

TORT

WHILE FEDERAL TORT REFORM EFFORTS PERSIST, STATES ARE EXPERIMENTING WITH A VARIETY OF MEASURES TO KEEP AWARDS FOR NONECONOMIC DAMAGES DOWN.

LISA GELHAUS

STATES SERVE AS LABORATORIES FOR CHANGE

Tort reform is a major legislative priority for the Bush administration. The president campaigned on the issue, he threw down the gauntlet in his State of the Union address, and he's followed up that speech with a national public relations tour to drive home what he believes is the key problem with the nation's medical liability system: Namely, the high cost of professional liability insurance—inflated by out-of-control jury awards in medical malpractice cases—is driving physicians and other medical specialists out of business.

Federal Action To Date

The president's answer is a plan to pass legislation that would cap noneconomic damages at \$250,000, except in specific instances; institute a two- to three-year statute of limitations for filing malpractice claims; limit punitive damages; and allow payment of jury awards to be made over several years. In addition, Bush would like to see a prohibition on joint liability claims that would stop plaintiffs from stacking damages against defendants. The proposal would make parties found liable of a civil claim to be responsible for paying only that portion associated with their degree of fault, and it would reduce the incentive for attorneys to seek deep pockets, accord-

ing to PriceWaterhouse-Coopers' Health Research Institute.

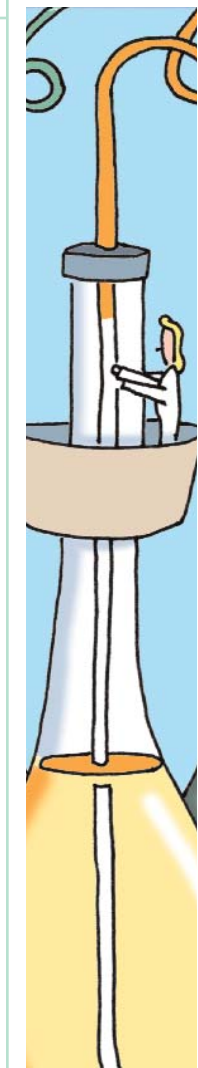
Tort reform on the federal level, however, still is focused on Congress, which is yet to conceive of an actionable bill. While the House passed limits on lawsuits last session—and similar proposals at least seven times in the past 10 years, according to *The New York Times*—tort reform legislation is yet to clear the Senate.

This current session, Republican leadership in the Senate has vowed to push for medical malpractice reform, but observers say the president lacks the requisite votes to obtain passage. However, the tide may be turning since the 2004 elections increased the Republican party's voting majority from 51-49 to 55-45 (including independent James Jeffords of Vermont, who votes with the Democratic caucus). Republicans are typically more supportive of tort reform.

Tort reform advocates already have achieved one victory at the federal level. Bush recently signed the Class Action Fairness Act, a tort reform measure that moved class action suits from state courts into federal courts. Any tort reform breakthrough on the federal level should be viewed as significant.

States Take The Initiative

While providers wait for a federal medical reform bill that would reduce the number of lawsuits and awards, state legislatures across the nation are considering hundreds of tort reform measures. Typically at issue are noneconomic damages such as pain and suffering and emotional distress,



not actual damages such as medical expenses, which none of the recent efforts seek to limit. Many states have already enacted provisions of Bush's medical malpractice reform proposal. And it's been reported that the president's proposed cap is based on a California statute. As former Supreme Court Justice Louis Brandeis wrote: "States are the laboratories of democracy."

State tort reform efforts are moving apace, arguably producing the best methods for reducing the number of lawsuits and the damage that large jury awards for noneconomic damages inflict, according to some advocates. What works in one state may not work in another because each state has its own mix of laws.

"There are three basic types of tort reform efforts," says Norman Estes, president and chief executive

officer of NHS Management, which operates nursing facilities in Alabama, Arkansas, Florida, and Missouri. One approach is to tackle the nursing facility professional liability issue separately, as was the case in Florida, where nursing-facility-only legislation was introduced and passed. A second approach occurs in states where nursing homes are considered medical providers much like doctors and hospitals, Estes says. The third approach is broader still, where providers join the larger business community for mutually beneficial reform.

Adversaries Square Off

In general, plaintiffs file suits against long term care providers under one of four major categories: resident rights, medical malpractice, consumer laws, or (wrongful) death statutes.

"The most common trend among all the reform efforts," says Priscilla Shoemaker, general counsel for the American Health Care Association (AHCA), "is to get a reduction in damages, mostly punitive damages."

Tort reform is the subject of heated political debate between traditional adversaries: business interests versus trial lawyers.

Trial lawyers have a long history of opposing caps on damages, limiting attorney fees, or making it more difficult to file a lawsuit. The trial lawyer lobby has deep pockets, with resources accrued from victories in the famous asbestos, tobacco, and lead paint class action lawsuits.

Until the 2004 election, trial lawyers had effectively staved off any change in the right to trial by jury by backing Democratic candidates, who traditionally oppose Bush-style tort reform.

But states again may have already set political precedent. The Texans for Lawsuit Reform have proven formidable opponents and were successful in passing a constitutional tort reform over the lobbying efforts of the Texas Trial Lawyers Association, Mothers Against Drunk Driving, and the state's AARP chapter.

While long term care operators' fight for reform may not have garnered the publicity of campaigns conducted by the American Medical Association, the U.S. Chamber of Commerce, and the National Association of Manufacturers, long term care is effectively lobbying on the state level, sometimes for long-term-care-specific reforms, sometimes coalescing with the larger medical community, and sometimes in the general business arena.

What's At Stake

The problem for long term care operators is similar to that faced by doctors—sky-high professional liability insurance is either forcing them out of business or to self-insure or go bare (without insurance or only minimal coverage). While caps are critical to

providing predictability for insurers, a cap itself does not solve the insurance problem, providers say.

Caps on noneconomic and punitive damages can control the dollars awarded by a jury, but the laws that grant greater latitude on the admissibility of survey and inspection evidence are also a factor. Laws that call for creating medical review boards to certify that lawsuits have a legitimate claim before trial begins would help reduce the number of lawsuits, as would the admission of arbitration agreements, experts say.

So states might need a package of

tort reforms to register a reduction in insurance premiums.

Adding to the complexity of obtaining reforms is the fact that plaintiff attorneys continue to challenge reforms through the state courts and are finding success in overturning reform laws.

In some instances, the court opinions gut the very protections providers had sought and achieved legislatively. Other state courts uphold and strengthen reforms that are beneficial to providers.

Effective tort reform organizations say that to achieve success it is critical

to raise money for political action committees, which can be used for media advertising and direct mail campaigns, but that it's also important to use contributions to support candidates running for various state offices to carry the message of tort reform to them.

Although tort reform involves a variety of complex legal and political strategies, providers believe staying involved is critical to providing quality care. Examples of what some states have done to initiate tort reform begin below.

Story continued on page 27

The Georgia Experience

Georgia is the most recent state to pass a tort reform package. Gov. Sonny Perdue (R) has signed a comprehensive medical liability bill that includes a \$350,000 cap on noneconomic damages, a \$250,000 cap on punitive damages unless the plaintiff can show specific intent to harm, and a mandatory medical review panel for all health claims. It also allows for the inclusion of arbitration agreements in admission contracts and eliminates the private right of action for resident rights violations. The law also tightens the venue rules in lawsuits (where the suit can be tried) and requires the plaintiff's attorneys to obtain a medical authorization form from the plaintiff

prior to filing a lawsuit. In addition, the law tightens the rules regarding the admission of expert testimony as to the plaintiff's condition and eliminates joint and several liability (in which each liable party is responsible for all damages awarded) in all cases. In case one or more sections of the bill are ruled unconstitutional, the law contains a severability clause to protect other provisions of the statute from being ruled out as well.

"The most important aspect of the bill was the \$350,000 cap," says Fred Watson, president of the Georgia Nursing Home Association. "We have been working two to three years on getting that passed."

Watson said electing a Republican-dominated House and Senate was key to victory. It is the first time in 130 years that the Georgia legislature is controlled by Republicans. Tort reform advocates supported legislative candidates who backed their plan and were able to defeat those candidates who opposed it. The law is effective immediately and is expected to ease the liability crisis.

"We were so close to Florida, we saw an increase in the number of lawsuits," says Watson. "Our liability went from \$250 per bed to \$2,000 per bed in two-and-a-half years. There are only one or two [insurance] carriers left in the state."

Texas' Proposition 12

Texas has been among the states hardest hit by excessive jury awards in malpractice cases. But that may not be the case for long, since voters recently approved a constitutional amendment that gives the state legislature the ability to cap noneconomic damage awards in lawsuits filed against health care providers.

Nursing facility loss costs were at

\$5,500 per bed in 2003, according to a 2004 report on liability costs by AON Risk Consultants, Columbia, Md.

Voters approved the new law, dubbed Proposition 12, one of 22 constitutional amendments on the Texas ballot. The state's largest nonprofit medical liability insurer, Texas Medical Liability Trust, lowered its rates by 12 percent as a result. Others are also

reducing their premiums, while some that had pulled out of the state are considering a return to Texas.

But other insurance companies have been slower to reduce rates, and still others are tentative about returning to the market.

"Texas professional liability insurance rates have experienced a slow trend down," says Gavin Gadberry, ►

an attorney with Amarillo, Texas-based Underwood, Wilson, Berry, Stein & Johnson and a lobbyist for the Texas Health Care Association. “Based on my conversations with insurance companies, insurers are cautious about coming into this market. But since the effective date of the legislation, lawsuits have slowed to a trickle.”

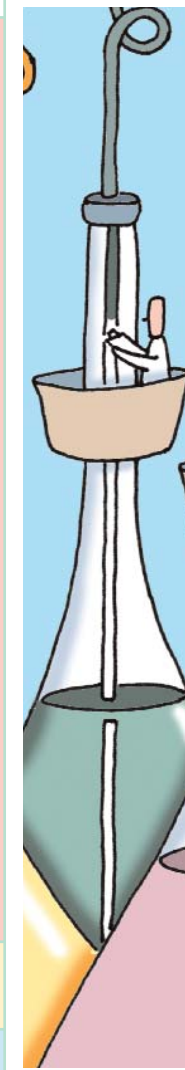
The Terms Of The Law

Proposition 12 included a \$750,000 per case cap on noneconomic claims for medical malpractice (not including loss of income or medical expenses). Under this cap, a plaintiff can collect a maximum of \$250,000 from a physician and an additional \$500,000 from one or more health care providers, such as long term care operators, for pain and suffering, disfigurement, or other compensation. Awards for the loss of income and medical expenses are not capped. The \$750,000 cap cannot be appealed in the courts.

Attaching the reform to the state’s constitution prevents challenges by plaintiffs’ attorneys questioning the constitutionality of the law. In Ohio, where reforms were passed by statute only, trial lawyers appealed caps to the state Supreme Court and had them successfully overturned on constitutional grounds.

But the real impact of the new Texas law won’t be felt for several years.

“Most tort reforms take two to three years to have an impact,” says Theresa Bourdon, AON Risk Consultants’ managing director, actuary, and co-author of “Long Term Care General Liability and Professional Liability 2005 Actuarial Analysis.” She is



reviewing preliminary data at press time. “Texas reforms are most likely to have the greatest impact in reducing the number of claims and the size of claims,” Bourdon says, adding, however, that there will likely be a jump in claim activity immediately prior to implementation of the reform, when the caps are not in force. “Texas usually has higher jury awards to patients and families than in other parts of the country, so a cap is going to have more impact.”

Another added benefit, she says, is that Texas also “wrote language so you can’t stack multiple damages against a nursing home, only a one-time \$250,000 cap for institutions.”

Florida As Ground Breaker

Long term care facilities in Florida had been particularly vulnerable because of the state’s residents’ bill of rights statute, which established 22 basic standards facilities had to meet, including residents’ “right to receive adequate and appropriate health care and protective and supportive services.” Plaintiffs and surviving family members could sue for compensatory and punitive damages for violation of the standards and collect attorneys’ fees if they won.

By 2000, national nursing facility companies had started pulling out of Florida. That year, the costs of insurance caused Milwaukee-based Extencare Health Services to stop operation of 28 Florida facilities, and Murfreesboro, Tenn.-based National HealthCare Corp. pulled 12. In 2001, Fort Smith, Ark.-based BEI (formerly Beverly Enterprises) stopped operating

49 Florida facilities. During this time frame, skilled nursing facilities (SNFs) were also suffering from steep Medicare reimbursement reductions, and in 2000, one in five nursing facilities were operating under Chapter 11 bankruptcy.

Assisted living facilities were also caught in the crosshairs because under Florida statutes they were required to have insurance, and the state’s oversight agency at one point threatened to close down any that didn’t.

In 2001, Florida’s legislature passed a nursing-facility-specific medical liability law that dealt with tort reform, insurance availability, and quality of care. SB 1202 capped punitive damages at three times the amount of compensatory damages, or \$1 million, whichever was higher. This provision also allowed plaintiffs to obtain punitive damages if they had “clear and

convincing” proof that a member of the nursing staff had a conscious disregard for the patient’s life, health, or safety.

In cases where a plaintiff proved that financial gain rather than patient care motivated nursing facility care, the plaintiff was entitled to four times the amount of compensatory damages, or \$4 million dollars, whichever was greater. All caps were off on punitive damages when a plaintiff proved the nursing facility intentionally harmed the patient. The law also required lawsuits against nursing facilities to be filed within two years of the time the incident was discovered.

The bill also required an increase in staffing and a series of strengthened regulatory enforcement and quality oversight requirements. In addition, it authorized a state-backed loan to create a state-based captive insurance ➤

plan and set up a committee to examine the progress of the bill.

Three years after passage, however, most providers in Florida are without affordable or available insurance.

“There has been no significant lawsuit decrease since 2001,” says Ed Towey, spokesman for the Florida Health Care Association (FHCA). “Nursing homes still can only get high-cost, low-coverage insurance; they are forced to insure on the open market.”

“I still can’t get commercial insurance in Florida,” says Norman Estes, president and chief executive officer of NHS Management. In 1999, Estes purchased his first Florida facility and was able to obtain “affordable” insurance. By the next year, 2000, he couldn’t, he says.

The Insurance Situation Today

A series of hearings held between December 2003 and March 2004 by the Florida Joint Select Committee on Nursing Homes revealed the legislation had not helped in the availability or affordability of insurance. The state’s Office of Insurance Regulations reported that only six insurance carriers were offering professional liability insurance to SNFs, compared with the 21 that once offered policies.

Filling the void were captive insurers that represented a single entity or group of finite policies. In 2002, the state set aside a \$6 million loan to establish the Long Term Care Risk Retention Group (RRG). As of Jan. 15, 2004, the RRG had 182 policies that covered two SNFs, four continuing

care retirement communities, and 176 assisted living facilities.

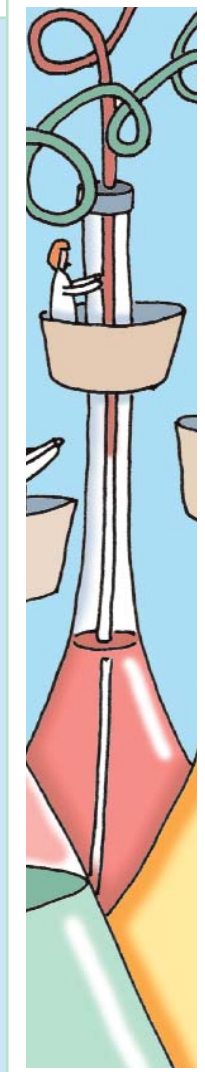
The finite policies often require SNFs to buy a \$25,000 to \$50,000 policy to comply with a new state law. But, for example, the SNF may have to pay \$32,000 for a \$25,000 policy. In addition, despite improvements in quality of care, the number of suits filed has not been reduced significantly.

FHCA testified before the Joint Select Committee that SB 1202 does not address the profession’s particular vulnerability to lawsuits because it cares for a population in the final stages of their lives, leaving SNFs open to extreme awards rendered by jurors who have been swayed by often heart-wrenching emotional arguments.

Recently, however, Florida has amended its state constitution via the general election.

In its November elections, Florida residents approved three constitutional amendments regarding medical malpractice, including a cap on attorney fees.

One amendment gives plaintiffs in medical malpractice lawsuits the ability to retain 70 percent of the first \$250,000 in damages awarded and 90 percent of damages awarded in excess of that amount, which essentially



places a cap on the amount of money the plaintiff’s attorney recovers.

It is too early to measure the impact of the reforms.

In response to the insurance crisis, many operators have tried to protect themselves by restructuring their corporations into limited liability organizations. However, a Florida Court of Appeals in Lakeland recently ruled that the owner of a facility could be held personally liable for injuries to a resident. Such rulings could leave long term care facilities vulnerable to large damage awards.

However, the Florida Supreme Court issued its own tort reform in a recent opinion in which it eliminated the right of some survivors of deceased nursing facility patients to recover damages for alleged abuse and neglect under the state’s residents’ bill of rights.

The court’s judgment in the case could impact an estimated 600 to 1,500 lawsuits in Florida filed before May 15, 2001, says Scott Mager, the Ft. Lauderdale attorney involved in the litigation.

He told *Law.com* that the decision could eliminate 20 to 50 percent of the estimated 3,000 nursing facility abuse and neglect cases that were in existence in 2001 and therefore entice insurers back into the state.

Reform Comes To California

The California Supreme Court in March 2004 delivered a devastating blow to the long term care profession by issuing a decision that overrode the protection of the long-standing Medical Injury Compensation Reform

Act (MICRA). The statute is perceived to be the “gold standard” of tort reform and is reportedly the basis for President Bush’s use of a cap in his medical liability proposal.

“California’s MICRA statute is often

held out as a paradigm to keep health insurance premiums low, but case law has developed to a point where we don’t have protection anymore,” says Mark Reagan, an attorney with the San Francisco office of Hooper, Lundy ➤

& Bookman, which represents the California Association of Health Facilities. “We’ve had a complete erosion of MICRA protection. There is no limitation on damages.”

In the case, the California Supreme Court said that plaintiffs who sue long term care providers under the elder abuse and neglect statute don’t need to comply with the MICRA-based judicial prescreening requirement when seeking awards of punitive damages.

“Trial attorneys have made an end run around MICRA through the posi-

tioning of abuse and neglect cases,” Reagan says. “There needs to be an extension of MICRA to include long term care, particularly where you have claims of abuse and neglect.” Trial lawyers have made this issue “their hill to die on,” he adds.

MICRA was intended to protect health care providers from excessive liability insurance costs, says Mark Johnson, an attorney with Hooper, Lundy & Bookman in San Diego. “It is likely that the result will only serve to produce more litigation against

all types of health care providers.”

“Lawyers who represent consumers have an ethical responsibility to zealously represent their clients, and they are going to find legally creative ways to do that,” says Reagan, but trial attorney influence reaches beyond the actual courtroom. Their opposition against caps, combined with a Democratic legislature, makes the chances of passing a tort reform bill that benefits long term care very slim.

“There’s more hope on the national level,” says Reagan.

Continued from page 21

Fighting against the trial lawyers could evoke images of a long-lasting game of “Whack-a-Mole.” If reform advocates close down one cause of action or venue, trial attorneys will just move to another cause, judge, court, or even state, experts say.

In 2004, after Mississippi Gov. Haley Barbour called for a special legislative session, it implemented a \$500,000 cap for pain and suffering under medical malpractice claims. The state also restricted its change of venue, but experts say other states are likely to feel the heat.

Tort trend expert Michelle White, a researcher at the University of California, San Diego, warned reform supporters, “On a cautionary note, if you get tort reform in Mississippi, you see more litigation in West Virginia.”

Providers have seen this happen. Fred Watson, president of the Georgia Health Care Association, says the number of lawsuits in the state have increased because of its proximity to Florida. Ken Beebe, president and chief executive officer of Legacy Health Care, Ridgeland, Miss., has warned facilities in Tennessee to watch out. Ten days after Tennessee’s worst nursing facility fire occurred in Nashville, the law firm of Wilkes & McHugh set up shop and has been bombarding the airwaves with commercials, according to Pallie Jones,

chief executive officer of Healthcare Management Services, Murfreesboro, Tenn.

“We’re seeing a lot of [lawsuit] activity,” says Jones.

Tort Reform Opponents

Wilkes is credited with being the father of nursing facility litigation. In 2004, the Wilkes firm made the *National Law Journal’s* “Plaintiffs Hot List,” where the firm reported winning more than \$64 million in jury verdicts during the past two years. It couldn’t be verified how many of these verdicts were against long term care. The firm was established in Tampa, Fla., in 1985 and has offices in nine states.

While many credit Wilkes with launching plaintiff attorneys into nursing facility litigation, the Association of Trial Lawyers of America (ATLA) has to take some of the credit as well. As one of the nation’s top lobbying groups, within the past several years it has set up the Center for Constitutional Litigation, a law firm within its organization to challenge any tort reform that comes to its attention. The center was established in 2002 to promote the rights of citizens’ access to courts and jury trials and to fight so-called tort reform, according to ATLA’s Web site. Last year the center filed challenges against Arkansas and Nevada for implementing limits on damages.

“Trial lawyers are the most sophisticated political organization that we have ever faced, not only on a national level but on a state level. They have the most effective grassroots program that I have ever seen, and it’s in every state,” says Estes who has participated in state reform efforts and AHCA’s federal communications activities.

Reforms that reduce attorney fees are beneficial in two ways, says Andrew Stephens, from the U.S. Chamber Institute for Legal Reform, Washington, D.C. They discourage attorneys from taking on cases, and they undermine attorneys’ ability to make political contributions, he says. Looking at reducing attorney fees “is important because the plaintiffs’ bar uses that money to maintain control over the legal system,” he says.

Impact On Medicaid

Providers are facing astronomical price increases in professional liability insurance, observers agree. Between 2001 and 2002, the costs associated with health care liability rose 143 percent, according to AON Risk Consultants, Columbia, Md. In many states, providers can’t obtain insurance because of a lack of available insurance carriers. More providers are considering self-insurance or captive insurance programs to establish necessary protection or are opting to go without insurance.

Liability costs also are increasingly absorbing more Medicaid dollars. AON estimated that in 2004, liability claims alone would cost the system \$1 billion. Professional liability and general liability losses in 2003 consumed an average of \$2,290 annually per occupied skilled nursing facility bed, up from \$310 in 1992. Translated into a cost-of-care basis, this means that \$6.27 per patient day needs to be set aside for litigation costs rather than care, or five cents of every Medicaid dollar.

More Reforms Needed

With President Bush's 2006 budget looking to cut \$60 billion from Medicaid, tort reform could be positioned as a fiscal policy, Capitol Hill watchers suggest.

"The costs associated with defending against lawsuits don't normally fall

within fiscal policy, but if you make any changes to liability it should be scored as a savings to Medicaid," says Nancy Armentrout, director of legislative affairs for the California Association of Health Facilities.

Trial lawyers are a sophisticated political organization, not only on a national level but on a state level.

"From the insurance carriers' viewpoint, the cost of insurability is directly related to predictability. Unlimited damages require unlimited premiums, and this increase is passed on to all of us," says Tra Beicher, director of Risk Management Support Services, TIS Insurance Services, Healthcare

Division, Knoxville, Tenn. Before a Senate Special Committee on Aging hearing on liability insurance and long term care, AON's Theresa Bourdon said, "Legislative changes that will reduce the cost of risk and provide greater predictability in the number and size of claims will directly impact litigation trends. By reducing the litigation trends, you will also be responding to the issue of insurance availability and affordability."

In addition to caps, AHCA and its Medical Liability Committee members believe a series of efforts still need to be undertaken, such as limiting the use of survey and inspection evidence.

Estes says Alabama has evidentiary protections that prohibit the state inspection and survey records from being used as evidence of a facility's pattern of neglect, unless they specifically relate to the claim.

Mark Reagan, an attorney with Hooper, Lundy & Bookman, agrees. “There needs to be more guidance to the courts to decide what survey documents are relevant to the claim,” says Reagan. “There is no other industry that has the hyper-regulation like nursing facilities, and there are a vast number of survey inconsistencies.”

“Nursing facility operators should support a national tort reform effort,” Estes says. “It would eliminate the need to fight battles in multiple states, and federal law trumps state constitutional challenges if the legislation is drafted correctly. However, I am not sure Congress has the desire to address this issue at this time given its involvement in other volatile national issues, but providers need to stay involved.”

Another reform that is needed, providers say, is more medical review panels. Indiana, Louisiana, and New Mexico are using medical panels to determine if a lawsuit allegation against a provider is a breach in the standard of care.

Alternative To Legislation

“Something providers can do right now if they haven’t yet is to look at employing private arbitration agreements through the use of the Federal Arbitration Act [FAA],” Estes says. “If they meet the FAA’s requirement then they are allowed to enter into binding arbitration agreements to resolve disputes or to put arbitration clauses into their admissions agreements. When implemented, arbitration is less expensive for both sides and in most cases results in out-of-court settlements.”

The natural human response “to protect the young, elderly, and frail has been manipulated and exploited by trial lawyers,” Estes says. “The values of verdicts are based on this appeal to emotion, and, in many cases, we tend to be punished unnecessarily because trial lawyers exploit what is a compassionate natural human tendency.

“Nursing facility operators want—and residents deserve—the ability to

receive some level of compensation where a legitimate mistake was made. However, the obscene amount of lawsuits filed and the severity of awards have crippled our ability to pay legitimate claims and negatively impact our efforts to provide quality care.

“The only known way to prevent

severity is through a cap, and frequency can be controlled through pretrial screening of evidence or establishing medical review boards,” he says.

On a rallying note, the U.S. Chamber’s Stephens advises, “If you want to achieve tort reform, you have to be in it for the long term.” ■