at risk of death or serious injury (i.e., immediate jeopardy). Georgia was close to average in the percentage of facilities with these most serious deficiencies (15%, compared to the national average of 15.5%).[10]

State surveys are frequently criticized for being an unreliable source of information for measuring nursing home quality, however. A 1999 U.S. General Accounting Office (GAO) report offered strong criticism of the nursing facility enforcement system, and noted large variations among states in the survey process.[11] Although a more recent GAO report noted improvements, it identified continued nursing home oversight shortcomings in several states. In Georgia, for example, more than half the surveys were predictable because they occurred in the last month of a 15-month period in which a survey is required.[12]

Nursing home staffing levels in Georgia are below the national average. Georgia facilities employed 3.4 licensed nurse and certified nursing assistant staff per resident day in 2004, compared to the national average of 3.7.[13] In 2002, Georgia ranked as one of ten states having the highest percentage of facilities with deficiencies in one or more of the top ten U.S. Survey Deficiency Categories.

Over the last three years, the Georgia Nursing Home Association has spent over $1 million on a quality improvement initiative. Directed by an independent contractor--My InnerView--the program promotes evidence-based management practices through monthly data collection, management training, and resident, family and employee satisfaction surveys.[14] Nursing facilities sign a quality pledge and pay $2,300 to join the program. These payments are reimbursed if a facility pays the entire fee, submits monthly data, and facility staff attend the program's training sessions. The data contributed by the participating facilities are used to identify weakness indicators, solve individual facility problems, and promote friendly quality competition among facilities. Since the project's inception, improvements have been seen in bed sore rates, restraint usage, and other quality indictors. Supervisory and management skills training are

emphasized. The American Association of Retired Persons, the Georgia Council of Community Ombudsmen, and the Alzheimer's Association provide financial support for this quality project. The goal is to eventually make city or regional nursing facility data publicly available. There was some concern among the program participants, however, that if individual facility-level data were made available to the public, plaintiff attorneys might use it to pursue litigation against the more poorly performing nursing facilities.

Nursing Home Litigation and Liability Insurance Trends in Georgia

Most publicly available data and research studies on professional liability in Georgia focus exclusively on medical malpractice costs and litigation claims for individual physicians and do not include long-term care facilities. However, two national studies provide a limited view of nursing home liability trends in Georgia. In addition, the Georgia Nursing Home Association also supplied summary data on the costs of liability insurance.

In a national study of nursing home general and professional liability costs, Aon Risk Consultants estimated that the frequency of nursing home claims in Georgia to be slightly below the national average (see Table 1). In 2003, Aon estimated that there were 14.0 liability claims per 1,000 beds in Georgia, compared to a national average of 15.3 claims per 1,000 beds.[b] However, in terms of claim severity, Aon estimated that the average award made in Georgia (either through a negotiated settlement or a jury award) was significantly higher than the national average. In 2003, Aon estimated average claim severity in Georgia at $220,000, almost 50% higher than the national average of $149,000 per claim. As shown in Table 1, average claim severity in Georgia was below the national average in the mid to late 1990s, but starting in 1999, claim severity started to increase dramatically. Both plaintiff and defense attorneys interviewed during the Georgia site visit indicated that settlement amounts had increased in Georgia after a number of jury trials had ended with multi-million dollar awards being made to the plaintiff. While very few liability cases go to jury trial, award amounts granted in jury trials drive negotiated settlement amounts.

As also shown in Table 1, due to Georgia's low Medicaid reimbursement rates, liability costs represent a higher percentage of Medicaid revenue in Georgia than in most other states. In Georgia, per diem loss costs averaged 7.6% of the average daily Medicaid reimbursement rate in 2004, compared to a national average of 5.0%. In 2001, the Georgia legislature appropriated an $18 million supplement to cover increased liability insurance costs for facilities whose costs had risen more than 25%. However, this was a one-time supplemental payment, and both state officials and nursing home representatives did not expect any additional supplemental payments in the future.

b. The Aon data include both general and professional liability claims, so that not all claims are necessarily related to patient care.

In 2005, Aon issued an annual update to its actuarial analysis of professional liability costs in the nursing home industry.[15] In its 2005 report, Aon's estimates of average loss costs in Georgia increased dramatically. For example, estimated lost costs in 2001 increased from $1,910 per bed to $5,110 per bed.[c] Aon attributed this increase to a 2000 claim occurrence that eventually led to a payout of over $10 million in 2004. This payout amount had a significant effect on settlement amounts in 2001, as insurers were forced to negotiate higher settlements in order to avoid the risk of a trial. These data demonstrate how individual cases that go to jury trial can have a large impact on average loss costs for outstanding claims. On the other hand, the 2005 Aon study also estimated that over half of all claim amounts are settled for less than $50,000.[16]

The Aon study sample is dominated by data contributed by multi-facility chain operators that are self-insured. A 2002 study, conducted by the Insurance Services Office (ISO), provides liability claims data for nursing homes that purchase professional liability insurance from commercial insurers.[17] Although the study samples are different, the ISO study findings are fairly consistent with the 2004 Aon estimates. The ISO study, which represented approximately 41.1% of all beds in Georgia and 26.7% of all nursing homes beds nationwide, also found Georgia outpacing the national average in terms of claim severity, and about equal to the national average in claims per 1,000 beds (see Table 2). Between 1998 and 2000, Georgia's claim frequency was slightly less than the national average (1.4 per thousand beds and 1.5 per thousand beds respectively). Average severity per claim for Georgia at $170,000 was in excess of the national average of $139,000. Pure premium costs in Georgia exceeded the national average as did the loss ratio (see Table 2).

Both the ISO and Aon studies indicate that while Georgia may not be outpacing the national average in frequency of claims made, the average severity per claim exceeds the national average in recent years.

Data from a Georgia Department of Insurance Survey (Table 3) showed a huge increase in insurance premium costs from 2001 to 2002. Insurance costs rose 123% for Georgia nursing facilities while projected payments also increased dramatically (160%) over the same period.

Nursing Home Liability Insurance Market in Georgia

The number of admitted insurance carriers writing liability policies for nursing facilities had decreased in Georgia, leading nursing facilities to seek alternate insurance arrangements. The Atlanta Business Chronicle reported in 2001 that many insurers had stopped writing liability policies for nursing facilities altogether, "shrinking the pool of would be insurers from 15 to less than five."[18] According to insurance industry brokers

[c.] Adjustments to estimated loss costs for a particular year can be made when actual resolutions of outstanding claims differ from actuarial assumptions previously applied to outstanding claims.

interviewed during the Georgia site visit, by 2004 there were no admitted insurance carriers (i.e., those which comply with state insurance regulations) operating in Georgia, but only direct carrier subsidiary surplus lines extending liability insurance coverage to nursing facilities (e.g., AIG is using Lexington to write policies, CNA is using Columbia, Great American is using American Empire). Admitted carriers are required to file financial statements, audit statements, actuarial reports, rate justifications and form filings with the state. Admitted carriers are also subject to examination by the Georgia Commissioner of Insurance. Additionally, should an admitted carrier become insolvent, there is a state reserve (in Georgia--$100,000 per policy) to pay claims. Surplus line carriers do not comply with state insurance regulations and claims are not covered by the state reserve in case an insurer becomes insolvent.

Nursing facilities reported during site visit interviews that they had opted to seek coverage through: (1) alternative risk transfer programs such as surplus line carriers; (2) forming captives; and (3) joining risk retention groups (RRGs). A surplus line carrier is unregulated and handles risks that admitted carriers are unwilling to write and although recognized as an insurance carrier, is licensed in another state. The advantages of being a surplus line carrier, rather than an admitted carrier, include the ability to set rates without oversight of the department of insurance and to operate in a less regulated environment.

Captive insurance programs are “an external funding mechanism whereby a provider (or group of similarly related providers or a trade association) creates a separate legal entity, typically a subsidiary or sister corporation, to act as the provider’s limited purpose insurance company.”[19] A captive can write insurance or reinsurance and is required to file financial statements, audit reports, and actuarial reports, but not rate justifications and form filings. Captives are also not covered under the state reserve fund. Self-insurance funds can be formed by a group or an organization and are “arrangement(s) whereby a provider contributes monies to a self-insurance reserve that is held by an independent entity and specifically dedicated to the payment of anticipated professional liability claims.” Advantages of alternative insurance arrangements include potentially lower premiums and control over how claims are paid or contested.

Similar to captives, RRGs are member-owned business associations that are formed specifically for the purpose of pooling and sharing similar business risks. RRGs are effectively exempt from state law except that the states can still collect premium and surplus taxes, force compliance with unfair claim settlement practices, and follow a few other requirements common to insurance companies. States may not, however, dictate rates, coverages, forms, methods of operations or investment activities, loss control or claims. RRGs are often used in conjunction with captives to insure various levels of risk. The Georgia Department of Insurance reported that in 2002 there were 48 registered RRGs in the state, increasing to 61 registered RRGs by February 2004. There were also 16 licensed captives as of the end of 2001. While current data on captives are not available, nursing facility organizations and insurance brokers estimated that over 50% of Georgia facilities were in some form of self-insured captive arrangement in 2004.

Georgia nursing facilities are not required by law to have liability insurance and there is no state oversight or data collection policy for determining if insured facilities are meeting carriers' requirements.

Legal and Legislative Environment in Georgia

The Tort Reform Act of 1987 and the Medical Malpractice Reform Act of 1987 represent early efforts at tort reform by the Georgia Legislature. These two Acts established standards for the award of punitive damages for all tort cases, including product liability cases. The main components of the Acts which impacted nursing facility liability tort cases include the following:

- Claimants were required to support their claim with an expert affidavit.
- Punitive damages had to be specifically requested in the complaint and not awarded automatically. Juries had to decide whether punitive damages would be awarded and the amount.
- Punitive damages were awarded only to penalize or deter a defendant and not to compensate a plaintiff.
- Punitive damages were only to be awarded when there is clear evidence of willful misconduct, and not in cases of simple negligence.
- In cases which do not arise from product liability, if it is found that the defendant acted, or failed to act with the intent to cause harm (or under the influence of alcohol or drugs) there is no limitation regarding the amount which may be awarded for punitive damages. The damages are the liability only of the defendant who acted (or failed to act) and not of the other defendants in the case.
- For cases where there is no product liability and the defendant was not found to act with the intent to do harm, punitive damages shall be limited to a maximum of $250,000.
- Collateral source payments (expenses covered by another party such as an insurer) can be admitted as evidence.
- The rule of joint and several liability is barred in the recovery of all damages when a plaintiff was assessed a portion of the fault.
- In subsequent court cases, the U.S. District court declared several of the provisions of the Acts which were related to product liability cases to be unconstitutional. (Georgia Power v. Falagan, No. S90A1245, April 1991)[20]

Starting in 2003, the Georgia Legislature proposed a number of bills that furthered efforts at tort reform. The main issues addressed in these bills included: caps on non-economic damages, expert witness qualifications, issues of joint and several liability and comparative negligence, collateral source requirements and periodic payments. On November 15, 2004, Senator Preston Smith (R-Rome) along with other members of the Senate Republican Caucus filed tort reform legislation Senate Bill 3.

Senate Bill 3 (S.B. 3) was enacted by the Georgia General Assembly on February 14, 2005 and signed into law by Georgia Governor Sonny Perdue on February 16th. The focus of the legislation was on medical malpractice reform, but many provisions of the bill also affect nursing home liability issues. Specific provisions of S.B. 3 which apply to nursing facility liability and medical malpractice cases are:

- Venue: If defendants who are residents of a venue are discharged from liability and any remaining defendants are not residents of that venue, the remaining defendants can request the case be transferred to an appropriate venue. For medical malpractice claims, a non-resident defendant can ask for the case to be transferred to the county of his/her residence (if that is where the act occurred). If the court determines that a different state or county will be more convenient to the parties involved, the court can transfer the case. This provision was intended to address the fact that many times plaintiffs would join a "dummy defendant" in order to establish venue in a more plaintiff-friendly county.

- Expert witness qualifications: In medical malpractice cases, experts (at the trial and in pre-trial affidavits) must have practiced or taught for three of the five years preceding the case in the appropriate area of specialty. The judge determines if the expert has the proper qualifications to testify regarding the diagnosis and treatment at issue in the case.

- Offers of settlement: When an offer of monetary settlement is made and rejected and the offeror has a favorable verdict (at least 25% more favorable than the offer), the offeror is entitled to collect litigation costs. The costs would be calculated from the day the settlement was offered and would include attorney's fees.

- Statements of apology: Statements of apology or sympathy made by health care providers to patients or their families can not later be admitted as evidence of the provider's liability.

- Liability in emergency departments: For emergency care, health care providers are not liable unless clear and convincing evidence of gross negligence is provided. This is not applicable once a patient is stabilized or if care is not related to the medical emergency.

- Apparent agency: This provision clarifies when a hospital is liable for the negligence of a health care provider that is not an employee.

- Proportional Share Liability: Each defendant is only responsible for their proportional share of the damages. This provision abolishes joint and several liabilities which makes all parties equally responsible for any damages.

- Non-economic damages: Non-economic damages are limited to a total of $1,050,000, with a cap of $350,000 per individual health care provider or medical facility. For multiple facilities, non-economic damages are capped at $700,000.

The provisions of S.B. 3 imposing caps on non-economic damages are those which have the greatest potential impact on the nursing home liability insurance market. The caps imposed in S.B. 3 are not as hard or as low as those imposed in the tort reform legislation recently enacted in Texas, so it remains to be seen what impact S.B. 3 will have on both claim frequency and claim severity in nursing home liability cases.

SUMMARY

Georgia experienced a rise in nursing home liability claims in the late 1990s and early 2000s that led to the exit of virtually all admitted insurance carriers in the state. Many attribute the increase in litigation activity in Georgia to the "spread" of nursing home litigation from neighboring Florida, and the expansion of plaintiff attorneys who had developed specialized expertise in nursing home litigation into new markets. As in many other states, the debate on nursing home liability reform in Georgia was caught up in a larger debate around medical malpractice reform. The medical malpractice crisis in Georgia led to the enactment of S.B. 3 in February 2005, which although focused on bringing stability back to the medical malpractice insurance market, is also expected to impact the nursing home liability insurance market, particularly in relation to the placement of hard caps on non-economic damages. However, as in other states that have recently enacted tort reform legislation, pricing stability in the insurance market has not been immediate. Insurers generally take a "wait and see" approach to tort reform legislation, and closely monitor actual impacts on claim severity and frequency before re-entering a market and/or reducing prices. Thus, stability in the nursing home liability insurance market in Georgia may still be several years away.

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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 Claims Analysis--Georgia vs. U.S. (National Averages)									
	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003****
Claims per 1,000 Beds*									
Georgia	4.1	3.7	6.2	7.8	9.9	7.9	13.0	12.3	14.0
U.S.	5.9	6.3	7.6	9.0	11.1	11.6	11.7	13.8	15.3
Severity ($) per Claim*									
Georgia	61,000	50,000	98,000	119,000	159,000	125,000	203,000	190,000	220,000
U.S.	95,000	133,000	170,000	187,000	155,000	179,000	169,000	149,000	149,000
Loss Costs ($) per Occupied Bed									
Georgia	80	340	660	1,290	1,730	1,640	1,910	2,370	2,730
U.S.	570	830	1,300	1,690	1,730	2,080	1,980	2,050	2,290
Per Diem Loss Costs as Percentage of Average Medicaid Reimbursement									
Georgia	0.3%	1.2%	2.5%	4.6%	5.7%	5.1%	5.7%	6.8%	7.6%
U.S.	1.9%	2.7%	3.9%	4.9%	4.8%	5.4%	4.8%	4.8%	5.0%

SOURCE: 2004 Aon study. Data represent 24% of all U.S. beds, 26% of Georgia beds, and are primarily from self-insured, for-profit facilities.

* Estimated data based on bar chart.
** Projected data.

TABLE 2: ISO Claims/Premiums[1]--Georgia vs. U.S. (National Average) 1998-2000				
State	**Claim Severity**	**Claim Frequency (Claims per 1,000 Beds)**	**Pure Premium per 1,000 Beds****	**Loss Ratio**
Georgia	$170,000*	1.4*	$230*	3.83%
U.S.	$139,000	1.5	$209	3.57%

* Estimated data based on bar chart.
** Pure premium is the total dollars of claims per occupied bed (historical loss cost).

1. Insurance Services Office. *Nursing Home Liability Insurance: A Discussion of the Current Insurance Crisis*. Jersey City, NJ: ISO Properties, Inc. No. LI-GL-2002-276, LI-PR-2002-084, August 2002

TABLE 3: Aggregate Nursing Home Professional Liability Insurance Costs and Projected Payments			
Expenses	**2001**	**2002**	**% Change from 2001 to 2002**
Insurance Costs	$13,000,400	$28,990,868	123%
Projected Payments	$6,485,298	$16,919,663	161%

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