



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 OHIO

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Office of the Assistant Secretary for Planning and Evaluation

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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 substantially in all areas of the country, though much higher increases have occurred in some regions than in others. Concurrently, the number of insurance carriers offering liability coverage for nursing homes has decreased, as many regulated 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 operating without any professional liability insurance coverage whatsoever.

A major factor contributing to the 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. Some contend that, for a variety of reasons, the increased costs of professional liability insurance are out of proportion to the increased liability exposure faced by the industry.

This report is one of five case studies being 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 home liability insurance market. Additional case studies were conducted of the nursing home liability insurance market in the states of California, Georgia, Florida, 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 Ohio.

The case study draws largely upon a week long site visit conducted by the study contractor in late September and early October 2003. The case study offers a brief background on the Ohio nursing home industry, nursing home quality, and litigation and liability insurance trends in Ohio. 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 not-for-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

^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>]

made, and additional background materials collected, during the fall of 2003 and spring of 2004 to augment the information obtained during the conduct of the site visit.

STATE ENVIRONMENT

Ohio was selected as one of the five case study states for two primary reasons. First, Ohio had been reported to be a state with a relatively low level of nursing home litigation activity. The selection of states for case studies was conducted with the intention of including both states with reportedly high and low levels of nursing home litigation. Other states selected were reportedly high litigation states. Second, Ohio had recently enacted tort reform legislation with the intention of limiting potential increases in lawsuit activity against nursing homes. There was interest in identifying the reasons why stakeholders felt the need to enact tort reforms aimed at the nursing home industry, as well as ascertaining what impact, if any, the enacted tort reforms had had on litigation activity and the liability insurance market.

Ohio Nursing Home Industry

Ohio's nursing home industry is distinctive in a number of ways that might affect the dynamics of the professional liability insurance market in the state. First, for-profit companies and regional and national chains control a larger than average share of the state's 976 nursing facilities. Three-fourths of Ohio's nursing homes are for-profit (75%), greater than the national average of 66%. Chain providers comprise 57% of facilities in Ohio, compared to 52% nationally.¹

Second, nursing home bed supply and utilization rates in Ohio are higher than the national average. Ohio has 91,941 certified nursing homes beds, 60 for every 1,000 people age 65 or older. This ratio is greater than the national average of 46 beds per 1,000 elderly. The bed supply is equally high when considering people age 85 or older, the age group most likely to use nursing facility care. Ohio's ratio of 441 beds per 1,000 people age 85 or older is 28% above the national average of 345 beds per 1,000.² Even with this high supply, Ohio's occupancy rate (88%) is slightly above average (86%).³

Third, Ohio's Medicaid reimbursement rate is one of the highest in the nation. In 2002, the state Medicaid program paid an average of \$144 per day. This rate was 5th among 46 states that responded to a recent survey of Medicaid payment policies.⁴ By contrast, the 2003 average private pay rate in urban areas, \$154, ranked 21st among the 50 states and DC.⁵

Fourth, despite the high Medicaid reimbursement rate, nursing facilities in Ohio are not more dependent on Medicaid than in other states. Medicaid is the primary payer for 64% of residents in certified facilities, close to the current national average of 66%. Medicare is the primary payer for 13% of residents, also close to the national average (12%).⁶

Fifth, Ohio has the largest proportion of non-certified nursing facility beds in the country. Over 26,000 beds not certified by Medicare or Medicaid are available only to private pay individuals and represent 22% of total nursing facility beds in Ohio, compared to the national average of 5%. As a result, Ohio is below the national average in the percentage of beds certified for Medicare and Medicaid. However, this may be changing as the percentage of Medicare-certified beds increased from 49% in December 2001 to 73% in June 2005. This increase reflected a national pattern during the same time period after changes were made in Medicare reimbursement policy. The national average increased from 60% to 82%. The percentage of Medicaid-certified beds remained constant during this time (77%), most of which are also Medicare-certified. Nationally, 91% of nursing facilities are Medicaid-certified.⁷

Nursing Home Quality and Oversight in Ohio

Data from Medicare and Medicaid certification surveys indicate Ohio has fewer deficiencies than nursing facilities across the country. In 2004, surveys identified 6.7 deficiencies per Ohio facility, compared to the national average, 9.2. Only 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). Ohio also had a lower than average percentage of facilities with the most serious deficiencies (11%, compared to the national average of 15.5%).⁸

State survey data are frequently criticized as an imperfect measure of 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.⁹ Although a more recent GAO report noted improvements, it identified continued nursing home oversight shortcomings in several states, but not Ohio.¹⁰

Nursing home staffing levels in Ohio are above the national average. Ohio facilities employed 3.9 licensed nurse and certified nursing assistant staff per resident day in 2004, compared to the national average of 3.7.¹¹

Nursing Home Litigation and Liability Insurance Trends in Ohio

Two studies have attempted to measure nursing home liability costs in Ohio. The findings of the two studies are not altogether consistent. The differences between the studies may be attributable to the fact that the two studies used different data sources for generating estimates of nursing home liability costs. The first study, conducted by the Insurance Services Office (ISO) in 2002, covered 26% of the beds in Ohio with commercial professional liability insurance.¹² The ISO study estimated the annual frequency of claim activity in Ohio over the three-year period of 1998-2000 at about 2.0 claims per 1000 beds, about 33% *higher* than the national average of all facilities included in the study. However, the ISO study also estimated that average claim

severity in Ohio was below average. The average claim amount in Ohio was about \$115,000 over the 1998-2000 time period, about 18% below the national average of \$139,411 per claim. Overall, ISO estimated average loss costs of about \$210 per bed in Ohio over this three-year period, almost exactly the same as the national average.

The second study, conducted by Aon Risk Consultants in 2004, included about 20% of the nursing home beds in Ohio.¹³ However, the sample of nursing homes that contributed liability cost data in the Aon study was significantly different from the sample of nursing homes in the ISO study. The Aon study consisted primarily of nursing homes owned by national multi-facility chains that were self-insured. The estimates of claim frequency in the Aon study are higher than in the ISO study for the comparable time period, while the estimates of claim severity are somewhat lower. For the 1998-2000 time period, Aon estimated claim frequency at about 3.0 claims per 1,000 beds, higher than the ISO estimate. The estimates of average claim severity were actually *lower* in the Aon study during the 1998-2000 period, in the range of \$80,000-\$85,000.

Differences in estimates made in these two studies could be attributable to differences in the liability experience of the nursing homes included in the respective studies, as well as to differences in the actuarial assumptions used by the study analysts. The estimates generated in these studies are partly dependent upon what assumptions are made about the eventual resolution of outstanding liability claims that are still in litigation, since most claims take about three years to be resolved.

Although average loss costs per occupied bed in the ISO report were about equal to the national average, Aon estimated loss costs among Ohio facilities significantly below the national average. In the Aon study, average loss costs in Ohio over the 1998-2000 time period were estimated at \$570 per occupied bed, only 31% of the national average loss cost of \$1,833 per occupied bed over the same time period.

In its 2004 study, Aon projected that claim severity would increase sharply in Ohio after the year 2000, increasing to an average claim payout of \$192,000 by 2003. This estimate was lowered significantly in the 2005 Aon study, when Aon estimated an average claim severity in 2003 of about \$110,000.¹⁴ This suggests a downward trend in settlements resolved between 2004 and 2005. Overall loss costs in Ohio were still estimated to be significantly below the national average.

Stakeholders interviewed during the September 2003 site visit confirmed the view that liability costs in Ohio were considerably below the national average. Most stakeholders characterized Ohio as a “low-litigation” state. Indeed, the estimates of claim frequency provided in the ISO and Aon studies are surprisingly high in comparison to the qualitative views of the stakeholders interviewed. Most respondents, including providers, indicated that lawsuits against nursing homes in Ohio were relatively rare. Note that the ISO and Aon studies include both *general* and *professional*

liability claims and losses, and neither study distinguished general liability claims from professional liability claims.^b

One factor that may contribute to low claim severity in Ohio is the positive reputation held by the nursing home industry in general. Stakeholders agreed that the nursing home industry in Ohio generally enjoys a positive public perception among the state's citizens. Most nursing homes in Ohio are owned by small independent operators--local business people who may own a single facility or a small chain of nursing facilities, generally in a rural area. These independent operators are generally perceived by local citizens as responsible business people and upstanding members of the community. In many rural towns, the nursing home is one of the largest and most stable employers. Given this environment, it was felt that Ohio juries tend to be more sympathetic to the views of defendants, relative to juries in other states. In turn, this generally led to lower settlements in nursing home litigation cases, which are largely predicated on each side's expectation of what verdicts would be if cases were to go to trial.

Ohio differed from the other case study states on another dimension--the dearth of trial attorneys with an interest in taking on nursing home litigation cases. In stark contrast to the other four case study states--Texas, California, Florida, and Georgia--it was difficult to find a trial lawyer or a firm which specialized in nursing home litigation. While there were a few attorneys who specialized in defending cases for nursing home operators and insurance companies, there were virtually no lawyers on the plaintiff side who specialized in this area. Given that average settlements in Ohio were reportedly small, it was hypothesized that the nursing home litigation "market" was not considered a particularly attractive area for specialization.

Nursing Home Liability Insurance Market in Ohio

As late as 1999, the cost of nursing home liability insurance in Ohio was only about \$50 per bed. About 60% of the nursing home liability insurance business in Ohio at that time was underwritten by one carrier--Monroe Guarantee, which pulled out of the market in 1999, reportedly because it foresaw huge losses in this product line due to historical underpricing and poor underwriting practices. With the exit of Monroe Guarantee and other admitted carriers, surplus line carriers began to enter the market, and prices quickly started to rise. In the year 2000, the average price per bed was in the range of \$80-\$160 per bed. In 2001, prices increased to about \$270 per bed; in 2002, about \$500 per bed, and in 2003, to about \$800 per bed.^c Thus, between 1999 and 2003, the cost of professional liability insurance in Ohio increased by about 16 fold.

^b. General liability claims include any liability claim made against the nursing home, for example, accidents involving a nursing home employee, or thefts of residents' property. Professional liability claims relate to claims related to the direct professional care of nursing home residents, such as abuse or extreme negligence.

^c. The average price per bed of nursing home liability insurance cited represent average prices quoted by nursing home providers and insurance brokers during our interviews.

Stakeholders in Ohio, both providers and insurance brokers, felt that the nursing home industry in Ohio was the victim of a “panic” in the nursing home liability insurance market created by carriers’ experiences in states other than Ohio, and by the reduced supply of insurance carriers in Ohio. Stakeholders believed that increases in the price of liability insurance could not be attributed to increased loss costs in Ohio itself, at least on the scale that they were experiencing. Several stakeholders stated that the annual Aon studies, which were the only studies generally available to the insurance industry, had actually contributed to increases in insurance prices and were not justified. These stakeholders expressed the view that the Aon estimates were biased upward in an attempt to justify the need for tort reforms.

In an interview with senior executives at one surplus line carrier in Ohio, executives acknowledged that the collapse of the regulated insurance market had created a business opportunity for their company. The company had been successful in increasing its market share in Ohio over the last several years, concentrating on securing the professional liability business of small independent operators, generally those with fewer than ten facilities. The average number of facilities per policy was 2.5. The company’s focus was on the accurate and fair pricing of its products, given expected loss costs in their portfolio of facilities. The executives did not have much faith in risk management programs, which they believed, in many cases, were merely “gimmicks.” They also expressed the view that most tort reform initiatives were ineffective in reducing liability costs. Rather than attempting to win market share by beating its competitors on price, this company reported that it focused on selling products that provided real insurance coverage at a fair market price, which was generally higher than other surplus line carriers. For example, it was the only carrier in Ohio still writing policies on an occurrence basis with a relatively low deductible (\$5,000).

When asked if the company was employing any innovative claims management strategies to minimize loss costs, the officials responded that their strategy was generally to settle early and get cases off the books as quickly as possible. Although they believed that the legitimacy of many liability claims were marginal at best, they also acknowledged that “usually something had gone wrong” in the nursing home to result in a claim. Furthermore, they believed that juries in nursing home cases were unpredictable, and that it was easy to lose a case that the company viewed as defensible. The company had conducted mock trials of nursing home cases, trying the exact same case in front of multiple juries. These mock trials had validated the unpredictability of jury verdicts. Thus, the company rarely took a case to court, and usually settled. The executives cited one case of a “wrongful death” suit involving a 111-year-old nursing home resident, in which the company had paid a settlement.

A significant development in the Ohio insurance market in recent years was the formation of a new captive called The Alliance Program. The Alliance Program was created by the state’s largest insurance broker--Neace Lukens--based in Cincinnati. Captives are essentially new insurance companies, created by their policyholders, and can take a variety of forms.¹⁵ Captives become an insurance alternative when coverage

in the commercial market is either unaffordable or unavailable. The Alliance Program was a captive created specifically for Ohio nursing home providers who collectively believed they could self insure at a price that was significantly less than the market prices offered by the surplus line carriers selling professional liability coverage in Ohio. The role of the insurance broker--Neace Lukens--was a critical part of the captive, since the members of the captive were relying on the underwriting, risk management, and claims management expertise of the captive administrator to keep it financially viable.

Prior to the formation of The Alliance Program, Neace Lukens had developed an extensive risk management program of its own, which it required *all* of its customers to adopt as a condition of buying liability coverage through the company. In return, Neace Lukens negotiated lower prices from commercial insurers for the risk pool it brought to the carriers, passing those savings along to its customers. Neace Lukens incorporated its risk management program into The Alliance Program, and added both an underwriting and claims management capacity in creating the Program. With many years of experience in serving Ohio's nursing homes as an insurance broker and risk management vendor, Neace Lukens had in-depth knowledge of the Ohio nursing home industry. With that experience, The Alliance Program captive was betting that it could effectively manage liability losses and provide liability coverage for its members at a lower cost than offered by the commercial market. Providers participating in The Alliance Program reported that premiums for professional liability insurance provided through the captive were one-half to one-third less than rates available in the commercial insurance market.¹⁶ By the end of 2004, about 25% of all nursing homes in the state were participating in The Alliance Program.

During the contractor's site visit in the fall of 2003, The Alliance Program was still in its early planning stages. At that time, there was an underlying tension in the provider community regarding which facilities were going to be "invited" to participate in the captive, and which facilities would be denied admission. While entry to the captive meant lower costs for liability coverage for its members (as long as the captive was effective in controlling loss costs) it also generally meant higher prices for those denied entry.

Legal and Legislative Environment in Ohio

While litigation activity against nursing homes in Ohio was the lowest of the five states selected for case study analysis, tort reform initiatives in Ohio were still active and continuous. Of particular interest is that tort reform initiatives in Ohio have been undertaken in the context of an ongoing dispute between the state legislature and the Ohio Supreme Court regarding the proper exercise of judicial authority.

In 1996, the state legislature enacted a comprehensive medical malpractice reform bill which, among other provisions, imposed caps on both non-economic damages and punitive damages. However, in August 1999, the Ohio Supreme Court, in a 4-3 decision, ruled that legislation unconstitutional. In its ruling on *State ex rel. Ohio*

Academy of Trial Lawyers v. Sheward, 86 Ohio St. 3d 451, 715 N.E. 2d 1062 (1999), the Court asserted that the legislature had “deliberately challenged the authority of the judicial branch by reenacting laws already declared invalid and attempting, with spurious findings and declarations of intent, to evade the Supreme Court’s rulings.”¹⁷ Specifically, the Supreme Court stated:

“The General Assembly has circumvented our mandates, while attempting to establish itself as the final arbiter of the validity of its own legislation. It has boldly seized the power of constitutional adjudication, appropriated the authority to establish rules of court and overruled judicial declarations of unconstitutionality, and, under the thinly veiled guise of declaring “public policy,” establishing “jurisdiction” and enacting “substantive” law, forbade the courts the province of judicial review.”¹⁸

Nonetheless, since the Supreme Court’s 1999 ruling, the state legislature continued to enact new tort reform laws, both in the area of medical malpractice, and more broadly across all areas of tort liability. Three pieces of legislation have directly affected the nursing home industry.

In August 2002, Governor Robert Taft signed House Bill 412 (H.B. 412) into law, a piece of legislation specifically targeted as a measure of relief for the nursing home industry. H.B. 412 included the following provisions:

- Extended state tort liability provisions governing hospitals and physicians to include licensed nursing homes and other residential care facilities, including assisted living facilities.
- Limited tort liability to actions or omissions the facility authorized, participated in, or ratified.
- Established a firm one-year statute of limitations for bringing malpractice lawsuits.
- Provided statutory guidance on the factors to be considered in awarding punitive damages, including a focus not only on a facility’s assets, income and net worth, but also on the facility’s future financial ability to provide services to the frail elderly if punitive damages are awarded against it.
- Excluded from evidence results of inspections, surveys and reports that are conducted for regulatory compliance purposes in all cases except in lawsuits brought by the Ohio Department of Health and/or the Ohio Department of Jobs and Family Services (ODJFS), which administers the Ohio Medicaid Program.
- Required proof of negligent or intentional misconduct before awarding compensatory damages against a home in “patients bill of rights” suits.
- Required notification of the ODJFS upon filing of a malpractice lawsuit so the state can exercise its subrogation rights.

In January 2003, the legislature enacted two additional tort reform bills that were primarily targeted at medical malpractice reform. Although early versions of the bills did not extend the provisions to nursing facilities, the final versions of the two bills were also applied to nursing homes, residential care facilities, and facilities for the mentally retarded.¹⁹

Senate Bills 281 and 120 collectively included the following provisions:

- Placed a cap of \$350,000 on non-economic damages for each victim in most cases, or a maximum of \$500,000 for each occurrence.
- Put a \$500,000 cap on non-economic damages for each victim in catastrophic injury cases--the most egregious cases of medical malpractice, such as loss of a limb. Death was not included because Ohio had a separate law prohibiting caps in wrongful death cases. There was an additional \$500,000 cap imposed on claims that a spouse or companion might bring.
- Required plaintiffs' attorneys whose contingency fees exceeded certain limits to make an application in the probate court for approval of the fees.
- Permitted defendants to introduce evidence of the plaintiff's receipt of collateral benefits.
- Established that arbitration between patients--hospitals--health care providers is binding when a patient signs a contract before the rendering of services. Such contracts become irrevocable after 30 days.
- Established a statute of limitation of one year after the cause of action occurs in which to bring a claim and a statute of repose barring claims initiated after four years after the occurrence of the act or omission constituting the alleged basis of the claim.
- Gave defendants the right to compel the court to hold a hearing to test whether a particular claim is supported by a reasonable good faith basis. Attorney's fees and costs are available to a defendant that prevails in a good faith hearing.
- Allowed defendants to pay future damages exceeding \$50,000 through the use of periodic payments, rather than one lump sum.
- Eliminated joint and several liability in most circumstances and established proportionate liability as the rule rather than the exception.

Despite these significant tort reform initiatives, the costs of nursing home liability insurance continued to rise after their passage. Although the initiatives included a number of provisions for weeding out frivolous lawsuits, the frequency of claims against nursing homes did not abate, nor were insurers/defendants more prone to defend

claims in a jury trial. Further, as discussed previously, the Ohio tort reform legislation included various exceptions to damage limits and other constraints that served to weaken the effect of the legislation. The authors of the 2005 Aon study characterized the caps on non-economic damages in Ohio as follows: “the exceptions are so broad that its potential impact on reducing long-term care patient liability is uncertain at this time.”²⁰ Finally, there was a consensus among stakeholders that another ruling by the Ohio Supreme Court on the constitutionality of the tort reform laws was likely, although recent changes in the make up of the Court may result in a decision that supports the legislation. In any case, in 2004, insurance captives, not tort reform, were perceived to have the greatest potential for reducing the costs of liability insurance for Ohio’s nursing home providers.

SUMMARY

Of the five case study states, Ohio had the lowest nursing home litigation activity. There was no organized plaintiff bar in Ohio specializing in nursing home litigation, as was the case in other states. The annual Aon studies estimated that claim frequency among Ohio facilities was significantly below the national average, while the ISO studies (based on 1998-2000 data) estimated average frequency. In regard to claim severity, both the Aon and ISO studies indicate that the average size of settlements for nursing home claims in Ohio is significantly below the national average. Lower claim severity in Ohio may be attributable to the fact that, relative to other states, nursing home operators enjoy a better reputation among the general public. Lower settlement amounts in Ohio, as negotiated in settlement agreements, are likely related to shared expectations of lower awards by juries, and/or more verdicts in favor of defendants, had the claims proceeded to jury trials.

In spite of lower claim severity in Ohio, the cost of nursing home liability insurance in the commercial market increased by a factor of 16 between 1998 and 2003. Stakeholders in Ohio attributed the rise in insurance costs to increased litigation activity in other states, and to insurers concerns that the litigation crisis would soon spread to Ohio. Nursing home providers saw themselves as victims of events external to Ohio. The Ohio state legislature has enacted a series of tort reform laws aimed at constraining the magnitude of nursing home litigation in Ohio and stabilizing insurance costs. Stakeholders agreed that these initiatives were largely “pre-emptive strikes” to prevent future increases in litigation activity in Ohio, and to send messages to both the out-of-state plaintiff bar and to the insurance markets of Ohio’s intent to not let the nursing home liability crisis get out of hand. However, the effectiveness of tort reforms enacted in 2002 and 2003 remains uncertain at this time. Some skepticism has been expressed about whether these tort reforms will have a substantial impact on reducing liability costs. The most effective response to rising insurance costs in Ohio has been the creation of a new insurance captive, started by a self-selected group of facilities that have formed their own risk pool, with the administrative support of one of the largest insurance brokers in the state. As of December 2004, about 25% of Ohio’s nursing homes were participating in the captive.

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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.

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>