



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 TEXAS**

June 2006

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# **THE NURSING HOME LIABILITY INSURANCE MARKET: A Case Study of Texas**

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# INTRODUCTION

The market for professional liability insurance for nursing facility operators is in a state of flux, and the cost of professional liability insurance has increased substantially in all areas of the country, though more so in some states than in others. At the same time, the number of insurance carriers offering liability coverage to nursing homes has decreased dramatically, as many admitted insurance carriers incurred huge losses in this product line in the late 1990s, and decided to get out of the market altogether. Those carriers that decided to stay in the market changed their terms and conditions for liability coverage dramatically, taking on less risk at much higher prices.<sup>a</sup> Consequently, in some areas of the country, many nursing facility owners have been forced to operate without any professional liability insurance coverage whatsoever.

A major 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 in the policy arena.

This report presents a case study of the nursing home liability insurance market in Texas. The report is one of five case studies that was 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, Ohio, Florida, and Georgia. The purpose of the study is to inform federal and state policymakers, providers, insurers, and consumer groups about trends and issues concerning the nursing home liability insurance crisis. This report presents the case study on nursing home litigation and liability insurance issue in the state of Texas.

The case study draws largely upon a week long site visit conducted by the study contractor in March 2003. The case study offers a brief background on the Texas nursing home industry, nursing home quality, and litigation and liability insurance trends in Texas before discussing perspectives on these issues as they relate to the recent tort reform debate in the state. 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, state agencies, state legislators, and the Office of the Governor. In June 2003, three months after the site visit was conducted, the Texas state legislature enacted significant medical malpractice reform legislation (House Bill 4) which

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<sup>a</sup>. 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>]

encompassed the nursing home industry as well as other health care providers in the state. Numerous follow-up calls were made, and additional background materials collected, during the summer and fall of 2003 to augment the information obtained during the conduct of the site visit. In August 2005, the case study was updated with the most recent information available pertaining to the effects of the implementation of House Bill 4 and related legislation.

# **STATE ENVIRONMENT**

Texas and Florida have emerged as the two states where the nursing home liability insurance crisis has proven to be the most severe. One study estimated that Texas and Florida alone account for more nursing home litigation--in claims and in dollars--than all other states combined.<sup>1</sup> Although the liability insurance situation is relatively new to the nursing home industry, the implications of these trends are familiar to observers of medical malpractice debates over the last 30 years--rising liability insurance premiums, increased practice costs, and market pullouts by insurers and providers. Much remains unexplored about nursing home liability trends in Texas. While several reports have focused on the scale, dynamics, and policy responses to nursing home litigation in Florida, few have focused on Texas.<sup>2,3,4,5,6,7,8,9</sup>

## **Texas Nursing Home Industry**

The nursing home industry in Texas is distinctive in a number of characteristics that have affected recent trends in the liability insurance market in the state. First, for-profit companies and regional and national chains control a large share of the state's 1,134 nursing facilities. Texas ranks second in the country in percentage of nursing homes that are for-profit (81%). While the percentage of chain providers decreased from 74% in December 2001 to 62% in June 2005, the current figure is still well above the national average (52%).<sup>10</sup>

Second, nursing homes in the state are substantially overbuilt. Texas' 115,000 certified nursing home beds have the ninth lowest occupancy rate in the country (77%).<sup>11</sup> The state's 52 certified nursing home beds per 1,000 people age 65 or older is greater than the national average of 46. The bed supply appears even higher when considering people age 85 or older, the age group most likely to use nursing facility care. Texas ranks fifth in the nation in nursing home beds per 1,000 people age 85 or older (468), 35% above the national average (345).<sup>12</sup>

Third, both public and private reimbursement rates are among the lowest in the country. In 2002, Texas' Medicaid program paid an average of \$98 per day. This rate was 37<sup>th</sup> among 46 states that responded to a survey of Medicaid payment policies.<sup>13</sup> The 2003 average private pay rate in urban areas, \$103, ranked 49<sup>th</sup> among the 50 states and DC.<sup>14</sup>

Fourth, Texas nursing facilities have decreased their reliance on Medicaid in recent years. In December 2001, Medicaid was the primary payer for 73% of nursing facility residents, above the national average of 67%. As of June 2005, Medicaid is the primary payer for 67% of residents, close to the national average of 66%. This trend is only partly explained by an increase in Medicare billing, which was slightly higher than the national increase. Medicare is the primary payer for 12% of Texas nursing facility

residents, which is the same as the national average. In December 2001, Texas was slightly below the national average (9% versus 10%).<sup>15</sup>

Fifth, Texas has seen a greater than average increase in Medicare-certified beds. In December 2001, Texas was below the national average in the percentage of Medicare-certified beds (50% versus 60%). By June 2005, Texas had caught up to the national average, which increased after changes in Medicare reimbursement (82%). The percentage of Medicaid-certified beds remained constant during this time (82%, most of which are also Medicare-certified). Nationally, 91% of nursing facilities are Medicaid-certified. Only 6% of beds are not certified for either Medicare or Medicaid, which is slightly above the national average of 5%.<sup>16</sup>

## **Nursing Home Quality and Oversight in Texas**

Data from Medicare and Medicaid certification surveys indicate Texas has slightly fewer deficiencies than nursing facilities across the country. In 2004, surveys identified 8.4 deficiencies per Texas facility, compared to the national average, 9.2. 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). Texas also had a lower than average percentage of facilities with the most serious deficiencies (12%, compared to the national average of 15.5%).<sup>17</sup>

Survey data may understate quality problems, 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.<sup>18</sup> Although a more recent GAO report noted improvements, it identified continued nursing home oversight shortcomings in several states, including Texas.<sup>19</sup>

Texas is one of a few states where nursing home staffing has declined since 1998. Licensed nurse and certified nursing assistant staff per resident day dropped from 3.8 in 1998 to 3.5 in 2004. Texas is now in the bottom third among states in nursing home staffing.<sup>20</sup>

## **Nursing Home Litigation and Liability Insurance Trends in Texas**

Nursing homes in Texas have faced considerable financial pressures as a result of claims and lawsuits in recent years. Except for Florida, no other state has been hit as hard by professional liability costs as Texas.<sup>21,22</sup> Table 1 outlines some of the available data for Texas and, where possible, includes national comparisons. Generally, the data in Table 1 indicate that nursing homes in Texas are experiencing greater professional liability loss costs per bed and higher frequencies of liability claims compared to nursing homes elsewhere in the United States.



The available data indicate that the frequency of nursing home liability claims in Texas exceed those of any state except Florida. Two estimates, one based upon liability claims submitted by nursing home providers and one based upon a survey of plaintiff and defense attorneys, put claims frequency in Texas at 2-3 times the national average.<sup>23,24</sup> In addition, the severity of claims in Texas is estimated to be among the highest in the nation, with punitive damages and large jury awards playing an influential role in pushing average settlement amounts per claim into the \$300,000-\$500,000 range.<sup>25,26</sup> Two high profile jury verdicts in Texas in 2001 were returned at \$82 million and \$315 million. To put these estimates into context, one report, based on a survey of lawyers, estimates that the attorneys for these two cases handled claims worth approximately 15% of Texas' annual nursing home expenditures in 2001.<sup>27</sup> The combination of these trends has led to substantially increased liability insurance premiums for nursing home providers. One survey conducted by the Texas Association of Homes and Services for the Aging estimated that premiums had increased, on average, from \$328 per bed in 1998 to almost \$3,000 per bed in 2002.<sup>28</sup>

Spiraling loss costs and insurance premiums have affected the stability of the liability insurance market in Texas. Almost all "admitted" liability insurers (i.e., those which adhere to state insurance regulations) have left the Texas market, and many nursing homes in Texas have had difficulty obtaining coverage.<sup>29</sup> Many facilities have had to rely on surplus-line insurance companies or other insurance arrangements, which tend to be even more expensive. Surplus-line insurance companies do not adhere to state insurance regulations. A 2001 study estimated surplus-line premiums for nursing homes at about \$2,500-\$5,000 per bed.<sup>30</sup> Two surveys of nursing homes conducted by the Texas Department of Insurance (TDI) and the Texas Association of Homes and Services for the Aging in March 2003 and February 2002, respectively, both estimated that around half of all nursing homes in Texas had no liability insurance coverage whatsoever.<sup>31,32</sup>

## **Nursing Home Liability Insurance Market in Texas**

As in other malpractice debates, a flashpoint in Texas has been failures in the liability insurance market. Providers point to diminished coverage options and spiraling liability premiums as indisputable evidence of the need for reform. In March 2003, when the site visit was conducted, both for-profit and not-for-profit providers reported that liability premiums had jumped 1000% over the previous five years, and that these increased rates were for reduced coverage (e.g., higher deductibles and claims-based rather than occurrence-based coverage). TDI estimated that almost half of all nursing homes had no liability insurance whatsoever. Consumer advocates posited that some facilities may go without insurance simply to limit their attractiveness as lawsuit targets. Providers emphasized that soaring premiums for liability insurance made it impossible for them to purchase coverage and remain financially viable.

Providers stated that increasing liability insurance costs and exposure to liability claims made it difficult to provide quality resident care given constrained resources.

Although Texas had instituted an add-on to the Medicaid rate for facilities with insurance coverage, providers stated that it was an inadequate boost to an already insufficient Medicaid rate. Specifically, the add-on increased the Medicaid payment rate by only \$2.40/bed/day for facilities that maintained mandated levels of insurance coverage.

One physician who worked as a medical director in several facilities estimated that liability-related costs represented almost 10% of the Medicaid per-diem rate for patient care. In addition, she reported that physicians who work in nursing homes--either as medical directors or as attending physicians--are being forced to discontinue this work due to several factors: physicians and other health care professionals are increasingly being named in nursing home liability claims (i.e., in addition to the nursing home itself); physicians no longer have umbrella coverage under facility policies; and physicians face substantially increased premiums or the threat of being dropped by their professional liability carriers if they continue to practice in nursing homes.<sup>33</sup> Finally, several not-for-profit providers maintained that the rise in liability claims had impeded their ability to fulfill their charitable missions, since donors were hesitant to contribute assets that might be tapped to pay litigation claims.

Plaintiff attorneys and consumer advocates, on the other hand, questioned how dire things really were financially for Texas' nursing homes and whether increased claims activity alone had led to increase liability insurance premiums. As evidence, they pointed to a report produced by the Texas state affiliate of the AARP. The report used cost report data from 1997-1999 and concluded that Texas nursing homes had remained profitable over this time period,<sup>34</sup> although these years pre-dated the more recent surge in liability premiums.

Consumer advocates and plaintiff attorneys expressed the view that rising liability premiums were primarily driven by cyclical economic forces affecting the liability insurance market more generally, such as reduced investment returns (or losses) in the stock market. One advocate indicated that the rise in premiums started well before any large nursing home verdicts had been awarded in Texas and that premium increases in the nursing home market were affected by the rise in medical malpractice costs more generally.

Representatives from the TDI expressed a different opinion, claiming that large awards in recent nursing home cases and insurance carrier pull-outs in the liability reinsurance market had played a significant role in recent premium increases. While acknowledging the difficulty in determining all the reasons for the implosion in the insurance market, TDI staff felt that price increases and market exits by insurance carriers began before the economic downturn and that insurance companies had relatively low exposure to the stock market that made them less susceptible to market fluctuations. A recent review of the medical malpractice insurance crisis conducted by the National Association of Insurance Commissioners supports this view:

“Given the relatively small impact of investment income on the overall income of insurers, this study concludes that underwriting losses, not a declining stock market, were the

major factor influencing the rate increases experienced by physicians and other health care providers.”<sup>35</sup>

During the site visit, nursing home providers discussed how they had changed their operations in light of these insurance trends. For-profit and not-for-profit providers responded somewhat differently, perhaps in part because of different liability experiences.<sup>b</sup> When asked how litigation trends had impacted their business practices, for-profit providers emphasized changes in risk management practices specifically designed to reduce litigation risk. Not-for-profit providers were more focused on quality improvement practices. While acknowledging that litigation had pushed them to place increased attention on documentation practices, not-for-profit providers were insistent that they were primarily focused on maintaining the highest quality standards possible throughout the rise in litigation.

## Legal and Legislative Environment in Texas

In the years prior to the 2003 (78<sup>th</sup>) legislative session, Texas lawmakers had already taken several steps to address nursing home quality and liability insurance market issues. The 76<sup>th</sup> and 77<sup>th</sup> state legislatures took steps in 1997 and 1999, respectively, to strengthen nursing home oversight and enforcement, increase standards of care and residents’ rights, create a nursing home guide for consumers, and address the emerging liability insurance situation.

In particular, the Omnibus Nursing Home Legislation (Senate Bill 1839 or S.B. 1839), passed in 1999 by the 77<sup>th</sup> legislature, attempted to address the availability and cost of liability insurance by authorizing the state’s insurer of last resort, the Joint Underwriting Association (JUA) to write professional liability insurance policies for all nursing homes. This option was previously available only to non-profit nursing homes. At the same time, Senate Bill 1839 mandated that all nursing homes have professional liability coverage, effective September 2003. This statute, which was also the topic of considerable debate in the 78<sup>th</sup> legislative session, mandated coverage of \$1,000,000 per occurrence and \$3,000,000 in total coverage per year. Other insurance-related aspects of the bill directed the TDI to develop risk management “best practices” for nursing homes and to require all liability insurers--both admitted and non-admitted--to submit claims<sup>c</sup> and settlement data to the TDI.

S.B. 1839 addressed other legal and regulatory issues related to nursing home liability. The bill clarified and re-affirmed the admissibility of nursing home survey documents in civil trials. On the regulatory side, the bill created “quality assurance

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<sup>b</sup> Although for-profits and not-for-profits alike face the consequences of liability insurance market failures, larger for-profit facilities--anecdotally--have been the target of more litigation claims.

<sup>c</sup> It should be noted that there is some debate about the definition of a “claim.” As noted below, 4590i letters to medical providers are formal, written requests for information from plaintiff attorneys regarding care for particular individuals. Plaintiff attorneys posit that these letters are not “claims” but rather requests for information in advance of making a decision of whether or not to pursue a claim. Plaintiff attorneys argue that the TDI counts these letters as claims, thus overstating the litigation problem.

monitors” and “rapid response teams” to work in a consultative--rather than punitive--way to improve quality of care and to assist troubled facilities. The bill allocated 82 full-time employees to the program, diverting resources from state survey activities to do so. In addition, S.B. 1839 transferred the informal dispute resolution process from the Department of Human Services (the survey agency) to the Health and Human Services Commission to minimize the potential for bias.

Finally, S.B. 1839 contained provisions related to nursing home financing. In particular, responding to a coalition of provider and consumer groups who were supportive of a Medicaid rate increase tied to staffing and quality improvements, S.B. 1839 appropriated an additional \$175 million in general revenues for the 2002-2003 biennium. Importantly, \$135 million of this amount was designated for staffing enhancements. Increased reimbursement was available to participating nursing facility providers that improved direct-care staffing levels and/or their level of compensation. It is unclear what portion of these resources were actually distributed as most nursing homes reportedly participated in the staff enhancement program.

The 78<sup>th</sup> Texas legislative session was dominated by a debate on tort reform. In this section, we describe the underlying perspectives that drove the debate, detail the reforms themselves, and highlight the views of various stakeholders. These issues include the etiology of claim increases, the impacts on the liability insurance market, and insurance premium trends.

The first issue of debate concerned the origins and magnitude of the nursing home litigation problem. Both sides of the debate agreed that the rise in nursing home claims in Texas stretched back to the mid to late 1990s, and was at least partly related to reforms enacted in the state’s worker compensation system that limited recoveries and attorneys’ fees. Consequently, the plaintiff bar in Texas focused increased attention on the nursing home market as a potential area for litigation.

One of the more contentious questions in any malpractice debate is the extent to which claims are driven by legitimate instances of substandard quality or rather more simply by the economic interests of attorneys and other individuals involved. Almost inevitably, a lack of reliable data confounds the ability to answer the question with clarity, leaving both sides to construct competing arguments.

Plaintiffs’ attorneys and consumer advocates in Texas argue that endemic poor quality in some of the state’s nursing homes is the primary factor underlying the increase in litigation activity in Texas. In their view, inadequate staffing, poor facility management, and misaligned corporate priorities (“balance sheet abuse” as one advocate called it) produce poor care outcomes and the justified liability claims that follow. Rather than following a further decline in nursing home quality, plaintiff attorneys and advocates claimed that the rise in litigation activity tapped into negligent care practices that had existed for years but which have only recently drawn claimants and attorneys due to the increased potential for sizeable awards.

Along these lines, one advocacy group--Texas Advocates for Nursing Home Reform (TANHR)--produced a book entitled "Faces of Neglect" for distribution to state legislators during the reform debate. The book contained stories and pictures of plaintiffs in claims against Texas nursing homes. Advocates view nursing home litigation (and the threat of it) as a tool to promote positive change for quality improvement. Toward this end, TANHR actively encourages families whose loved ones have experienced abuse and/or neglect in nursing homes to come forward, and refers these families to recommended attorneys with expertise in nursing home litigation.

The nursing home industry and defense attorneys had a decidedly different view of the factors which underlay the rise in nursing home litigation. They expressed the view that plaintiff attorneys are primarily motivated by the opportunity to "make an easy killing" against the nursing home industry that has been made an easy target for resident outcomes that, in many cases, are not within their ability to control. Many providers stated that family members had unrealistic expectations about the aging (and dying) process, and wanted to hold nursing homes accountable for outcomes, that were, in many cases, unavoidable. While acknowledging that there are indeed real cases of abuse and neglect within the industry that warrant litigation and compensation to injured parties, many providers expressed the belief that the size and frequency of liability awards is considerably out of proportion to the adverse outcomes caused by negligent care practices.

The "legitimacy" of professional liability claims against nursing homes for negligent and/or substandard care is a difficult question to evaluate without thorough and in-depth reviews of actual cases. Even then, there may be disagreement regarding the culpability of providers for incidents which lead to filing of a claim or lawsuit, be it a fall, excessive weight loss, or pressure ulcers. One figure cited by both sides in Texas to debate this question is the low proportion (10-15%) of "4590i letters" that go on to become actual claims. 4590i letters refer to a statute in the Medical Liability and Insurance Improvement Act of Texas which requires that individuals send a written letter notifying healthcare providers of a potential claim before filing a lawsuit. Providers and their insurers have 60 days to investigate and respond to these letters, after which point the injured party can decide whether or not to pursue the claim. While providers assert the low proportion of these letters that actually move forward is indicative of attorneys conducting "fishing expeditions," plaintiff attorneys assert that it reflects an effective system for filtering out the more legitimate claims without tying up the courts.

The 78<sup>th</sup> legislative session in Texas was dominated by debate on House Bill 4 (H.B. 4), a comprehensive tort reform bill covering claims against health care providers, manufacturers, and retailers. Supported by the House and Senate leadership, and by the Governor, H.B. 4 proposed sweeping changes in Texas' tort system, which could radically change the nursing home litigation environment in the state. Although the legislation was fiercely debated throughout the legislative session, H.B. 4 eventually won approval in June 2003 by significant voting margins of 110-34 and 28-3 in the House and Senate, respectively.

Caps on damages in medical malpractice cases existed in Texas even before H.B. 4 was passed. Texas Civil Statute 4590i included caps on non-economic damages of \$500,000 in 1977 dollars, indexed to inflation (around \$1.4 million in 2003 dollars). In addition, Chapter 41 of the Texas Civil Practices and Remedies Code limited punitive damages in cases arising after September 1, 1995 to two times economic damages plus an amount equal to non-economic damages, not to exceed \$750,000. Thus, in arguing against caps within H.B. 4, plaintiff attorneys were quick to point out that Texas already had caps in place and questioned whether more severe caps would have any marginal impact on the liability insurance situation.<sup>36</sup> However, the pre-existing statutes contained loopholes. Although the caps on non-economic damages contained in 4590i were intended to apply to all medical malpractice cases, they were held in 1988 to be constitutional only in wrongful death and survival action cases. In addition, punitive damages caps did not apply to certain felonies (e.g., fraud, malice, or a willful act, omission, or gross neglect) or to injuries of children, the elderly, or the disabled. The latter exemption essentially left awards for non-economic damages in nursing home cases uncapped.

H.B. 4 set a \$250,000 hard cap on non-economic damages in lawsuits against physicians and individual health care institutions and a \$500,000 cumulative cap if claims extended across multiple providers.<sup>d</sup> Another clause restricted the ability of multiple parties (e.g., different family members) to claim damages related to the injury or death of a single individual. In addition, for wrongful death and survival actions, H.B. 4 limited *all* damages, including non-economic and exemplary damages, to \$500,000, regardless of the number of defendants or the number of separate causes of action on which the claim is based.<sup>e</sup> The combination of the changes outlined above ensures that the cap on damages is a *hard cap*; in other words, filing multiple claims against multiple defendants or under multiple causes of action cannot circumvent the newly imposed limits. In addition to the caps outlined above, H.B. 4 extends punitive damages caps to encompass nursing home cases,<sup>f</sup> and requires unanimous jury verdicts to award punitive damages.

H.B. 4 was signed into law by the Governor on June 11, 2003, and went into effect in September 2003. Accompanying the passage of H.B. 4 was House Joint Resolution 3, a resolution proposing a constitutional amendment that allowed the legislature, by statute, to establish liability limits for non-economic damages and losses in health and other liability claims. The proposed amendment--known as Proposition 12--was put to voters on September 13, 2003 in an effort to circumvent potential court challenges to the constitutionality of the law. The resolution passed by a close 51-49 percent margin.

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<sup>d</sup>. For more detail of the provisions of H.B. 4 that impact the nursing home liability situation, see the "Texas Association of Homes and Services for the Aging 78th Legislature Wrap-up" compiled by David Thomason of TAHSa and "Key Provisions of House Bill 4" on the Texas Medical Association website ([http://www.texmed.org/liability/hb4\\_78leg.asp](http://www.texmed.org/liability/hb4_78leg.asp)).

<sup>e</sup>. The cap for wrongful death cases is in 1977 dollars. Indexed to inflation, it is now approximately \$1.4 million.

<sup>f</sup>. Injuries to children, the elderly, and the disabled were previously exempt from punitive damages caps, but H.B. 4 amended this statute to include under the caps injuries to these individuals that "occurred while providing health care as defined by [the law]."

While the reform debate in Texas centered on damage caps, several other measures relevant to nursing home quality and litigation were also deliberated in the 78<sup>th</sup> legislative session. These included whether to delay or repeal the liability insurance requirement that had been passed in the 77<sup>th</sup> legislature (which required nursing homes to obtain liability coverage no later than September 2003), whether to allow state survey findings to be admitted as evidence in nursing home liability cases, and whether to deem Medicaid-only nursing homes certified through Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation. On each of these measures, the legislature enacted legislation aimed at achieving a more fair and efficient system.<sup>9</sup>

As noted previously, provisions in S.B. 1839, enacted in 2001, required that all Texas nursing homes carry professional liability insurance in the amount of \$1,000,000 per occurrence and \$3,000,000 total per year. Coverage could be provided by the JUA, admitted carriers, or surplus-lines carriers. Notably, self-insurance and off-shore captive arrangements did not meet the requirements outlined in the legislation. Providers argued that S.B. 1839 was too restrictive (e.g., not allowing self-insurance) and that--given the current condition of the liability insurance market--it was unrealistic to expect nursing homes to be able to purchase insurance with specified amounts of coverage. Lawmakers agreed and delayed the mandated insurance requirements to September 1, 2005. Minimum levels of insurance were maintained at previous levels, but self-insurance and off-shore captive arrangements were also made acceptable forms of insurance coverage.

One key barrier reported by providers in complying with the requirements was the JUA's inability to make coverage available *and* affordable. According to providers, the JUA addressed the availability part of the equation but did little to deal with the question of affordability. The JUA priced its own policies on a tiered-basis according to a nursing home's previous claims experience and its performance on various quality indicators. Rate tiers were assigned based on CMS-reported quality information and self-reported claims information. According to the TDI, most of the small number of homes that had participated in the JUA insurance pool (45 homes--mostly non-profit facilities participated at the time of the interview) had been in the lowest (i.e., cheapest) tiers. It remains to be seen whether the JUA can provide insurance coverage for a broader range of facilities in the future.

Another issue that had been debated in previous sessions of the state legislature concerned the state's performance in regulating nursing home quality. While consumer advocates agreed that nursing home oversight and enforcement had improved considerably over the last few decades, they also maintained that weaknesses in the state's regulatory system continued to persist. In addition, advocates expressed concern that the Department of Human Services, the state's survey agency, was becoming too consultative and not sufficiently aggressive in its regulatory approach.

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<sup>9</sup> Another bill, S.B. 313, moved to protect the endowments of not-for-profit nursing homes from legal judgment.

Providers, on the other hand, supported the Department of Human Services leadership for adopting a more consultative rather than punitive approach. The previous legislature had replaced 82 state surveyors with “quality monitors” who were directed to work with nursing homes in a consultative manner to improve the quality of care. Although providers were supportive of this change in regulatory oversight, others, including state agency staff, cautioned that it was too early to evaluate its effectiveness.

The legislature proposed another change to the state’s regulatory approach in the 78<sup>th</sup> session. Lawmakers introduced legislation (H.B. 2292) to use JCAHO rather than state certification for Medicaid-only nursing homes (around 15% of Texas nursing homes are Medicaid-only certified).<sup>h</sup> Supporters of the change touted its potential to reduce nursing homes’ regulatory burden and focus attention on care processes rather than “paper compliance.” Those opposed to the legislation characterized it as an effort to “privatize” the nursing home survey process and said it would weaken resident protections.<sup>i</sup> H.B. 2292 was enacted, authorizing the state to apply for a Medicaid waiver to allow Medicaid-only nursing homes to obtain deemed status through JCAHO.

The JCAHO accreditation plan raised another ongoing issue. Consumer advocates expressed concern that plaintiff attorneys would not be able to subpoena JCAHO survey results because of the confidentiality of this private exchange. This question parallels the larger debate about whether state survey findings should be admissible in litigation cases. Plaintiff attorneys and advocates argued that survey information is critical evidence in nursing home litigation cases. In particular, they argued that including inspection records in the discovery process can establish whether there is a pattern of provider behavior that is key to assessing whether punitive damages are appropriate. In arguing against the admissibility of survey evidence, providers and defense attorneys raised several key objections, including that survey results are often irrelevant to the case at hand, that juries do not know how to interpret survey findings, and that inspection results are often known to be wrong. Providers were particularly vigorous in asserting the potential inaccuracy of survey results, claiming that a high percentage of disputed deficiencies are ultimately overturned. In the end, the 78<sup>th</sup> legislature voted to restrict the use of inspection reports in nursing home litigation. H.B. 4 limits the admission of survey evidence<sup>j</sup> to instances where these reports include the particular legal incident or individual in question or instances that are substantially similar to the legal incident and within one year of the alleged incident.

Two years after the passage of H.B. 4 and Proposition 12, the nursing home liability insurance market is definitely stabilizing. According to the most recent analysis

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<sup>h</sup>. The legislation may not apply to nursing homes that accept Medicare payments because of federal law; the state would have to get a Medicaid waiver from the Centers for Medicare and Medicaid Services to institute the proposed changes as a pilot program. The state would maintain its enforcement functions over these homes.

<sup>i</sup>. JCAHO generally focuses more on structure and care processes, while the federal/state survey processes have strived to focus more on resident quality of life and care since Omnibus Budget Reconciliation Act of 1987. For more detail, see U.S. Health Care Financing Administration, Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System (Baltimore, MD: HCFA, 1998).

<sup>j</sup>. Including violations of conditions of participation (i.e., deficiencies), monetary fines, and other sanctions.



conducted by Aon Risk Consultants in March 2005,<sup>37</sup> the long-term care environment in Texas has shown marked improvement. Examining data from a sample representing 19% of the total licensed beds in the state, the report found that the average loss costs per occupied bed had declined to \$3,390 in 2004, down from a 2002 peak of \$6,720 and a drop from \$4,260 in 2003.<sup>38</sup> Aon data also showed that claim frequency has declined steadily, starting in 2001. The authors of the report conclude that tort reform in Texas largely explains the improvements in the liability insurance market, stating that the combination of H.B. 4 and Proposition 12 “appear to be having the greatest impact of any reforms among the states reviewed in this study on reducing general and professional liability claim costs.”<sup>39</sup>

While the nursing home liability insurance market in Texas has definitely stabilized, Texas providers still face higher than average costs for professional liability insurance. When measured as a percentage of the Medicaid reimbursement rate, loss costs for Texas’ long-term care facilities still exceed the national average. Nationally, providers’ loss costs average around 5% of the Medicaid rate, while in Texas the figure is closer to 9%. While loss costs are trending down in Texas, the state still has the 6<sup>th</sup> highest average loss costs in the nation. Meanwhile, average claim severity has not declined, remaining in the \$175,000 to \$250,000 range since the late 1990s, according to Aon.<sup>40</sup> Tort reform advocates in Texas have pointed out that while the 2003 measures represent significant improvements, further reforms are necessary to ensure the security of the industry in the future.

## **SUMMARY**

The nursing home liability insurance situation in Texas played out in an environment of a much larger liability crisis in the state, cutting across the entire health care industry, as well as other business markets. The policy response of the 78<sup>th</sup> Texas legislature was to enact significant tort reforms that placed hard caps on non-economic damages and punitive awards for all health care providers. The enactment of H.B. 4 in June 2003, and the subsequent approval of Proposition 12 by Texas voters in September 2003, is viewed as a test case by other states and by the nursing home industry regarding whether substantial tort reforms can have a positive effect on stabilizing the liability insurance market. Industry observers generally agree that among the various tort reform initiatives enacted by states, the tort reform measures enacted under H.B. 4 have the greatest chance of reducing the frequency and severity of nursing home liability claims. The preliminary evidence two years after the enactment of H.B. 4 is that the legislation has indeed reduced average loss costs significantly for nursing home providers. However, whether commercial insurance carriers are willing to re-enter the Texas nursing home market, and offer liability insurance coverage at rates that nursing home providers can afford, remains to be seen.

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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

<b>TABLE 1: Texas Nursing Home Liability Estimates vs. U.S. (National Average) Based on Various Data Sources</b>						
Year	Mean Loss *Cost per Occupied Bed (TX)	Mean Loss Cost per Occupied Bed (US)	Mean Claims per 1,000 Occupied Beds (TX)	Mean Claims per 1,000 Occupied Beds (US)	Mean Severity per Claim (TX)	Mean Severity per Claim (US)
1997	\$259 (1) \$809 (2) \$3,530 (3)	\$1,210 (3)	14 (3)	7.8 (3)	\$255,000 (3)	\$156,000 (3)
1998	\$1,511 (1) \$1,562 (2) \$3,970 (3)	\$1,630 (3)	15 (3)	9.1 (3)	\$275,000 (3)	\$179,000 (3)
1999	\$2,165 (1) \$2,476 (2) \$3,860 (3)	\$1,820 (3)	18 (3)	10.9 (3)	\$225,000 (3)	\$167,000 (3)
2000	\$2,727 (2) \$3,920 (3) \$250 (5)	\$2,100 (3) \$209 (5)	18 (3) 0.7 (5)	11.5 (3) 1.5 (5)	\$230,000 (3) \$380,000 (5)	\$182,000 (3) \$139,000 (5)
2001	\$4,870 (3)	\$2,340 (3)	23 (3) 32 (4)	12.8 (3) 9.2 (4)	\$225,000 (3) \$552,000 (4)	\$182,000 (3) \$406,000 (4)
2002	\$6,310 (3)	\$2,880 (3)	27.5 (3)	14.5 (3)	\$240,000 (3)	\$198,000 (3)
2003	\$4,260 (6)	\$2,270 (6)	22 (6)	12.6 (6)	\$200,000 (6)	\$180,000 (6)
2004	\$3,390 (6)	\$2,310 (6)	20 (6)	13.1 (6)	\$175,000 (6)	\$176,000 (6)

**DATA SOURCES:** (1) Texas Department of Insurance (TDI) survey; (2) TDI closed-claims analysis; (3) Aon Risk Consultants 2003; (4) Stevenson and Studdert; (5) Insurance Services Office (ISO); and (6) Aon Risk Consultants 2005. Each of these data sources has distinct limitations and should be interpreted and/or compared with caution. Some estimates from Aon and ISO studies are approximations based on charts presented in their data. ISO estimates are three year averages for 1998-2000. The bottom line is that there is a paucity of reliable, state- and national-level data on this issue.

- (1) TDI conducted two recent studies of nursing home liability trends in Texas. The first is based on a 1999 survey of nursing homes. These data are limited in the fact that they are based on self-report of the survey respondents.
- (2) The second TDI study is based on an analysis of closed-claims. Although much more reliable, claims can take a number of years to close, potentially yielding estimates that are not as timely as possible.
- (3) Aon Risk Consultants, Inc. conducted analyses for the American Health Care Association (AHCA), the national for-profit nursing home association. These estimates are based on a non-representative sample of nursing facilities that is heavily weighted to for-profit, chain facilities, potentially affecting their validity. It is also difficult to determine how some indicators in the report are calculated. For instance, frequency is calculated as "the number of claims *projected* for the given time period divided by the number of occupied beds during that same time period." [emphasis added] The report can be found on the AHCA website at [http://www.ahca.org/brief/aon\\_ltcanalysis2003.pdf](http://www.ahca.org/brief/aon_ltcanalysis2003.pdf).
- (4) Estimates of frequency, severity, and scale for Texas are also included in a recent article by Stevenson and Studdert. These results are based on a national survey of attorneys and potentially subject to biases as well (e.g., recall bias and non-respondent bias).
- (5) A final study conducted by the Insurance Services Office includes estimates for Texas (and other states). ISO estimates are based on data from admitted carriers and, thus, exclude facilities that self-insure or use non-admitted carriers. In addition, Texas estimates are based on only 4.8% of the state's nursing home beds. Both of these factors raise questions about how generalizable these data are to other nursing homes.
- (6) See note (3) above for limitations. The 2005 Aon report can be found on the AHCA website at [http://www.ahca.org/brief/aon\\_ltcanalysis2005.pdf](http://www.ahca.org/brief/aon_ltcanalysis2005.pdf).

# **NURSING HOME LIABILITY INSURANCE MARKET**

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***Recent Trends in the Nursing Home Liability Insurance Market*** (Main Report)

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HTML: <http://aspe.hhs.gov/daltcp/reports/2006/NHliab-CA.htm>

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