Quality of Care and Litigation in Tennessee Nursing Homes

Final Report

Prepared for:
AARP

Submitted by:
The Lewin Group, Inc.

March 4, 2009

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Acknowledgements

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Executive Summary

A. Background

People of all ages enter nursing homes for a variety of reasons.[1] The quality of care and quality of life in nursing homes has long been a concern, nationwide and in Tennessee. For a number of reasons, nursing home quality problems often go unreported and fail to be resolved in a timely manner. Hence, litigation can become a last recourse for injured residents and their families to hold nursing homes accountable and seek compensation.

In recent years, nursing home operators in Tennessee and other states have lobbied for protection from costly litigation. In early 2008, the Tennessee Legislature introduced a bill that included provisions to restrict lawsuits against nursing facilities by capping non-economic damages at $300,000 and explicitly allowing facilities to require a signed binding arbitration agreement as a condition of admission (HB4053 and SB4075). Nursing facility operators, resident advocates, plaintiff attorneys, and policy makers, fiercely debated the proposed legislation, raising many questions related to quality of care and litigation in Tennessee nursing homes.

B. Study Purpose

AARP commissioned The Lewin Group to conduct research to help inform policy discussions about quality of care and litigation in Tennessee nursing homes. Specifically, the study addresses the following overarching policy questions:

- What are the factors driving litigation in Tennessee?
- What are the nursing home litigation trends in the state?
- What positive or negative outcomes does litigation have for nursing home residents?
- What steps have nursing facility operators in Tennessee taken to reduce the frequency and cost of litigation, and what are the implications for nursing home quality?
- What are the potential impacts of tort restrictions, based on the experiences of other states?

Based on the findings, the report discusses considerations and potential strategies for ensuring delivery of quality services in Tennessee nursing homes.

C. Methodology

This study used a qualitative approach, based on: (1) a literature and website review; (2) interviews with key informants representing diverse stakeholders in Tennessee; and (3) an in-depth analysis of the methodology and findings of a 2008 study entitled *Long Term Care 2008 General Liability and Professional Liability Actuarial Analysis* conducted by Aon Global Risk Consulting under contract with the American Health Care Association. Significant gaps and limitations of existing data on quality of care and litigation dictated this approach.

In the literature review, the sources we consulted (news articles, reports, testimony, and websites) provided scarce information on nursing home liability trends in Tennessee, but they did at least indicate the direction of trends or emergent issues. Where we lacked Tennessee specific information, we reported evidence on trends occurring around the country, which may not necessarily reflect the situation within Tennessee.

D. Major Findings

Factors driving nursing home litigation in Tennessee

The available research suggests that Tennessee nursing homes exhibit several distinguishing quality and structural characteristics—below average staffing levels, large average facility size, and a high percentage of for-profit and chain-owned facilities—associated with increased risk of quality problems and litigation. In addition, Tennessee surveyors have performed far below the national average in accurately detecting serious violations of quality standards, which may lead residents to turn to litigation to resolve problems. Tennessee nursing homes also performed poorly in incidence of pressure ulcers and physical restraint use, two of the most common allegations in nursing home lawsuits. An average of 6.2 percent of Tennessee nursing home esidents use physical restraints daily, significantly higher than the national average of 4.6 percent. The Center for Medicare and Medicaid Services'quality goal is 5 percent or less. Tennessee nursing homes are close to the national average in the percent of residents who suffer from high risk pressure ulcers (11.7 percent in TN and 11.8 percent nationwide), but below the quality goal of less than 10 percent. The presence of a residents' rights law in Tennessee makes it easier for residents to bring claims when their rights are violated.

Key informants identified heavily advertised plaintiff attorneys with Tennessee-based practices as another potential factor contributing to litigation. Some informants asserted that the chance of winning a "jackpot award" motivated trial attorneys and residents' family members to make frivolous or unnecessary claims. However, most cases lack a public record to verify their merit, because nearly all lawsuits are settled out of court or dismissed.

Litigation and liability insurance trends in Tennessee

While some informants indicated that litigation posed a huge problem for the entire nursing home industry in the state, others suggested that it affected large and profitable facilities disproportionately because they were more likely to be sued. The primary source of data on liability trends, a 2008 Aon study, reported large increases in the frequency and cost of lawsuits in Tennessee. However, the study's limitations in its data, methods, and potential representativeness, make it a less than rigorous source.[1]

[1] The results are based on respondents that combined have 12,400 beds. Although these beds reportedly represented approximately 32 percent of Tennessee nursing home beds, information about the number of providers these beds represent, or the characteristics of these facilities was not available. The majority of beds in the national sample were owned by large, for-profit chains, and the national sample also included long-term care providers other than nursing homes. It should also be noted that the Aon report provided limited information about the study's data and methods, and Aon declined to provide us with any of the

Informants representing both for-profit and non-profit facilities discussed large increases in litigation as a critical problem affecting the nursing home industry in Tennessee. However, other informants contended the increase was limited to a few incidents or providers. Two informants specifically mentioned a 2003 fire in a Nashville nursing home that resulted in multiple deaths and injuries, and multiple claims with large payouts.[2] Aon's data support the contention that the single incident skewed the trends: the average claim amount for Tennessee in 2003, which included claims related to the catastrophic fire, was higher than any other year in the 10-year period and nearly double the claim amount in the previous year.[2]

Aggressive defense strategies can also increase litigation costs and the time it takes to resolve a case. Nationally, Aon found that the amount nursing homes spend to defend liability claims greatly increased.[3] Although a plaintiff attorney we consulted reported that nursing homes in Tennessee are spending more on defense and using more aggressive defense strategies, we were unable to verify this because Tennessee specific information was not available.

Informants also expressed different opinions on whether nursing homes have difficulty obtaining affordable liability insurance coverage as a result of litigation. The literature lacks detailed studies on trends in nursing home liability insurance availability and cost in Tennessee, and the exit of regulated carriers and variations in policy terms complicate efforts to obtain reliable data.

Outcomes of litigation for nursing home residents

Little is known about how frequently plaintiffs prevail in cases against nursing homes or the compensation received, because nearly all lawsuits are settled out of court or dismissed and these cases lack public records. In some cases settlement agreements or jury verdicts may require operational changes that can benefit all residents. However, it is unknown how often this occurs because usually the parties do not disclose settlement terms. The threat of litigation may also serve as a deterrent to harming residents, however this area lacks hard data as well.

Informants representing the nursing home industry argued that litigation diverts resources from resident care, thus having an adverse effect on quality. However, some studies cast doubt on the premise that the money nursing homes spend to defend and pay claims would otherwise have been used to improve staffing and quality.[4] Two studies by the General Accountability Office (GAO) found little relationship between the amount of money available to nursing homes and their spending on resident care.

In one study, GAO examined the relationship among nursing home expenditures, staffing levels, and deficiencies in three states.[5] Although the findings may not apply to all nursing homes in the country, they do provide insight into nursing home spending patterns. Overall, GAO found no clear association between a facility's total spending or spending and the proportion of money it spent on nursing care or between spending and deficiencies. In Ohio

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information we requested. Thus, our critique of the Aon study is based on the limited information provided in their report.

[2] In 2004, the Tennessee General Assembly passed legislation requiring all licensed nursing homes to be fully sprinklered. As of December 2008, all nursing homes in the state were in compliance with this requirement. Tennessee Department of Health. (March, 2008). *Report to the General Assembly: Nursing Home Inspection and Enforcement Activities* (Rep.). Author. Retrieved February 10, 2009, from http://health.state.tn.us/Hcf/PDF/2008_Nursing_Home_Report.pdf.

and Washington, nursing homes with higher spending spent a higher proportion of total spending on capital, operations, and administrative expenses, not on nursing care. In Mississippi, the share of total spending devoted to nursing was the same in the highest-spending and lowest-spending facilities.

The second study included more than one-third of all skilled nursing facilities nationwide.[6] GAO assessed the impact of a temporary Medicare reimbursement increase intended to encourage homes to increase their nursing staff, one of several such increases since 1998. The results showed that average nursing time changed little after the increase in Medicare payment for staffing. Although the payment change could have paid for about 10 added minutes of nursing time per resident per day, average nursing time increase by less than two minutes per resident per day. Furthermore, the portion of residents covered by Medicare was not a factor in whether nursing homes increased their nursing staff time.

Nursing home industry efforts to reduce litigation costs, and implications for quality

Although Tennessee specific information was scarce, national studies suggest that nursing home operators have used diverse strategies to reduce their risk of litigation and lower litigation costs, with mixed implications for nursing home quality:

- Strategies aimed at reducing resident injuries (e.g., falls prevention) and reducing the risk of litigation show promise for improving quality. Recent data indicate that Tennessee nursing facilities are participating in national voluntary nursing home quality improvement programs at a rate similar to the national average. Respondents also reports that Tennessee nursing homes have been stepping up risk management efforts.
- Re-structuring as Limited Liability Companies (LLCs) and purchasing of nursing homes by private investment groups, in which assets are shielded from liability, may reduce quality of care and leave injured residents with no legal recourse. A *New York Times* analysis found that many nursing homes reduced staffing after being purchased by private investment groups, and these facilities also received more quality of care deficiencies than other nursing homes.[7] The number of nursing homes owned by LLCs has greatly increased (from 49-95 out of 329 homes) in Tennessee in recent years. Some of the large chains that have been purchased by private investment groups are also operating nursing facilities in Tennessee.
- Some facilities in Tennessee reportedly limit which populations they serve and the types of services provided to lower their litigation risk. As a result, advocates indicated that some people with disabilities had difficulty finding the services they need. However, information on how often this has occurred was not available.
- Nationwide, Aon reported that there had been an "exodus of the larger, deep pocket providers from the more litigious states."[8] However, no evidence was found of nursing homes exiting Tennessee due to high litigation costs to date. The total number of nursing homes in the state has actually increased slightly according to the most recent data, from 324 in 2003 to 329 in 2006.[9]

Potential impacts of tort restrictions

States have enacted various tort restrictions aimed at reducing nursing home litigation by restricting access to the courts or capping plaintiff compensation awards. The impact of these laws has not been well documented in the literature. Further, the provisions of state laws addressing the issue vary a great deal, making it more difficult to compare their impacts.[10] The limited available data suggest that:

- Research on the effectiveness of tort restrictions in lowering litigation costs has been inconclusive. Aon's data and results from other studies suggest that Texas provides the only evidence of tort restrictions lowering costs.
- Caps on non-economic damages and other tort restrictions could leave injured nursing home residents with no legal recourse.
- Binding arbitration agreements appear effective in lowering litigation costs, but they force residents to relinquish their right to a jury trial and hence have been challenged as unconstitutional.
- Even if tort restrictions ultimately prove effective in lowering litigation costs, it is unclear whether providers would devote any savings to improve quality of care.

E. Considerations and Potential Strategies for Ensuring Quality in Tennessee Nursing Homes

Our findings suggest the following considerations and potential strategies for ensuring quality in Tennessee nursing homes:

- Tort restrictions do not appear to be effective at reducing litigation costs.
- Increasing staffing levels can improve quality of care.
- Strengthening monitoring and oversight can also improve quality of care.
- Encouraging small home-like facilities with transparent ownership could improve quality of life and make it easier for residents to hold owners responsible.

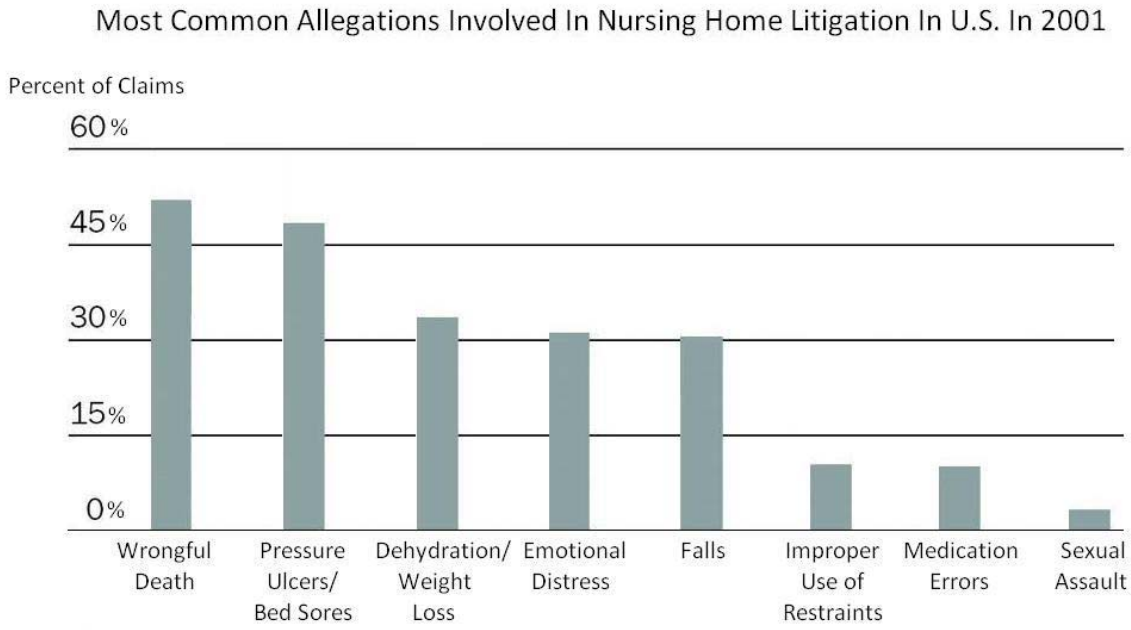
I. Background

People of all ages enter nursing homes for a variety of reasons.[11] Some enter for a brief time when they leave the hospital because they need sub-acute care, such as skilled nursing care, medical services, and therapies. Others need long-term assistance with self-care and other everyday activities, due to functional or cognitive limitations.

The quality of care and quality of life in nursing homes has long been a concern, nationwide and in Tennessee. Nursing home quality problems are often not reported and resolved in a timely manner, for a number of reasons. Nursing home abuse victims, witnesses, and family members often express reluctance to report complaints due to fear of reprisal.[12] In some cases, residents cannot communicate what happened to them. An Office of the Inspector General report indicated that insufficient staffing for the Long-Term Care Ombudsman program, in which individuals advocate on behalf of residents, severely limits its ability to pursue residents' complaints.[13] A May 2008 Government Accountability Office (GAO) investigation revealed that state nursing home inspectors routinely overlook or minimize problems, such as malnutrition, severe bedsores, overuse of prescription medications, and abuse of nursing home residents.[14] Tennessee was among the nine states most likely to miss deficiencies.

Hence, litigation can become a last recourse for injured residents and their families to hold nursing homes accountable and seek compensation. Residents' rights laws provide a basis for nursing home residents to sue when they are injured by negligent or abusive care. All nursing homes that receive Medicaid and/or Medicare funds are subject to federal resident rights as specified in the 1987 Federal Omnibus Budget Reconciliation Act (OBRA 1987). Several states have supplemented the federal bill of rights either through legislation or case law. More than half the states in the U.S., including Tennessee, have some form of a residents' bill of rights.[15] Lawsuits against nursing homes may also be based on medical malpractice law or elder abuse law (e.g., Tennessee Adult Protection Act). According to a 2001 national survey of defense and prosecuting attorneys involved in nursing home litigation, the most common types of lawsuits filed against nursing homes involve wrongful death, pressure ulcers and bed sores, dehydration and weight loss, emotional distress, and falls (see ***Exhibit 1***).[16]

Exhibit 1:



SOURCE: Stevenson, David G., and David M. Studdert. "The Rise Of Nursing Home Litigation: Findings From A National Survey Of Attorneys." Health Affairs 22 (2003): 219-29.

Prior to the mid-1990s, it was difficult for nursing home residents and their families to sue and obtain compensation, compared to younger medical malpractice victims.[17] Most nursing home residents could not claim lost earnings, and reduction of an injured nursing home resident's life expectancy was typically small compared to that of a younger hospital patient with the same injury. In the late 1990s, large awards for pain and suffering, previously more common in medical malpractice claims against physicians, began to be awarded more frequently to injured nursing home residents.[18] Most experts agree that nursing home litigation has become more common in recent years, although the amount of increase is uncertain. As a result, it is generally agreed that average litigation costs, including the costs to defend cases and pay claims, have risen in some states, although precise figures on the scope of cost increases are lacking.

In recent years, nursing home operators in Tennessee and other states have lobbied for protection from costly litigation. In early 2008, the Tennessee legislature introduced a bill that included provisions to restrict lawsuits against nursing facilities by capping non-economic damages at $300,000 and explicitly allowing facilities to require a signed binding arbitration agreement as a condition of admission (HB4053 and SB4075). Nursing facility operators, resident advocates, plaintiff attorneys, and policy makers fiercely debated the proposed legislation, raising many questions related to quality of care and litigation in Tennessee nursing homes.

II. Study Purpose

AARP commissioned The Lewin Group to conduct research to help inform policy discussions about quality of care and litigation issues in Tennessee nursing homes. Specifically, the study addresses the following overarching policy questions:

- **What are the factors driving litigation in Tennessee?** Do lawsuits reflect serious quality problems and weak oversight, or frivolous or unnecessary claims?

- **What are the trends in nursing home litigation and liability insurance in Tennessee?** Is litigation increasing in the state? Are some types of facilities more likely to be sued than others? Has litigation affected the ability of facilities to obtain affordable liability insurance coverage?

- **What positive or negative outcomes does litigation have for nursing home residents?** How frequently do residents prevail in cases? Is litigation effective in resolving quality problems? Does litigation have any adverse effects on quality or access to care?

- **What steps have nursing facility operators in the state taken to control the risk or cost of litigation, and what are the implications for residents' rights and quality?** Has the threat of litigation motivated facilities to voluntarily address quality problems through risk management or voluntary quality improvement programs? Have facilities in the state taken actions that shield their assets from liability, and if so how might this affect residents' rights and quality of care? What other steps have facilities taken to reduce the risk or cost of litigation and what are the implications for nursing home residents?

- **What are the potential impacts of tort restrictions, based on the experiences of other states?** Are tort restrictions effective in lowering the frequency and cost of litigation? If so, have the resulting savings been used to increase staffing and improve quality of care? How might caps on damages and other tort restrictions affect residents' rights? Are binding arbitration agreements effective?

Based on the findings, the report discusses considerations and potential strategies for ensuring quality in Tennessee nursing homes.

III. Methodology

This study used a qualitative approach, based on a literature and website review, interviews with key informants representing diverse stakeholders in Tennessee, and an in-depth analysis of the methodology and findings of a 2008 study entitled *Long Term Care 2008 General Liability and Professional Liability Actuarial Analysis* conducted by Aon Global Risk Consulting under contract with the American Health Care Association. Significant gaps and limitations of existing data on the issue dictated this approach.

A. Literature and Website Review

The Lewin Group conducted a review of literature and websites related to nursing home liability insurance and litigation issues. Key sources included:

- Articles in newspapers and trade publications,
- Federal and state government reports and testimonies,
- Reports conducted for advocacy organizations representing various perspectives,
- Articles published in scholarly journals and law reviews, and
- The websites of various state agencies, organizations that analyze the insurance industry, research institutions, and other groups.

In the literature review, the sources we consulted (news articles, reports, testimony, and websites) provided scarce information on nursing home liability trends in Tennessee, but they do at least indicate the direction of trends or emergent issues. Where we lacked Tennessee specific information, we reported evidence on trends occurring around the country, which may not necessarily be indicative of the situation within Tennessee.

B. Discussions with Key Informants

To build and expand on the information gleaned from the literature and website review, the study team also held nine telephone discussions with diverse key informants knowledgeable about nursing home liability issues in Tennessee (***Exhibit 2***).

Exhibit 2: Study Key Informants

State agencies	Tennessee Department of Commerce and Insurance Tennessee Department of Health
Advocates and attorneys representing nursing home residents	A disability advocacy organization A consumer advocacy organization The state long-term care ombudsman program State association of plaintiffs' attorneys
Nursing facility representatives	State provider association representing for-profit, non-profit, and government owned long-term care facilities State provider association representing primarily non-profit facilities A large for-profit nursing home chain with multiple facilities in Tennessee.

Studies by Aon provide one of the few sources of quantitative data on the issue and get widely cited in the debate over nursing home liability issues. This report includes an in-depth analysis of the results, methods, and limitations of Aon's 2008 study. We also compared Aon's data and findings with those of other sources. The review assessed what conclusions could or could not be drawn from Aon's data. We requested additional information and a number of clarifications from Aon staff, including:

1) Median values for the data on costs and the number of claims (the report provided average values only)

2) Confidence intervals and significance levels for the average values provided

3) The number of providers included in the samples for the individual state analyses

4) How many of the providers and "beds" were skilled nursing versus assisted living, home health, or other type of long-term care

5) How many of the beds in the sample were operated by multi-state chains versus regional chains or small independent providers

6) Similarly, information on for-profit and non-profit respondents

Aon declined to provide all requested information, on the basis that either the information was not readily available or because of confidentiality agreements.[19] Detailed results of the Aon study critique are included in the ***Appendix***.

IV. Major Findings

A. Factors Driving Nursing Home Litigation in Tennessee

Although lacking systematic data on the factors associated with litigation in Tennessee, studies from other states have found links between litigation and certain key indicators of quality, as well as facility size and ownership structure.

Tennessee nursing home quality and structural characteristics may increase the risk of quality problems and litigation.

Quality and structural factors increasing the risk of litigation:

1. Low RN and CNA staffing levels
2. Large number of beds
3. For-profit ownership
4. Owned by a chain

The most comprehensive and rigorous of these studies, Johnson, Dobalian, Burkard, Hedgecock, and Harman (2004), analyzed whether organizational structure, case-mix, and quality factors influenced the number of lawsuits, based on data from 2,378 nursing homes across 45 states from 1997 to 2001.[20] The researchers obtained data on lawsuits from Westlaw's Adverse Filings Lawsuit database and used binomial regression to control for resident acuity levels and year effects. The use of random sample of 2,378 nursing homes in 45 states, stratified by ownership, chain membership, and state in this study ensured representation of subgroups in accordance with their prevalence within the nursing homes. Nonetheless, the authors note limitations of their data sources, specifically that the quality of inspections varies by state, the sources account only for urban nursing homes (not rural homes), and many lawsuits were probably not included in the Westlaw database.

In a state-specific study of 577 California nursing homes, the California Advocates for Nursing Home Reform (CANHR) analyzed the content of lawsuits filed against nursing homes which comprised potential "elder abuse type" litigation.[21] Information on litigation was obtained through records maintained by the California judicial system. Hence, CANHR only identified claims that had proceeded to the point of entering the court system and did not include claims that were settled prior to out of court.[22] The researchers searched through personal injury,

malpractice, wrongful death, negligence, civil rights abuse, elder abuse, breach of contract and other general categories. Each lawsuit was then examined to make sure it involved a nursing home resident and if it was filed against a freestanding nursing facility. In this way, the study singled out cases alleging negligent care from other general and professional liability cases that may be unrelated to the care of residents.

These and other studies suggest that quality and structural factors of Tennessee nursing homes, including the low registered nurse (RN) and certified nursing assistant (CNA) staffing levels, the large and increasing number of beds per facility, the large and growing percentage of for-profit nursing homes, and the large and increasing proportion of facilities owned by chains, all seem to be contributing factors leading to an above average risk for litigation against Tennessee nursing homes relative to other states. ***Exhibit 3*** compares Tennessee nursing homes with the nation on these key quality and structural measures, based on the most recent available data.

Exhibit 3: Nursing Facilities in Tennessee Compared with the Nation, 2006

	Tennessee	Nation
Average RN hours per resident per day	0.5	0.6
Average CNA hours per resident per day	2.1	2.3
Average number of beds per facility	115.7	107.8
For-profit facilities	73.4%	66.4%
Chain-owned facilities	63.0%	52.5%

Source: Harrington, C., Carrillo, H., & Woleslagle Blank, B. (2007). *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2000 Through 2006* (Rep.). University of California San Francisco. Department of Social & Behavioral Sciences. Retrieved September 8, 2008, from http://www.pascenter.org/nursing_homes/nursing_trends_2006.php.

Low staffing levels. Johnson et al. found that nursing homes that operated below Centers for Medicare and Medicaid Services (CMS) recommended long-stay staffing levels of 0.75 hours of care per resident per day for RNs, and 2.8 for CNAs experienced an increased likelihood of being sued. The CMS long-stay staffing levels were based on a study conducted by Abt Associates for CMS which found that these staffing levels, which also include 0.55 hours care from licensed vocational nurses (LVN) or licensed practical nurses (LPNs) for a total of 4.1 hours of care per day per resident, were necessary in order to prevent harm to residents.[23]

Although a majority of states average less than the recommended RN and CNA staffing levels, in 2006, Tennessee's certified facilities ranked among the bottom 10 worst states in terms of total RN staff levels, with an average of 0.5 RN hours per resident per day, compared with a national average of 0.6, and CAN staff levels providing 2.1 hours a day compared to a national average of 2.3.[24] Tennessee's status of having the second largest shortage of registered nurses in the U.S contributes to these low staffing levels.[25] However, Tennessee ranked above the national average for LPN/LVN hours, providing an average of 0.9 hours per resident per day, compared to a national average of 0.8. Informants reported that LPNs in Tennessee nursing homes do more work traditionally performed by RNs, due to the RN shortage. One informant said this has caused problems and raised issues regarding the scope of practice for nurses.

Additional insights into the staffing shortages in Tennessee have recently come to light through the release of the CMS 5-star quality rating system.[26] The system was designed to help consumers evaluate the relative performance of nursing facilities in their state. Although the system can not compare the relative quality of nursing homes between states, CMS did include a staffing performance measure, based on how closely a nursing facility met the CMS recommended long-stay recommended staffing levels.[27] According to the CMS data, 45.9 percent of Tennessee nursing homes received a 1-Star rating, the lowest possible rating, in their overall staffing level. This is among the highest in the country. In order to qualify for a 1-star rating a nursing facility must have either (1) a combination of a RN staffing level of $\leq$ .221 hours per resident per day and a total staffing level (RN, LPN, and Aide) of $\leq$ 3.376 hours, or (2) a RN staffing level of $\leq$ .298 hours and a total staffing level of $\leq$ 2.998. Only seven of the 298 rated nursing homes in Tennessee received a 5-star rating, five of which were non-profits and two were government owned facilities, which indicates that they currently meet or exceed the CMS recommended staffing levels.

Several informants mentioned increasing staffing as key to improving quality and reducing the risk of litigation in Tennessee nursing homes. A few informants suggested instituting minimum nurse staffing levels. Florida was mentioned as an example of a state that has established minimum staffing levels per resident per day. A provider respondent said that low Medicaid reimbursement rates limit the amount of staff time that facilities can provide and suggested increasing reimbursement rates. A 2007 study by Harrington and colleagues suggests that, while both solutions may be valuable, minimum staffing ratios may be more effective.[28] The study found that the relationship between staffing and Medicaid reimbursement rates was positive, but not as strong as the relationship with state minimum staffing standards.

Informants also reported that some provider-led efforts have been made to train new RNs in Tennessee through loan forgiveness programs and increasing the capacity of institutions which train nurses. The Tennessee Center for Nursing provides a loan forgiveness program to improve recruitment and retention of nursing staffing. The Tennessee Health Care Association gives scholarships for careers in nursing, through its Tennessee Health Care Education Foundation. It is unknown how well these programs will address future staffing needs in the state.

Large size facilities. Johnson et al. found that larger facilities experienced a higher rate of litigation than smaller facilities from 1997-2001. By holding other variables constant, they found that the rate of litigation increased by 1 percent for each bed in a nursing facility.[29] It is unclear whether larger facilities were at a greater risk for litigation due to having a higher number of residents who could potentially sue, or because larger facilities tend to have worse quality. However, other research has found that residents of small, house style nursing homes experience more satisfaction, a better quality of life, and lower incidence of decline in activities of daily living than do residents of traditional large nursing homes.[30]

The average number of beds per facility in Tennessee has increased from 109 in 2000 to almost 116 in 2006.[31] This trend in facility size may put Tennessee nursing homes at increased risk of litigation and potentially poorer quality of care.

For-profit ownership. Johnson and colleagues found that for-profit facilities had a higher overall mean number of lawsuits, were less likely to meet recommended long-stay staffing ratios, and had poorer quality indicators in comparison to non-profit homes.[32] In addition, a series of studies conducted by Charlene Harrington at the University of California demonstrated that for-profit nursing homes were more likely to have lower staffing levels and higher rates of deficiencies than nonprofit nursing homes,[33] both of which are indicative of greater risk for litigation.[34]

A 2008 study by the Office of Inspector General of the U.S. Department of Health and Human Services also found that, in 2007, 94 percent of for-profit nursing homes were cited for deficiencies, compared to 88 percent of not-for-profit and 91 percent of government-owned homes.[35] Results were based on CMS data from all nursing home surveys conducted in the U.S. that year. For-profit homes also had a higher average number of deficiencies per home than other types of nursing homes. Similarly, a 2001 study by Harrington and colleagues found that investor-owned nursing homes received more deficiencies and provided less nurse staffing than not-for-profit or public homes.

The percentage of for-profit nursing homes in Tennessee has increased from 69.2 percent in 2000 to 73.4 percent in 2006; this is 7 percentage points higher than the national average (66.4%).[36]

While no state bars for-profit nursing homes, New York prohibits publicly traded corporations from operating nursing homes.[37]

Ownership by a chain. Research on the effects of chain ownership has been mixed. Interestingly, Johnson et al. found that nursing homes that are members of a chain were 16 percent *less* likely to be sued. This is contrary to theory which suggests that, considering their financial resources, nursing home chains would be targeted more often by plaintiffs.[38] Further empirical analysis is needed to determine why chains were less likely to be sued, but it may be a result of implementing more sophisticated defense strategies, corporate restructuring to protect assets,[39] national and regional chains divesting in states with high rates of litigation,[40] or other factors.

Contrary to the findings of the Johnson study, key informants said that, in Tennessee, facilities that were part of chains were sued more frequently than smaller independent facilities. In addition, the 2008 OIG study found that a greater percentage of nursing homes that were part of multi-facility chains were cited for deficiencies, compared to single-facility homes, suggesting that chain-owned facilities would be at greater risk of litigation due to a higher incidence of quality problems. Similar differences between chain-owned and other facilities were observed in 2005, 2006, and 2007.[41]

As of 2006, 63 percent of the nursing homes in Tennessee were owned by chains. This is the tenth largest percentage in the nation. Half of the states that were ranked higher than Tennessee have been experiencing a decline in the percentage of chain owned nursing facilities since 2000. Tennessee, in contrast, has been experiencing an upward trend during the same period.

Weak oversight and enforcement may also contribute to litigation in Tennessee.

As a Tennessee Department of Health official and a nursing home industry representative pointed out, CMS is currently addressing flaws in the survey system, and increased enforcement may not necessarily be indicative of an increase in quality problems. Nonetheless, the available research suggests that a greater number of deficiencies increases a facility's risk of being sued. Johnson et al. also found that each deficiency reported on state surveys increased the rate of litigation by 3 percent. CANHR found that, compared with facilities that were not sued, the 10 percent of facilities that accounted for almost half of the lawsuits (47%) averaged almost 100 percent more deficiencies and nearly 200 percent more complaints.[42]

In 2008, Tennessee nursing homes received fewer average deficiencies per home than nursing homes nationwide (5.5 vs. 7.0) (see ***Exhibit 4***).[43] However, results of a 2008 GAO investigation suggest that this likely reflects significant underreporting of quality violations by Tennessee surveyors, rather than above average quality of care. GAO found that, from 2002 to 2007, survey teams in Tennessee missed at least one G-L deficiency (Actual Harm or Immediate Jeopardy level) 26.3 percent of the time, nearly twice as often as the countrywide average of 14.5 percent of the time.[44] In federal observational surveys, 20.7 percent of Tennessee surveys were rated as below satisfactory in deficiency determination, more than double the national average of 9.2 percent below satisfactory surveys. These weaknesses in the enforcement system may contribute to litigation. An advocate for people with disabilities noted that litigation is sometimes seen as the only way to get things done and protect people when oversight is lacking.

Exhibit 4: Deficiencies and Survey Performance in Tennessee and the U.S.

	Tennessee	Nation
Facilities cited for actual harm or immediate jeopardy (G-L) (2007)[a]	16.2%	17.8%
Average number of deficiencies per nursing home surveyed (2008)[b]	5.5	7.0
Comparative surveys with at least one missed G-L deficiency (2007)[c]	26.3%	14.5%
State surveys receiving below satisfactory ratings in deficiency determination (2007)[c]	20.7%	9.2%

[a] Harrington, C., Carrillo, H., & Woleslagle Blank, B. (2008, September). *Nursing Facilities, Staffing, Residents and Facility Deficiences, 2001 Through 2007* (Rep.). Retrieved February 11, 2009, from http://www.nccnhr.org/uploads/File/Harrington_01-07_OSCAR_complete_2008.pdf.

[b] Tennessee Department of Health (February, 2009). Report to the General Assembly: Nursing Home Inspection and Enforcement Activities, from http://health.state.tn.us/Hcf/PDF/2008_Nursing_Home_Report.pdf.

[c] US Government Accountability Office (GAO). (May, 2008). *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses, GAO-08-517*. Washington, DC. Retrieved October 13, 2008, from http://www.gao.gov/new.items/d08517.pdf.

However, enforcement appears to be strengthening in the state. The suspension of admissions of new residents at Tennessee nursing homes as a result of "Immediate Jeopardy" violations in the state increased from 6 in 2005 to an all-time high of 22 in 2007.[45] Informants explained that this is because the Tennessee Department of Health saw a rise in the types of incidents that CMS required them to investigate as complaints. It should also be noted that citations in Tennessee have been decreasing since 2004: the percentage of facilities in the state receiving at least one Immediate Jeopardy or Actual Harm deficiency was higher in 2005 (17.6%) than in both 2006 (11.5%) and 2007 (16.2%), which is down from a 6-year high of 24.1 percent in 2004.[46] Several key informants agreed that reports of poor care in Tennessee nursing homes have grown in recent years, leading to an increase in suspensions of new admissions due to quality violations. One informant commented that this increased nursing home oversight might lead to lower litigation in the future.

> *The presence of a residents' rights law in Tennessee makes it easier for plaintiffs to bring cases against nursing homes when these rights are violated.*

In the Johnson et al. study, another major factor correlating with increased rates of litigation was whether or not the state had residents' rights statutes in place.[47] States which had these statutes in place throughout the course of the study experienced a 61 percent higher litigation incidence rate than states without these laws. The inclusion of these laws, specifically in Florida which has had these laws in place since 1976, has made litigation against nursing homes much easier because plaintiffs may win a verdict if they can demonstrate that a nursing home violated one of these protections.[48,49] Thus, the presence of a residents' rights law in Tennessee may be another factor contributing to higher litigation rates in the state.

Increasing visibility of plaintiff attorneys representing nursing home residents in Tennessee.

Increased interest among attorneys in representing injured nursing home residents may also contribute to increased litigation in Tennessee. Although many nursing home lawsuits do not result in a jury trial, in 2004 the Tennessee legislature's Joint Tort Reform Subcommittee heard testimony that a number of observers believed the increases in medical malpractice awards were largely attributable to enhanced evaluations by jurors of pain and suffering and other non-economic loss, making pursuing such cases more worthwhile both for nursing home residents and attorneys who represent them.[50] The Subcommittee also heard testimony that some plaintiff attorneys from out of state had begun to solicit clients for nursing home cases in Tennessee.[51]

Informants also reported that prominent firms representing nursing home residents have established practices in the state and have been advertising their services to nursing home residents via billboards, radio, and television, which has contributed to the increase in litigation. Informants noted that the ads sometimes name specific facilities, the ads have increased in recent years, and smaller firms in rural areas have begun to advertise in addition to the larger firms in urban areas.

Informants mentioned two law firms based in other states, one in Florida and one in Texas, as the source of much of the advertising. A nursing home representative said that the reason for the increase in litigation has been that, after other states including Florida and Texas enacted caps on damages, law firms representing nursing home residents left those states, and many of their attorneys moved to Tennessee, Kentucky, and Arkansas, which had no limits on damages. A plaintiff attorney we consulted explained that, nationally, until there was some indication that jurors were willing to award significant damages for nursing home residents, lawyers continue to be reluctant to take those cases. First, it would not make business sense for the attorney. Second, it would not be worthwhile for the resident and family, because they would incur high out-of-pocket costs and attorney fees that would be deducted from the award.

The extent of frivolous lawsuits is unknown.

Proponents of tort restrictions have argued that the increases in litigation reflect a significant number of lawsuits that are frivolous, unnecessary, or are not supported by the evidence.[52,53]

However, several of the key informants we consulted doubted that frivolous claims had occurred, for various reasons. First of all, the high cost of litigation means it does not make business sense for an attorney to pursue a frivolous claim.

In addition, informants said that the cases they had seen were all claims involving allegations of serious injuries or death. Finally, Federal Rule of Civil Procedure 11 (Rule 11) provides that a District Court may sanction attorneys or parties for frivolous arguments or arguments that have no evidentiary support.[54] Rule 11.02 of the Tennessee Rules of Civil Procedure also establishes legal criteria that claims or other representations to the court must meet, specifying that a claim must be: 1) not presented for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation; 2) warranted by existing law; and 3) have evidentiary support.[55] Rule 11.03 specifies that, if the court determines that these criteria have

been violated, the court may impose a sanction upon the attorneys, law firms, or parties responsible for the violation.[56] However, the party may avoid a sanction by withdrawing their claim within 21 days.

Informants said that no evidence has been seen of such sanctions being issued for filings of frivolous cases on behalf of nursing home residents in Tennessee. Although these rules are designed to prevent frivolous and unwarranted lawsuits, they are limited in that they only apply once the lawsuit goes to trial.

Although informants agreed that allegations are serious, several contended that some lawsuits may be unnecessary or that the allegations may have no basis in fact. For example, a representative of a large nursing home chain said he believed that often family members were being contacted by lawyers and asked to file a lawsuit based on who owns the facility and "how deep the pockets," rather than the facts of the case. Similarly, a provider association representative said he had heard anecdotal stories of family members suing when the family had always expressed satisfaction with the care provided, then when the person died of natural causes, the family sued and acknowledged that the reason for suing was so they could get money from the insurance company. These claims were substantiated by a long-term care ombudsman, who stated that there has been an increase in recent years of cases which have "no basis in fact."

However, there is a lack of empirical evidence to verify if more than a small minority of these cases are without merit, because nearly all lawsuits are settled out of court or dismissed and these cases lack public record. Key informants who we consulted indicated that, with the increased costs of pursuing litigation and the risk of having their image "tarnished" through a public trial, nursing homes and their attorneys and insurance companies elect to settle out of court even when they believe the charges have no merit. Although at the micro-level settling out of court appears to be within the best interests of an individual nursing home, on a macro-level, assuming that many of these cases are in fact without merit, this behavior may be driving litigation rates higher by creating a perverse incentive structure. Of the cases that have gone to court, there is no evidence that Rule 11 sanctions have been levied against a plaintiff's attorney in any of the cases which have gone to jury trial in Tennessee.

Although we lack data on the nature of cases filed in Tennessee, empirical studies from other states indicate that the vast majority of lawsuits are warranted by existing law in that the claims allege serious abuse and neglect.[57] The Florida Task Force on Availability and Affordability of Long-Term Care conducted a study on 225 lawsuits in Hillsborough County and found that no frivolous claims had been filed.[58] An analysis of 924 lawsuits conducted by the *South Florida Sun Sentinel* and *Orlando Sentinel* found that a vast majority of the lawsuits filed in Florida were not frivolous.[59] Six of the lawsuits went to trial, 440 were settled out of court, 3 were dismissed by judged, 15 were dropped, and the rest were pending. In addition, a study into 501 lawsuits by the California Advocates for Nursing Home Reform (CANHR) found that all of the lawsuits were based on "serious claims of abuse and neglect."[60] CANHR did not provide information on the outcomes of the lawsuits, but noted that few elder abuse lawsuits go to trial.

B. Litigation and Liability Insurance Trends in Tennessee

Although some facilities in Tennessee--primarily members of large for-profit chains--have experienced increased litigation, it is unclear whether this represents a general trend.

Informants representing both for-profit and non-profit facilities discussed large increases in litigation as critical problems affecting the nursing home industry in Tennessee. An official from a large nursing home chain said that litigation in Tennessee had reached "a critical stage." He said that the average loss costs and severity of claims reported by Aon were in line with those experienced by his company (which provided data for Aon's study). However, he also noted that lawsuits were primarily targeting large chains with "deep pockets." He added that smaller nursing homes, and those that were unprofitable or had been re-structured such that their assets were shielded from liability, were generally not being sued in the state.

Other informants contended the increase was limited to a few incidents or providers and litigation in the state had not increased overall. An advocate for people with disabilities said that a few very high profile lawsuits had occurred, but she had not seen a lot of cases or a general trend towards increased litigation. She also noted that Tennessee tends to be a fairly litigious state in general. A plaintiff attorney reported that, although litigation has increased, verdicts are still few and far between. He said, "I do not believe there's been a mass explosion of litigation in Tennessee." Two informants specifically mentioning a 2003 fire in a Nashville nursing home that resulted in multiple deaths and injuries.

Aon's data support the contention that trends can be skewed by a single incident: the average claim amount for Tennessee in 2003, the year that included claims related to the catastrophic fire, was higher than any other year in the 10-year period and nearly double the claim amount in the previous year.[61]

The primary source of data on liability trends is the 2008 Aon study, which reported large increases in the frequency and cost of lawsuits in Tennessee. However, the study has many serious limitations in its data, methods, and the results cannot be extrapolated beyond the 12,400 beds owned by the respondents to Aon's survey, which likely includes a high proportion of for-profit chains (see ***Appendix***).[3] Other than the Aon study, no hard evidence was available on trends in nursing home litigation in Tennessee.

Nationally, Aon found that nursing homes had been spending more to defend liability claims and using more effective defense strategies.[62] Among the providers in the study, the average amount spent to defend a claim nearly doubled since 2001, from $29,933 in 2001 to $59,378 in

[3] Although these beds reportedly represented approximately 32 percent of Tennessee nursing home beds, information about the number of providers these beds represent, or the characteristics of these facilities was not available. The majority of beds in the national sample were owned by large chains, and the national sample also included long-term care providers other than nursing homes. It should also be noted that the Aon report provided limited information about the study's data and methods, and Aon declined to provide us with any of the information we requested. Thus, our critique of the Aon study is based on the limited information provided in their report.

2006. Aon reported that this increased spending on defense had led to a stabilization of the amount paid to claimants nationally.

Although Tennessee specific data were not available, a plaintiff attorney we consulted reported that nursing homes in Tennessee are also spending more on defense. As a result, the cost of litigation and the time it takes to resolve a case have increased on the plaintiff side as well. He said that nursing homes are filing numerous motions and "stonewalling," more so than in other types of cases.

The nursing home liability insurance trends in Tennessee are also uncertain.

Despite the persistent attention toward the medical malpractice and professional liability insurance markets in recent years, the literature lacks detailed studies on trends in nursing home liability insurance availability and cost in Tennessee. A 2006 GAO study on nursing home liability insurance in several states around the country elucidated the complexities in obtaining reliable data on liability insurance premiums.[63] These complexities extend from the fact that as carriers regulated by the state insurance department, also known as admitted carriers, have exited the nursing home liability insurance market over the past decade, they have been replaced by a growing alternative insurance market which is not subject to state department of insurance regulation or requirements for reporting or rate setting.[64] The alternative market includes surplus lines coverage (a market for companies who cannot obtain coverage through the standard market), self-insurance/captive insurance, and risk retention groups (insurance companies owned by one or more companies which provide liability insurance to members). Another overarching issue is that tightened underwriting criteria and other changes in the terms and conditions of coverage make it increasingly difficult to compare premium rates across policies.[65]

In 2004, the Tennessee legislature's Joint Tort Reform Subcommittee reported that medical malpractice insurance premiums for nursing homes in the state had been increasing in the past two to three years at a greater rate than in previous years, however specific data were absent from their final report.[66] Furthermore, considering that medical malpractice insurance was the focus of those hearings, it is unclear if there was sufficient representation from the nursing home industry and providers of nursing home liability insurance to illustrate the full scope of the market conditions as they existed in the lead up to 2004.

Although studies have shown that numerous other factors have had a more prominent role in influencing liability insurance premiums, these studies seem to focus on the broader liability insurance market including medical malpractice insurance. However, the nursing home liability insurance is only a very small subset of the insurance products provided by most carriers, which is why sophisticated underwriting or risk management for nursing homes were not in place prior to the recent increases in litigation.[67] Nationwide, most of the carriers that provided nursing home liability insurance in the mid-1990s have left the market, after incurring large financial losses in the late 1990s. For those insurers that remain in the nursing home liability insurance market, improved underwriting practices have become increasingly important to profitability. Some liability insurers have also developed risk management programs, which they have mandated on policyholders as a condition of coverage.

Several key informants agreed that liability insurance was not currently a problem in Tennessee, as it is in some states. Just as in every other state, the Tennessee Department of Commerce and Insurance has authority to control rates set by insurance companies, which may help keep premiums under control. Tennessee law requires that rates charged by property and casualty insurance companies not be excessive, inadequate, or unfairly discriminatory.[68] The Department's Insurance Division reviews rate, rule, and policy form filings by licensed insurance companies. The representative of the Tennessee Department of Commerce and Insurance said she had not heard of any problems with liability insurance or medical malpractice insurance in the state. Nursing homes she met with were concerned primarily about litigation costs, rather than insurance, arguing that larger plaintiff firms were targeting nursing homes and could push the larger nursing homes out of the state. However, she said, the industry has also expressed concern to the Department that insurance premiums might rise in the future, due to increased litigation.

A representative from a large nursing home chain, however, noted that large chains in the state are unable to purchase insurance and are self-insuring instead. He said the costs of self-insuring have increased significantly. His company created its own captive insurance company, which had to set aside over $17 million in 2008. He said that small nursing homes, in contrast, are able to buy liability insurance, because they are not being sued and only need to be insured for a small amount. An official from a provider association also said that premiums had significantly increased and coverage has declined. For example, deductibles have increased, coverage limits have decreased, and punitive damages are no longer covered under many policies. Although insurance is available, the cost may be exorbitant. As a result, many facilities are now covered by self-insurance or second line insurance. Some have "gone bare," operating with no liability insurance coverage because they cannot afford reasonable coverage. Additional research is needed to get a more complete picture of the liability insurance trends in Tennessee and the factors behind these trends.

C. Outcomes of Litigation for Nursing Home Residents

Research on the impacts of litigation on quality and access to care was not available. Conversations with key informants suggest some potential positive and negative impacts of litigation. Additional research is needed to ascertain whether litigation has significantly improved or harmed quality or access to care in Tennessee nursing homes overall.

Little is known about the outcomes of cases.

Although specific information on the outcomes of nursing home cases was unavailable, informants agreed that most cases end up being settled or dropped. A plaintiff attorney estimated that approximately 10 percent of cases go to trial. Experts also noted that these cases often do not result in a favorable outcome for the defendant, regardless of the merits of the case. A plaintiff attorney said that because Tennessee is a very conservative state, it is hard for plaintiffs to prevail against nursing home operators and most verdicts favor the defendant.

In some cases, settlements or jury verdicts may require changes in operations that can benefit all residents of the facility; however it is unknown how often this occurs because settlement terms are usually not disclosed. A disability advocate commented that, because litigation is

individually based, it may or may not improve a situation for an individual and it is uncertain whether it has systemic effects.

The threat of litigation may also provide a deterrent effect, motivating facilities to voluntarily improve quality; however, research on this issue was also not available.

It is unknown whether money spent to defend and pay claims would otherwise have been spent on resident care and quality improvements.

An official from a provider association expressed the view that litigation diverts facility resources from resident care, including financial resources and manpower. For example, when a facility is sued, the Director of Nursing and other staff have to be involved in documentation and disposition, even if the case is settled. This, he said, increases the chances of poor care and more lawsuits, leading to a vicious cycle. He suggested that any laws aimed at lowering litigation expenses include provisions to ensure that the money saved would be directed to staffing and resident care. However, no evidence was found to support the claim that money spent on defending and paying claims would otherwise have been spent on staffing and resident care.

Another industry representative said that litigation and the subsequent media coverage promotes fear and guilt among nursing home residents and family members, and makes the field less attractive for staff. However, it is unknown how widespread such feelings may be, and the same could be said of any media reporting about quality problems in nursing homes.

D. Nursing Home Industry Efforts to Reduce the Frequency and Cost of Litigation, and Implications for Residents' Rights and Quality

According to some of the key informants, the primary nursing home industry response to rising litigation has been to lobby for caps on damages and binding arbitration agreements. These proposed legislative approaches are discussed in the next section. However, some evidence was found that nursing homes across the country have also implemented various strategies to prevent lawsuits or limit their liability, with varying implications for residents' rights and quality.

Risk management and voluntary quality improvement programs may reduce litigation while improving quality.

Nationwide, Aon reported that some nursing homes have undertaken various activities designed to lower their liability risk, including resident safety programs, family education plans, increased staffing ratios, and increased investment in homes and equipment.[69] Data are not available on how many providers have implemented these strategies. Several key informants reported that Tennessee nursing homes have been investing more in risk management. An official from a large nursing home chain in the state reported that his company had stepped up its risk management efforts. These include efforts to prevent residents from developing pressure ulcers, a falls reduction program, and resident and family satisfaction surveys. He said that these programs have helped reduce the risk of lawsuits by significantly reducing pressure ulcers and falls with significant injuries in their facilities. However, he said these efforts have not stopped what he referred to as "the unwarranted

lawsuits." A provider association representative also said that nursing homes are doing more risk management, for example setting reasonable expectations.

One voluntary practice that can improve quality is the presence of organized groups of residents or family members who meet regularly to discuss and offer suggestions about policies and procedures affecting resident care and quality.[70] The groups may also meet to plan resident and family activities and for any other purposes. In 2007, 94 percent of Tennessee nursing homes had resident groups, close to the national average of 95.2 percent. A higher proportion of Tennessee nursing homes have family groups (43.5%) than the national average (35.7%).

A number of nursing homes have also participated in other voluntary improvement efforts. One such effort is the Quality Award sponsored by the American Health Care Association and the National Center for Assisted Living (AHCA/NCAL). Since 1996, facilities may apply for an award based on meeting certain quality criteria.[71] In 2008, AHCA/NCAL presented Quality Awards to 341 facilities nationwide, 8 of which (or 2 percent) are in Tennessee. This participation rate is consistent with the proportion of certified nursing homes nationwide located in Tennessee (2 percent).[72]

Aon assessed the effects of qualifying for the AHCA Quality Award on litigation costs by comparing the costs of providers that had won an award during the past three years with costs of other providers.[73] This information was available for approximately 108,400 of the 265,000 beds in the study. Award winners represented approximately 25,500 licensed beds, and non-award winners represented approximately 82,900 licensed beds. Award winners, on average, experienced 34 percent lower loss costs per occupied bed and 28 percent lower claim frequency than facilities that had not won a quality award.

Another voluntary national quality improvement initiative is Advancing Excellence in America's Nursing Homes campaign, a public-private partnership launched in September 2006. The campaign involves a coalition of long-term care providers, caregivers, medical and quality improvement experts, government agencies, and consumers.[74] The campaign has also established 49 Local Area Networks for Excellence (LANEs), which exist in almost every state to provide peer support, information, best practices, and technical assistance to campaign participants. In December 2008, 48 percent of Tennessee nursing homes participated in the quality initiative, slightly above the national participation rate of 45.4 percent.[75] Although Tennessee nursing homes have demonstrated some improvement on the eight quality measures, they currently perform worse than the national average on 5 of the 8 measures and only meet one of the quality objectives (Objective 3: reducing pain in long-stay residents) (see ***Exhibit 5***).[76]

Exhibit 5: Tennessee Results for Advancing Excellence in America's Nursing Homes Campaign

Quality Measure	Goal (by September 2008)	Tennessee average	National average
Clinical Quality Goals			
1. Average % of residents with high risk pressure ulcers	Below 10%	11.7%	11.8%
2. Average % of residents in daily physical restraints	At or below 5%	6.2%	4.6%
3. Average % of long-stay residents experiencing moderate or severe pain	At or below 4%	4.0%	3.8%
4. Average % of post-acute residents experiencing moderate or severe pain	At or below 15%	18.1%	19.6%
Organizational Improvement Goals			
5. % of nursing homes that have set annual clinical quality targets using the target-setting system at www.nhqi-star.org	90%	35.5%	32.7%
6. % of nursing homes that regularly assess resident experience of care and incorporate into their quality improvement activities (of facilities that selected this goal)	More than 80%	19.8%	21.1%
7. % of nursing homes that measure staff turnover and develop action plans as appropriate to improve staff retention (of facilities that selected this goal)	More than 80%	10.5%	12.5%
8. % of nursing homes that employ "consistent assignment," i.e., assigning caregiving staff to regularly care for the same residents.	1/3 of nursing homes	24.6%	25.0%

Source: Campaign Data by State. (n.d.). In *Advancing Excellence in America's Nursing Homes*. Retrieved February 12, 2009, from http://www.nhqualitycampaign.org/star_index.aspx?controls=states_map

Considering that pressure ulcers and improper use of restraints are among the most common complaints in nursing home lawsuits,[77] Tennessee's poor performance in these areas may explain some of the litigation in Tennessee.

> *Re-structuring as LLCs and purchasing of nursing homes by private investment groups may leave injured residents with no legal recourse and reduce quality.*

The Tennessee Department of Health's 2008 annual report on "Tennessee Nursing Home Trends" reveals changes in the business structures of nursing homes in the state.[78] The number of Limited Liability Company (LLC)-owned nursing homes in the state increased from 49 in 2001 to 95 (90 for-profit and 5 non-profit) in 2006, comprising 29 percent of the 329 total nursing homes in Tennessee in 2006. LLCs are a relatively new business structure allowed by state statute, which combines features of a corporation and a partnership.[79] LLCs are similar to a corporation in that owners have limited personal liability for the debts and actions of the LLC.

Other features of LLCs are more like a partnership, providing management flexibility and the benefit of pass-through taxation.

The rapid growth of LLCs (nearly all of which are for-profit) in Tennessee has offset the decline in nursing homes owned by for-profit corporations/associations, which over the same period decreased from 156 to 105 (**Exhibit 6**).[80]

Exhibit 6: Tennessee Nursing Homes by Type of Ownership, 2001 – 2006

	2001	2002	2003	2004	2005	2006
Total	338	340*	324	323*	324*	329
Non-profit	61	62	70	68	64	69
LLC	-	-	4	4	4	5
For-profit	245	242	221	226	226	234
LLC	49	57	67	69	75	90
Government	32	35	33	28	26	26

* Total includes nursing homes with type of ownership not reported.
Source: Tennessee Department of Health, March 2008.

The reasons for the rapid growth of nursing homes owned by LLCs, especially in the face of rising premiums and increased litigation, are an area for further research. However, a 2006 article in the journal *Trial* reported that many individual facilities were being set up as LLCs as a means of shielding the owners' assets from lawsuits.[81] A provider association representative we consulted pointed out that there might be other reasons for the recent nursing home restructuring in Tennessee. He noted that multi-facility ownership has increased while the number of individual owners has declined and individual owners might sell their facilities for a variety of reasons.

This trend has also been reported in other states with high nursing home litigation costs. The 2008 Aon study reported an increase in LLCs in Florida in the late 1990s, at a time when average liability costs in the state were very high.[82] The study noted that, after several large providers left the state of Florida or re-structured operations, the continued operations were often smaller or LLCs with reduced need or access to commercial or self-insurance, reducing the compensation available for liability events. Aon noted that this might have contributed to declining liability costs after that time.

Another national trend, observed by *The New York Times*, has been the purchase and reorganization of both national nursing home chains and small chains by large private investment groups.[83] As of 2007, investment groups had agreed to purchase 6 of the 10 largest chains nationwide, which equal about 9 percent of all nursing home beds. *The Times* reported that nursing homes purchased by these investment groups undergo a complex reorganization of their corporate structure that obscures who actually controls the nursing home. Under this reorganization, the parent company often leases the building to another company which in turn can sublease various operational segments to other companies. For example, in the case of nursing homes purchased by Formation and leased to Warburg Pincus, management of the homes was spread across dozens of other corporations including "some companies that had no

employees or offices." By creating such a complex web of management and ownership, it is nearly impossible for the parent company to be held liable for damages that occur in an individual home. The structure is designed in such a way that the individual homes are essentially shell companies with virtually no assets, while all revenue is channeled upward through the organization.[84] Some of the large chains that have been purchased by private investment groups are operating nursing facilities in Tennessee. The problems in establishing who is liable for damages in nursing homes owned by private investment groups has reportedly led to a significant reduction in the number of claims filed nationwide.[85] Estimates suggest that 70 percent of lawyers have had to abandon nursing home litigation as a result of increased costs, the difficulty of prosecuting due to complex corporate structures, and many nursing homes operating as shell companies with no assets to pursue. The parent companies have successfully argued that they are "not nursing home operators, and thus not liable for deficiencies in care."

Although a representative from Formation Properties I, a private investment group, stated that the company "should be recognized for supporting this industry when almost everyone else was running away," the *New York Times'* analysis of data from the Center for Medicare and Medicaid Services suggests that the purchase of nursing homes by private investment groups is associated with a serious reduction in quality.[86] The *Times* examined data from more than 1,2000 nursing homes purchased by private investment groups since 2000 and more than 14,000 other facilities and found staffing levels and quality to be significantly worse in homes purchased by investment groups:

- At 60 percent of homes bought by private investment groups from 2000 to 2006, managers cut the number of RNs, sometimes far below levels required by law. During that period, staffing at many of the nation's other homes fell much less or grew.

- Homes owned by large investment companies typically provided only one hour of RN or LPN care a day, while the average home was close to meeting the CMS recommended RN/LPN staffing level of 1.3 hours per resident per day.

- Homes owned by large private investment firms provided one clinical RN for every 20 residents, 35 percent below the national average.

- Quality-of-care deficiencies, such as moldy food, restraining residents for long periods of time, or administering the wrong medications, rose at every large nursing home chain after it was acquired by a private investment group from 2000 to 2006, even as citations declined at many other homes and chains. The typical number of serious health deficiencies cited by regulators in 2006 was almost 19 percent higher at homes owned by large investment companies than the national average.

Residents harmed while in the care of these facilities have essentially no legal recourse. In one case in Florida, the plaintiff had to sue 22 different companies as part of a lawsuit against just one nursing home, and while receiving a verdict of $400,000, he was only able to collect $25,000. Even federal regulators have had trouble collecting from these corporations.

Although the tactic has circumvented high nursing home litigation costs, it raises serious ethical questions, especially when there is significant increased risk of harm to the vulnerable

population in these homes. Resident advocates have lobbied for increased transparency of nursing home ownership. Some organizations, including the National Citizens' Coalition for Nursing Home Reform, have suggested that companies which own the land and building be legally liable for the nursing home, and others have even suggested completely making these complex corporate structures illegal for nursing homes.[87]

Some facilities in Tennessee are reportedly limiting services to lower their litigation risk; however the extent to which this poses challenges to accessing services is unknown.

A disability advocate we consulted reported that many nursing homes in Tennessee have been refusing to admit residents with more complex medical needs, due to concerns about risk. For example, she said, only one nursing home in Tennessee could be found that would accept an individual who needed a ventilator. Other individuals with severe medical problems have also had great difficulty obtaining nursing home care in the state. A representative of a provider association agreed that there may be some turning away of high risk prospective residents, especially those with violent tendencies or other behavioral issues, because serving such individuals can cause issues for both regulatory compliance and litigation. However, one informant representing another provider association reported that there have not been cuts to the supply of services as result of litigation, but rather that litigation has had a more direct effect on profits. Data on the scope of the problem were not available.

No evidence was found of nursing homes exiting Tennessee due to high litigation costs

Nationally, another nursing home strategy to reduce the risk of litigation is to cease operations in high-cost states. Aon reported that there had been an "exodus of the larger, deep pocket providers from the more litigious states."[88] The report suggested that the exit of these providers may have contributed to reductions in liability costs in some states. However, details on the number of providers who exited a state due to liability costs were not available.

In Tennessee, no evidence was found of nursing homes having left the state due to litigation costs to date. Although the corporate structures of nursing homes operating within the state have varied significantly from 2001 to 2006, the total number of homes has changed very little.[89] the total number of nursing homes in the state has actually increased slightly according to the most recent data, from 324 in 2003 to 329 in 2006 (see ***Exhibit 7***).[90]

Exhibit 7: Number of nursing facilities in Tennessee, 1997 - 2008

	National Average	Tennessee
1997	313	356
1998	308	362
1999	302	357
2000	301	349
2001	300	338
2002	303	340
2003	304	324
2004	303	323
2005	299	324
2006	306	329
2007	306	333
2008	(not available)	330

Sources:

1997 -2006 data on licensed nursing homes in Tennessee are from Tennessee Department of Health, *Tennessee Nursing Home Trends,* March 2008.

2007 and 2008 Tennessee data are from Tennessee Department of Health, *Report to the General Assembly: Nursing Home Inspection and Enforcement Activities*, March 2008 and February 1, 2009.

National data for 2001 – 2007 are from Harrington, C., Carrillo, H., & Woleslagle Blank, B. (2008, September). *Nursing Facilities, Staffing, Residents and Facility Deficiences, 2001 Through 2007* (Rep.). Retrieved February 11, 2009, from http://www.nccnhr.org/uploads/File/Harrington_01-07_OSCAR_complete_2008.pdf.

National data for 1997 – 2000 are from Harrington, C., Carrillo, H., & Woleslagle Blank, B. (2008, September). *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 1996 Through 2002* (Rep.). Retrieved February 11, 2009, from http://www.nccnhr.org/public/50_155_4541.cfm.

As another indicator of stability in the nursing facility industry in Tennessee, 2008 began with two Tennessee nursing homes in bankruptcy; December ended with zero.[91]

E. Potential Impacts of Tort Restrictions

States have enacted various tort restrictions aimed at reducing nursing home litigation. These measures—including caps on damages, binding arbitration agreements, and limits on plaintiff attorneys' fees—restrict residents' access to the courts and compensation, although the degree of restriction varies significantly depending on the details of the state statute.

The impact of these laws has not been well documented in the literature. Further, the provisions of state laws addressing the issue vary a great deal, making it more difficult to

compare their impacts.[92] In addition, the nursing home liability insurance market has evolved rapidly within the last few years (commercial carriers exiting the market, influx of surplus line carriers, and nursing homes switching to alternative insurance), and this makes interpreting the effectiveness of these strategies in improving the availability and affordability of insurance difficult to assess. This compounded with the fact that there is no comparative data detailing policy characteristics (i.e. liability insurance limits and deductibles) with premium rates only further complicates any interpretation of aggregate data on insurance premiums.

It is unclear whether caps on damages and other tort restrictions are effective in lowering litigation costs.

One of the most hotly debated policy options is legislation designed to control litigation through various measures that restrict lawsuits and access to the courts, such as:

1) Measures to restrict access to the courts directly (e.g., shortened statutes of limitation or pre-trial reviews intended to weed out frivolous lawsuits),
2) Provisions that regulate liability conditions and processes (e.g., changing the standard of proof, joint and several liability, etc),
3) Measures that limit compensation, such as caps on damages, and
4) Limits on attorneys' fees.

Such tort restrictions were earlier enacted in response to the medical malpractice insurance crisis affecting primarily hospitals and physicians, and have since been extended to the nursing home sector.[93] In some cases, states have combined such laws with provisions aimed at improving quality of care in nursing homes. Florida and Texas are frequently cited as examples of states that have taken this approach.

However, studies examining other states suggest that restrictions on lawsuits might not be effective in lowering lower liability costs. Aon's analysis of the impacts of tort restrictions, discussed fully in the ***Appendix***, is extremely limited in its data and methods and does not provide evidence for the effectiveness of tort reform in any state other than Texas. In addition, a 2006 Medstat study for the U.S. Department of Health and Human Services examined the impacts of state legislation to address nursing home liability costs in six states (Florida, Ohio, Georgia, Texas, and California, and Texas), and Texas was the only state where tort restrictions were found to be effective in lowering litigation costs.

Georgia has attempted to pass several bills on tort restrictions in medical malpractice and liability issues dating back to 1987 with the passage of the Medical Malpractice Reform Act and Tort Reform Act.[94] However, the Georgia judicial system has repeatedly declared several provisions of these acts relevant to nursing home cases as unconstitutional. More recently, passage of S.B. 3 in 2005 sought to cap noneconomic damages at $350,000 per provider or medical facility. The 2006 Medstat report concluded that it was unclear how much of an effect S.B. 3 would have in reducing claim frequency and severity. However, in a 2008 Superior Court Ruling in Fulton County, Georgia the noneconomic damage cap in S.B. 3 was ruled to be unconstitutional. There is no evidence to demonstrate how effective the short life of this bill has had in reducing claim frequency and severity.

California has had tort restrictions on medical malpractice cases in place since the passage of The Medical Injury Compensation Reform Act of 1975.[95] The caps on non-economic damages were later expanded for elder abuse and negligence claims, and the statute of limitation was extended by an additional year when The Elder Abuse and Dependent Adult Civil Protection Act was passed in 1991. Despite these tort restrictions, both the severity of claims and claim frequency have been on an upward trend since 1997 according to recent studies by Aon and the Insurance Services Office. However, the CANHR study disputes the claim that there has been a significant increase in litigation against California nursing homes.[96,97] Regardless, the upward trend in litigation in California reported by some studies is contradictory to the claim that tort reform will have a significant impact in reducing claim frequency and severity.

A 1999 study by the Center for Justice and Democracy, a consumer advocacy organization, examined the impact of tort restrictions by analyzing Insurance Services Office (ISO) data on insurance premiums and loss costs in every state over a 14-year period, from 1985 through 1998.[98] The ISO is a private organization that collects information for state insurance regulators.[99,100] Although ISO data may provide useful information on nursing home liability insurance,[101] a limitation of this data source is that ISO does not operate in all states, and it collects data on admitted carriers only, excluding the increasing numbers of providers who are either self-insured or covered by non-regulated insurers.[102]

The Center for Justice and Democracy categorized states into three categories based on the number of tort law changes enacted by the state over the time period. A limitation of this method is that it treats all types of tort restrictions as equal and does not allow for assessing whether some are more effective in lowering insurance premiums than others.[103] Another limitation of the study is that states with zero tort restrictions were placed in the same category as states that passed only one limit. The study examined the impacts of tort laws on lines of insurance subject to general tort reform, product liability, and medical malpractice. Results indicated that states with little or no tort restrictions had experienced the same level of insurance rates as states with severe restrictions.

An American Insurance Association (AIA) press release criticized the Center for Justice and Democracy study, saying that it used an "incorrect time period analysis," and an "irrational method of classifying states."[128] At the same time, the AIA supported the study's conclusion that limits on the right to sue do not necessarily lower insurance rates. "Insurers never promised that tort reform would achieve specific savings, but rather focused on the benefits of fairness and predictability," the AIA said. The AIA also noted that restrictions on lawsuits are just one factor determining the cost of insurance and that other factors include accident frequency, population density, medical inflation, underlying economic conditions, state taxes, and the degree of market competition.

Measuring the impacts of medical malpractice laws has been similarly challenging. A 2003 Government Accountability Office (GAO) study on medical malpractice analyzed data collected from the National Association of Insurance Commissioners (NAIC) and other sources.[104, 105] GAO found that NAIC data lacked several important data elements needed to assess the impacts of changes in medical malpractice laws on malpractice insurance. A key finding of the study was that, "Comprehensive data on the composition and causes of increased losses were lacking." GAO's only recommendation was that Congress consider encouraging the NAIC and

state insurance regulators to identify and collect additional data necessary to understand the medical malpractice insurance market.

An official from a large nursing home chain suggested limits on attorney fees as another potential solution. On the other side, a plaintiff attorney commented that it would be unfair to cap attorney fees for the residents' attorneys, but not for attorneys representing nursing homes.

For medical malpractice cases, Tennessee law has established a limit of 33 1/3 percent of all damages awarded to the claimant (Tenn. Code Ann. § 29-26- 120). Although Tennessee has not established specific limits on attorney fees in nursing home lawsuits, state bar association rules provide general guidelines for attorney fees that, if exceeded, would be considered to be excessive.[106] The Tennessee Bar Association's Rules of Professional Conduct (2008) outlines the following factors to be considered in determining the reasonableness of attorney fees and charges for expenses:[107]

1) "the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;
2) the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;
3) the fee customarily charged in the locality for similar legal services;
4) the amount involved and the results obtained;
5) the time limitations imposed by the client or by the circumstances;
6) the nature and length of the professional relationship with the client;
7) the experience, reputation, and ability of the lawyer or lawyers performing the services;
8) whether the fee is fixed or contingent;
9) prior advertisements or statements by the lawyer with respect to the fees the lawyer charges; and
10) whether the fee agreement is in writing."

A 2003 study by the Connecticut Office of Legislative Research identified 16 states, including Tennessee, which had established a specific numeric or percentage limit on fees that plaintiff attorneys may charge clients who file medical malpractice cases.[108] The study did not find any state that sets such a limit on the fees that health care providers or their insurers may pay for legal representation. However, the study did find several states that allow or require the court to determine the reasonableness of the attorney' fees, which applied to defendants as well as to plaintiffs.

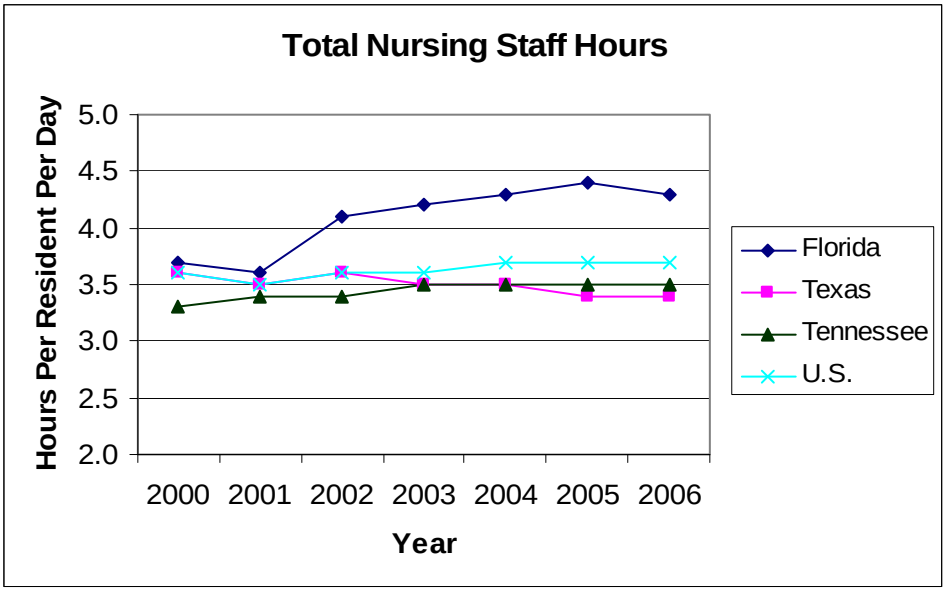
Tort Restrictions Have Not Been Proven To Improve Quality of Care

No studies have conclusively linked savings from tort reform with increased quality of care or efforts to increase staffing levels and pay. We examined quality indicator trends from Texas and Florida to assess whether any improvements in deficiencies, staffing levels, or staff pay had occurred following the passage of tort restrictions in those states. Although any correlation does not necessarily imply causation, it is interesting to note the directional trends.

One short-term indicator that nursing homes invest these savings in quality improvements may be evident through efforts to both increase staff wages and hire new staff. ***Exhibit 8*** shows annual changes in nurse staffing levels in Texas, Tennessee, Florida, and the U.S. Despite the

expected cost savings from the 2003 tort reforms, nurse staffing levels at nursing facilities in Texas have not increased and remain below the national average. The growth in staffing levels in Florida is likely more attributable to the legislative requirement for increased staffing levels in nursing facilities, which was passed as part of legislation that also included tort restrictions. Tennessee nurse staffing hours have also been consistently below the national average.

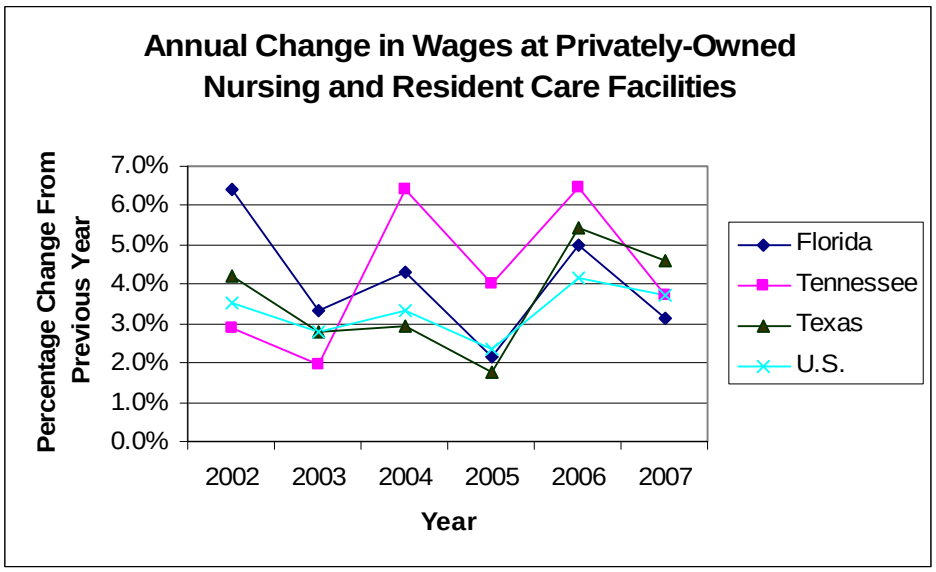
Exhibit 8: Staffing hours in Florida, Tennessee, and Texas nursing homes, 2000-2006



Source: Harrington et al., 2007

Exhibit 9 provides recent data on annual wages for staff of nursing and resident care facilities. The annual change in the rate of the pay varies in magnitude for each state, but tends to rise and fall at the same time. The annual increase at Texas facilities closely follows the national average.

Exhibit 9: Wages in Florida, Tennessee, and Texas Nursing Facilities, 2002-2007

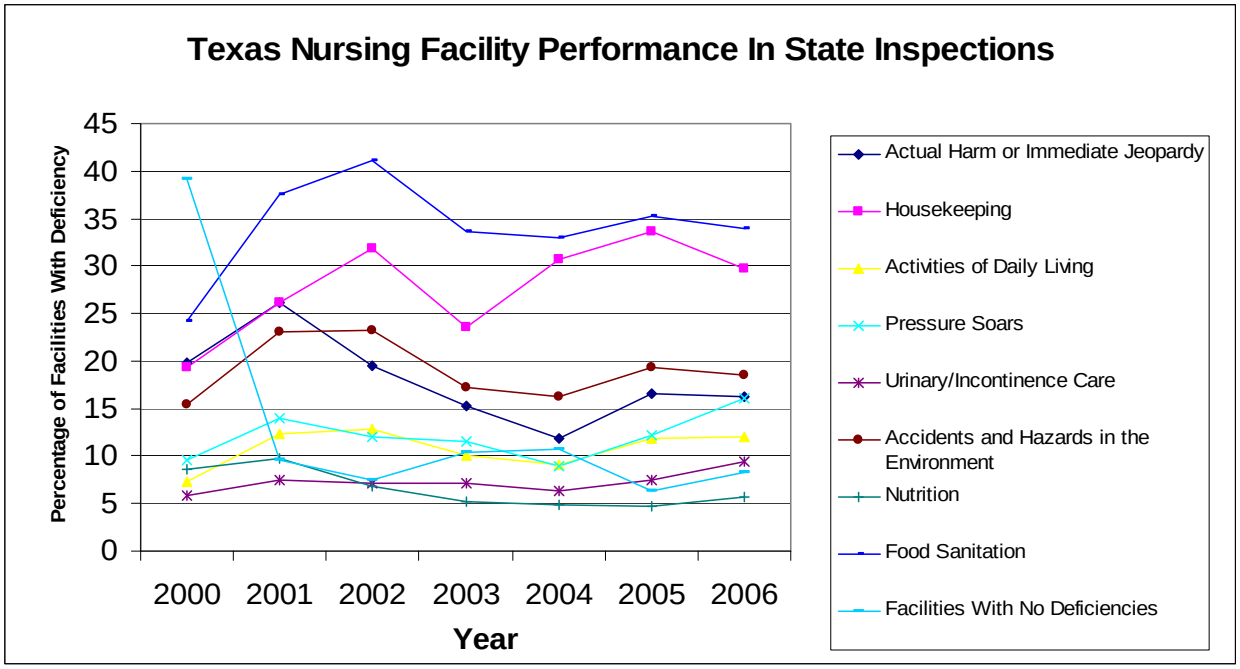


Source: Bureau of Labor Statistics, State and County Wages (Quarterly Census of Employment and Wages).

The fact that there has been very little discernable change in either quality or staffing in Texas nursing homes since their tort reforms were enacted may indicate: (1) Texas nursing homes may have elected to invest in quality improvements which may take several years to demonstrate noticeable improvement; (2) nursing homes may not have directly realized any significant cost savings in the form of lower liability insurance costs or less litigation; or (3) the tort reforms have provided no incentive to invest more heavily in staff and quality improvements.

Even with the extensive tort reforms implemented in Texas, the performance of Texas nursing homes in annual state inspections have shown no significant reduction in deficiencies since the reforms were enacted in 2003 (***Exhibit 10***). Although the percentage of facilities being cited for actual harm or immediate jeopardy deficiencies decreased between 2000 and 2006, the average number of deficiencies per facility has actually increased from 4.1 in 2000 to 7.4 in 2006. In the short run, there does not appear to be any discernable reduction in deficiencies associated with strict tort reform in Texas. Quality improvements may in fact lag cost savings, and further study over the next few years will be necessary to detect any significant quality improvements directly associated with the 2003 tort reform measures over the long term.

Exhibit 10: Texas Nursing Facility Performance in State Inspections, 2000-2006



Source: Harrington et al., 2007

Caps on non-economic damages and other tort restrictions could leave injured nursing home residents with no legal recourse.

Regardless of whether or not tort restrictions are ultimately shown to be effective in lowering nursing facilities' liability costs, opponents of these measures have stated that damage caps have made it difficult for plaintiff attorneys to accept cases against nursing homes.[109] Caps on *non-economic damages* (see ***Text Box***), in particular, can greatly limit the chances for injured nursing home residents' to seek compensation through the courts. In bringing nursing home tort restrictions in line with medical malpractice, some states have placed caps on non-economic damages while providing no limit on economic damage awards.[110] However, unlike medical malpractice cases, claimants in nursing home litigation often do not qualify for significant *economic damages*, because they lack any earnings or wealth that would be affected by physical injury.[111] According to a Harvard study conducted by David Stevenson and David Studdert, approximately 80 percent of the total amount awarded in nursing home cases is for non-economic damages.[112] A separate study, conducted by Lucinda Finley,

Types of Compensation

Economic damages: Damages for economic losses, such as loss of wages, medical bills, and damage to property.

Non-economic damages: Damages for pain, suffering, loss of companionship, consortium (love of spouse). Occasionally, laws limit the amount of "non-economic" damages which can be recovered for torts.

Punitive damages: Monetary compensation awarded to an injured party that goes beyond that which is necessary to compensate the individual for losses and that is intended to punish the wrongdoer.

Source: The 'Lectric Law Library, http://www.lectlaw.com/

concluded that non-economic damage caps "disproportionately disadvantaged" vulnerable groups such as women, children, and older persons.[113] It was on similar grounds that non-economic damage caps were ruled to be unconstitutional by the Fulton County Superior Court in Georgia because it discriminates against poor and middle class plaintiffs.[114]

Because non-economic damages comprise a majority of the awards in nursing home cases, caps on these damages have made it difficult for nursing home residents who do not qualify for economic damages to find legal representation.[115,116] Therefore the reduction in nursing home litigation seen in states with stricter restrictions on non-economic damages has been argued to be a function of elder claimants being unable to find representation for otherwise valid claims, and not from a decrease in the volume of frivolous or unwarranted lawsuits.[117]

Several informants expressed concern that a very low cap, such as the $300,000 cap on non-economic damages established in Tennessee, would seriously undermine a residents' ability to obtain any compensation at all. A plaintiff attorney said, "It would be almost irresponsible for any lawyer to recommend to a family that they pursue a case" if such a cap were in place, because nursing home residents are often unable to claim economic damages (because they have no lost wages). From the $300,000 maximum award, the plaintiff would have to deduct attorney fees, plus other out-of-pocket expenses that would likely be over $100,000, and it could take three to four years to pursue the case. A representative of a large nursing home chain agreed that a $300,000 cap would be too low, but argued that some cap was needed in order to control liability costs.

> *Binding arbitration agreements appear to lower litigation costs, but they force residents to relinquish their right to a jury trial and hence are being challenged as unconstitutional.*

A controversial practice that has received increased attention is nursing homes asking or requiring residents to sign binding arbitration agreements, often as a clause in the admissions contract.[118] Such agreements stipulate that, if a dispute arises, the resident or family will have the case heard by an arbitrator, relinquishing their right to a jury trial. Proponents of such agreements note that arbitration results in quicker, less costly, and less adversarial settlements.[119] On the other side, resident advocates and trial attorneys have expressed concern that residents might sign away their right to a jury trial, possibly without being aware of the significance of what they are signing.[120]

Traditionally, binding arbitration has been argued to reduce litigation costs, arrive at resolutions faster, and generally award less for damages than litigation going through the court system. It is theorized that the savings generated through requiring binding arbitration as a condition of admission to a nursing home will translate into lower premiums through lower litigation costs, however there is no data to support this claim. In fact, some OB/GYNs in Florida have reported that their liability insurance premiums have not decreased at all since requiring binding arbitration.[121]

In early 2008, Tennessee legislation was considered that included provisions to explicitly allow nursing homes to require signing binding arbitration agreements as a condition of admission (HB4053 and SB4075). Recent court cases involving the use of arbitration agreements, however, have challenged whether these contracts are enforceable or if they constitute a *contract of*

adhesion. A contract of adhesion exists when there is a relatively disproportionate bargaining power between the two parties and the less powerful party is forced to accept the terms of the contract. In Raiteri ex rel. Cox v. National Healthcare Corporation (NHC) Healthcare/Knoxville, Inc., a Tennessee appellate court ruled in 2003 that the arbitration contract as a condition of admission was "outside the reasonable expectations of a reasonable consumer" and therefore unenforceable. A similar judgment was also ruled in Howell v. NHC Healthcare-Fort Sanders, Inc. In both cases the NHC contracts were deemed contracts of adhesion.

In response to the concerns raised by allowing nursing homes to include binding arbitration agreements as a condition of admission, several bills have been introduced to make these agreements unenforceable. The federal "Fairness in Nursing Home Arbitration Act" (S. 2838, H.R. 6126) seeks to make all arbitration agreements in nursing home contracts unenforceable, even those that have been signed voluntarily.[122] Opponents such as Keith Nelson, Principal Deputy Assistant Attorney General in the Department of Justice's Office of Legal Affairs, have argued that the federal government does not have the authority to regulate nursing home contracts since they do not constitute interstate trade.[123] Proponents, on the other hand, representing several consumer groups, have cited numerous Supreme Court cases which have cited that Congress has the authority to regulate "general business practice which substantially affects interstate commerce."[124] Under this authority, they argue, Congress does have the power to regulate nursing homes based on the fact that this case law "firmly establishes Congress' power to regulate purely local activities that are part of an economic 'class of activities' that have a substantial effect on interstate commerce." Even if the federal bill does not pass, it is likely that the legality of binding arbitration agreements will be challenged, which makes the future prospects for including them in nursing home contracts uncertain.

Informants agreed that more nursing homes in Tennessee have begun using arbitration agreements, in response to rising litigation. Reportedly, many facilities encourage residents to sign the agreements voluntarily but do not make them mandatory as a condition of admission. One large chain does make them mandatory as a condition of admission, but the resident or family member may revoke consent to the agreement within 10 days. Firm data on the outcomes of arbitration are not available. Although key informants did not dispute that binding arbitration could lower litigation costs, several informants raised concerns that such agreements unfairly take away residents' constitutional right to a jury trial.

An informant representing a large nursing home chain, however, asserted that, when done right, binding arbitration agreements can be very effective in resolving disputes in a less adversarial manner. Similarly, a provider association official said he had heard anecdotal evidence of success stories where disputes were resolved in a less adversarial manner through arbitration. However, informants also noted that any arbitration agreement is subject to challenge.

V. Considerations and Potential Strategies for Ensuring Quality in Tennessee Nursing Homes

In the absence of evidence to support the claim that nursing home litigation negatively impacts quality or access to care, it becomes unclear whether interventions aimed at lowering litigation costs are needed.

No evidence was found that litigation adversely affects nursing home residents in Tennessee. Although providers claimed that litigation costs diverted resources from resident care, research suggests that nursing home reimbursements and expenditures have little relationship to staffing levels and quality. Moreover, evidence is lacking that tort restrictions would be effective in lowering litigation costs, or that any savings would be used to improve quality.

Increase nursing staff and improve quality.

National data indicate that, while nursing homes nationwide suffer from understaffing, the problem is particularly acute in Tennessee, which is among the nine worst states in terms of total RN staffing levels, has the second largest shortage or RNs in the nation, and is among the 10 worst states for CNA hours. In addition, data from the CMS 5-star quality rating system show that 45.9 percent of Tennessee nursing homes received the lowest possible rating (1 star) for staffing levels, one of the highest rates in the country. Tennessee nursing homes also performed poorly in incidence of pressure ulcers and physical restraint use, two of the most common allegations in nursing home lawsuits. An average of 6.2 percent of TN NH residents use physical restraints daily, significantly higher than the national average of 4.6 percent. The quality goal is 5 percent or less. Tennessee nursing homes are close to the national average in the percent of residents who suffer from high risk pressure ulcers (11.7 percent in TN and 11.8 percent nationwide), but do not meet the quality goal of less than 10 percent.

Several informants suggested that increasing staffing levels is key to improving quality and reducing the risk of litigation in Tennessee nursing facilities. Specific suggestions included instituting minimum nurse staffing ratios, increasing Medicaid reimbursements to help providers provide more staffing, and other initiatives to improve recruitment, training, and retention of nurses and certified nursing assistants. Research suggests that, while all these efforts may be valuable, minimum nurse staffing ratios have a stronger effect on staffing levels than increasing Medicaid reimbursement rates.[125]

Encourage small home-like facilities with transparent ownership.

The size and ownership structure of facilities are another consideration in ensuring quality of care and residents' rights in Tennessee nursing homes. Compared with national trends, nursing homes in Tennessee are larger in average facility size, and a higher proportion are for-profit and chain-owned—all characteristics that have been associated with increased risk of quality problems and litigation. Another trend is that many nursing homes in the state have been re-structured as Limited Liability Companies, with assets shielded from liability.

Proposed policies for addressing these issues include promoting the construction of small, home style nursing homes, mandating transparency in nursing facility ownership, requiring

that companies which own the land and building be legally liable for the care provided in a nursing home, and making complex corporate structures for nursing homes illegal.

Strengthen monitoring and oversight.

Federal studies have documented serious underreporting of quality problems by Tennessee nursing home surveyors. This weak oversight, combined with the growing percentage of Tennessee nursing homes owned by Limited Liability Companies, could leave injured, abused or neglected residents without any recourse. Informants gave several suggestions for improving monitoring and oversight, including:

- Strengthen the nursing home survey system.
- Strengthen the long-term care ombudsman program.
- Provide incentives for good quality care, paired with oversight and citations of deficiencies.
- Provide nursing home residents and their families the right to install video cameras in residents' rooms.
- Encourage nursing homes to strengthen resident and family councils and use council feedback to improve care.

Appendix: Analysis of Aon Findings

A. Current Trends in Tennessee

Litigation trends

The 2008 Aon study reported that the average frequency and costs of litigation have dramatically increased in Tennessee and are significantly higher than the national averages. However, serious limitations in Aon's data and methods hinder the ability to draw conclusions about all Tennessee nursing homes based on the study.

The Aon study found "turbulent" nursing home liability costs in a few states, including Tennessee, where the average loss costs per occupied bed and severity of claims are reportedly much higher than the countrywide averages.[126] Aon reported that, between 2001 and 2007, the frequency and costs of litigation dramatically increased in Tennessee:

- The average **frequency of claims** among the Tennessee providers in Aon's study increased from an average of 7 to 10 claims per 1,000 beds.
- The average **severity per claim** in Tennessee soared from $200,000 to $450,000. This is three times the national average of $137,500.
- **Loss costs per occupied bed** rose from an average of $1,590 in 2002 to $4,510 in 2007 among Tennessee respondents, making Tennessee second only to Arkansas for loss costs in 2007, among the 13 states profiled in the study.

The primary source of data on the issue, the 2008 Aon study, has many serious limitations in its data, methods, and the results cannot be extrapolated beyond the 12,400 beds included in Aon's sample.[4]

Aon findings may not apply to all segments of the nursing home industry. A major criticism of previous Aon studies has been that the data were based on a limited convenience sampling of providers who responded to AHCA's data call and not representative of all providers.[127] A 2006 study by Thomson Medstat for the U.S. Department of Health and Human Services pointed out that, over the five years that the Aon studies were conducted, between 60 and 108 separate nursing home operators provided claims data, representing only a small percentage of all nursing home operators.[128] Medstat also noted that the operators that participated in past Aon studies included many of the large for-profit nursing home chains. For example, in the 2004 study, just eight operators accounted for 77 percent of the total liability losses reported. Medstat cautioned that these large for-profit chains were known to have incurred the highest

[4] Although these beds reportedly represented approximately 32 percent of Tennessee nursing home beds, how many nursing home providers these beds represented is unknown. It is possible that the Tennessee data are skewed by a small number of large providers, and the sample may include providers other than nursing homes. It should also be noted that the Aon report provided limited information about the study's data and methods, and Aon declined to provide us with any of the information we requested. Thus, our critique of the Aon study is based on the limited information provided in their report.

rate of liability claims and thus did not represent the liability experience of the nursing home industry as a whole.

For the 2008 Aon study, responses were received from a total of 37 long-term care operators nationwide operating approximately 265,000 long-term care beds (15 percent of total beds in the United States), an average of over 7,000 beds per provider.[5] Seven of the largest long-term care providers in the national sample represented approximately 69 percent of the loss data reported to Aon.[129] The 37 providers in the study included 9 for-profit multi-state chains, 15 regional operators with facilities in two to five states, and 13 small independent providers concentrated in one state. Providers were recruited through a request for data that AHCA, state associations, and other stakeholders disseminated to their memberships.

It is possible that a particular segment of the industry, such as for-profit providers, could have been over-represented. It also unclear how many of these beds are part of multi-state chains versus other types of providers. Such information is relevant because, as discussed below, other research has demonstrated that facilities owned by multi-state chains are more likely to be sued than are other types of long-term care facilities. As noted earlier, Aon refused our request for information regarding the study sample.

As a point of comparison, the 2006 Medstat study demonstrates the difficulties in obtaining representative and accurate claims data from nursing facilities. Most of the respondents were large, for-profit chains, despite efforts by Medstat to elicit data from all segments of the industry. The authors also reported that, although a concerted effort was made to collect information from providers, the data reported were inconsistent and incomplete in several respects. Medstat noted that, "Due to these limitations, the conclusions that could be drawn from the quantitative component of the study were extremely limited."

Limitations of Aon Data on Litigation Trends in Tennessee:

1. Large for-profit chains may be over-represented
2. Unknown how many Tennessee providers responded
3. Unknown how many respondents were nursing homes versus other types of long-term care
4. Reporting average values only may be misleading
5. Data for recent years are actuarial estimates, not actual costs
6. Claims unrelated to care of residents may be included

It is unclear how many Tennessee providers were represented. In the individual state analyses, Aon reported how many beds were represented, but not how many facilities or how many providers. The participants in Tennessee represented approximately 12,400 licensed beds in the state of Tennessee. Although these beds reportedly represented approximately 32 percent of Tennessee nursing home beds, how many providers

[5] To calculate the percentage of nursing home beds, Aon used the Centers for Medicare & Medicaid Services OSCAR Data Current Surveys, June 2007 (Aon 2008, p. 80). Percentages were calculated by dividing study skilled equivalent beds to the total beds. However, the number of licensed beds reflects the total number of beds (including independent living, assisted living, and other settings) obtained for the study.

these beds represented is unknown. It is possible that the Tennessee data are skewed by a small number of large providers.

It is unknown to what extent the study facilities were nursing homes versus other types of long-term care providers. Aon reported that "most" of the respondents provided primarily skilled nursing care, but an unspecific number of independent living, assisted living, home health care, and rehabilitation beds were also included.

Reporting mean (average) values only may be misleading. Another limitation of the Aon study is that it reports data on loss costs, frequency of claims, and severity of claims in terms of mean (average) values only. The study authors said that they were unable to provide medians.[130] For skewed data that have a few large numbers that will distort the mean, the median is the preferred measure of central tendency.[131] When extreme values or outliers occur on a variable, the mean is distorted or pulled toward them.

In some cases, claims related to a single incident can strongly skew the average nursing home claim amount. Aon noted that Tennessee data for 2003 included claims related to a catastrophic fire. The average claim amount that year was over $500,000, higher than any other year in the 10-year period and nearly double the claim amount in the previous year.[132] Several key informants also mentioned that the fire greatly increased overall litigation costs in the Tennessee. In West Virginia, a single $5.3 million claim in 1999 caused a sharp spike in the loss cost that year, in which the average loss cost was more than double the average loss cost in any other year during the 10-year period examined by Aon.[133]

Aon's data show that a small number of extraordinarily large claims were included in the national sample. Approximately 15.8 percent of the claims reported in 1999 to 2005 were greater than $250,000, and 0.1 percent were over $5 million. The data below indicate the median claim would be less than $50,000 while the average reported was $138,000. Thus, any increase in average costs may reflect a single incident or small number of incidents, rather than a trend towards increasing costs.

Claims reported to Aon:

0-50K:	58.7%	
50k-100k:	10.1%	
250K – 500K:	9.2%	15.8%
500K – 1M:	4.3%	
1M – 2M:	1.7%	
2M – 5M	0.5%	
5M & up	0.1%	

In addition, a study by California Advocates for Nursing Home Reform (CANHR) provides evidence that average litigation rates can be skewed by lawsuits in a small number of facilities.[134] Ten percent of the 577 nursing homes in CANHR's study accounted for 47 percent of the lawsuits filed, and 23 percent of the facilities accounted for over 71 percent of the lawsuits filed.

A way of determining how closely an average value for a sample represents the population from which the sample is drawn is to calculate a *confidence interval*, which tells the probability

that the actual population average falls within a certain range.[135] The Aon study does not provide confidence intervals and confidence levels for the average values provided, and Aon declined Lewin's request for this information.

Data for the more recent years are based on Aon's actuarial assumptions, rather than actual costs. Another limitation of the study is that, as in the previous Aon studies, because it takes an average of three to four years for a liability claim to be resolved, data for the more recent years are highly dependent on Aon's actuarial assumptions about the ultimate resolution of the case.[136] For the 2008 study, the estimates were based on historical reporting patterns provided by seven of the largest long-term care providers, representing approximately 69 percent of the loss data reported to Aon.[137] Historical reporting patterns were not available from the other long-term care providers. These historical patterns may or may not continue in the same direction. As Aon acknowledged in its 2008 report, inherent uncertainty exists in actuarial estimates about future events, and actual payments may differ from the reported estimates.[138]

Liability claims unrelated to the direct care of nursing home residents may have been included. As in Aon's earlier studies, loss costs reported included general as well as professional liability losses. Thus, liability claims unrelated to the direct care of nursing home residents may have been included, for example, lawsuits brought by employees.[139] Aon did not disaggregate what proportion of total loss costs was related to general liability versus professional liability claims.

The Aon study reports loss costs as a percentage of Medicaid reimbursement. However, this is misleading because these costs are not always reimbursable by Medicaid.

The role of Medicare and Medicaid

Aon's 2008 study states that because Medicare or Medicaid help pay for the majority of nursing home resident stays, "the cost of patient care liability is largely funded by taxpayer dollars."[140] Citing Aon's report, AHCA has argued that reductions in the frequency and severity of claims against nursing homes are "excellent news for U.S. seniors and taxpayers" and help save money in the Medicaid program.[141] Aon reported that the average loss cost (the cost of settling and defending claims) "as a percent of Tennessee Medicaid reimbursements" has been increasing since 2001 to 8.9 percent in 2007. In 2007, the average loss cost per bed was $11.95, and the average Medicaid per diem reimbursement in Tennessee was $135.01.

However, reporting loss costs as a percentage of Medicaid reimbursements is misleading because not all loss costs are reimbursable by Medicaid. In Tennessee, legal fees are allowable in the Medicaid cost report only if the provider wins the suit.[142] Legal fees are not allowed if there is an out of court settlement, and most cases are settled out of court. Legal fees are never allowed in the cost report if the provider is found responsible for the allegations alleged in the suit. A nursing home representative noted that, even when the nursing home prevails in a case, expenses may not be reimbursable due to caps on the amounts that Medicaid will reimburse for legal expenses.

It should also be noted that most Medicaid residents contribute some money towards the cost of their stay. In addition, many residents pay their bills entirely out of pocket, and others have their stays covered by Medicare, private long-term care insurance, or other sources.

B. Potential Impacts of Tort Restrictions

Aon estimated that plaintiff attorney fees in nursing home cases averaged 24.2 percent of claims paid nationwide.[143] Nursing facilities' defense costs, which include costs for defense attorneys and investigation, were 31 percent; data were not available for how much of the defense costs went to attorney fees versus other expenses. Specific data on attorney fees in the state of Tennessee were also not provided.

Caps on damages and other restrictions on lawsuits and access to the courts

AHCA has touted the 2008 Aon study as evidence of the effectiveness of such tort restrictions.[144] The study analyzed the liability trends of seven states that passed caps on non-economic damages and/or tightened the rules for filing allegations of resident care liability between 2001 and 2005 (Florida, Georgia, Louisiana, Mississippi, Ohio, Texas, and West Virginia).[145]

Aon found that the total loss costs, frequency of claims, and severity of claims for the seven states combined rose sharply between 1997 and 1998, but then the total combined costs for the seven states declined between 1998 and 2007 (see ***Figure 1***). Specifically, loss costs per bed shrank from an average of $7,190 to $1,270; the number of claims per 1,000 occupied beds declined from 18.7 to 12.2; and the average severity per non-zero claim dropped from $384,000 to $104,000. However, these findings should be interpreted with caution, for several reasons.

It is impossible to tell based on Aon's analysis to what extent the lowered costs can be attributed to restrictions on lawsuits versus other factors. The study did not separate out the effects of tort restrictions by comparing costs before and after tort restrictions in each of the seven states. Rather than calculate the difference in litigation frequency and costs before and after each state's tort restrictions were passed, the study compared data for the whole group from 1997 to 2007. Other factors that may have contributed to the decreased costs include more aggressive nursing home defense strategies, quality improvement efforts, increased use of binding arbitration, reduced available limits of liability insurance in some states, and the exit of large nursing home chains from some states.

Because the "tort reform states" had, on average, exceptionally high costs to start with, the reductions may also have been in part a return to normal after a short period of unusually high costs. As shown in ***Table 2***, both groups of states experienced sharp increases in the average frequency and cost of litigation between 1997 and 1998. The table below shows that the cost and frequency of litigation were far higher in the "tort reform states" than in other states. In addition, relying on averages creates the inherent problems discussed previously.

Costs and Amount of Litigation, Based on 2008 Aon Data

	Ave. loss cost per occupied bed			Ave. # claims per 1,000 occupied beds			Ave. severity per non-zero claim		
	1997	1998	2007	1997	1998	2007	1997	1998	2007
"Tort reform states" (FL, GA, LA, MS, OH, TX, WV)	4,610	7,190	1,270	15	18.7	12.2	304,000	384,000	104,000
All states excluding "tort reform states"	480	750	1,530	5	5.1	9.7	108,000	147,000	157,000

Source: Data from Aon, 2008
* Estimate based on published chart. Exact numbers not provided in Aon report.

Several of the "other" states had also passed some measure to restrict lawsuits. Aon's data are difficult to interpret, because many of the states not classified as "tort reform states" had also passed measures to restrict lawsuits. Aon reportedly did not categorize these states as "tort reform states" because of "the limited amount of data available on these states to measure the impact of the specific provisions."[146]

Aon's own data, and results from other studies, suggest that Texas is the only state where clear evidence of tort restrictions lowering costs has been found. Aon provided individual analyses for four of the "tort reform states:" Texas, Florida, West Virginia, and Ohio. Individual analyses were also provided for Arkansas, which capped punitive damages at $1,000,000 but was not included in Aon's analysis of "tort reform states" because it did not include any other caps. The impact of caps on damages in these states was mixed in the individual state analyses. Below, we compare the Aon findings with Medstat's findings for the states that were also analyzed by Medstat and other studies. These studies suggest that Texas is the only state where evidence of the effectiveness of tort restrictions has been found.

Findings from Aon and Other Studies on the Impacts of Tort Restrictions

State	Aon Findings	Findings from other studies
AR	Liability costs sharply increased in 1998, then gradually declined after the enactment of a $1,000,000 cap on punitive damages in 2003. Arkansas nonetheless had the highest per bed loss cost in the survey in 2007.	
FL	Liability costs declined after the 2001 passage of caps on damages, but costs had been declining since 1998. Aon noted that several factors may have contributed to the declining costs, including nursing facilities leaving the market or restructuring as LLCs.	Florida's S.B. 1202 established caps on punitive damages of $1 million or three times compensatory damages and reduced the statute of limitation to two years. However other provisions of the bill included mandating an increase in staffing levels and requiring all facilities to carry liability insurance (no minimal coverage was set).[147] Although restrictions on lawsuits were included in the bill, the provision requiring facilities to carry liability insurance with no minimal coverage was cited by the experts interviewed by Medstat as having the greatest effect on curbing litigation costs. The MedStat study noted that in the wake of the Florida tort restrictions, surplus line carriers of liability insurance began exclusively offering policies with liability limits in the range of $25,000 to $50,000 per occurrence.[148] This finding was further validated in the testimony of attorneys representing the nursing home industry before the Joint Select Committee on Nursing Homes, which stated that "liability insurance policies with minimal coverage limits (e.g., $25,000) had discouraged plaintiffs from filing lawsuits."[149]
OH	Aon reported, "There have been no clear trends in the number of claims or average claim size over the last eleven years."[150] Aon also noted that, like West Virginia, Ohio was near countrywide average loss costs at the time the caps were passed.	The Medstat case study of Ohio concluded the creation of insurance captives (alternative insurance market) in the state had the greatest influence on reducing insurance costs, and that the effectiveness of tort restrictions had yet to be determined.[151]
TX	Texas nursing homes experienced a drop in average loss cost from $6,000 to $1,000 following the passage of caps on damages. The average frequency and severity of claims also declined. Aon stated, "The favorable trends in Texas offer the most dramatic results of meaningful tort reform."	Contrary to the other states, Texas has seen a substantial reduction in both claim frequency and severity since enacting H.B. 4 and Proposition 12 in 2003. With hard caps on noneconomic and punitive damages of $250,000 and $750,000 respectively, and even caps on economic damages and wrongful death claims, H.B. 4 is recognized as having some of the toughest provisions of any tort restrictions act currently in place.[152] For this reason, H.B. 4 has been expected to have a greater effect in reducing liability costs than legislation in any other state.[153] To circumvent the potential constitutional issues arising from implementing this legislation, Texas voters also passed Proposition 12 (by a slim 50.2 percent to 49.8 percent margin), which was a constitutional amendment allowing non-economic damage caps on medical malpractice claims.[154]
WV	Costs have remained stable and close to the national average continuously, with the exception of a spike in costs in 1999 due to a $5.3 million claim. No reduction in costs was observed after the 2003 passage of caps on non-economic damages.	

Binding Arbitration

In the 2008 Aon study, data on arbitration were limited because most study participants that used arbitration had only recently implemented the approach or the arbitration claims were not easily identified.[155] Aon was able to analyze data from one of the large providers in the study that implemented its binding arbitration program in 2003 and used a robust coding system that allowed for arbitration claims to be easily identified. Analysis of this limited data set indicated that litigation costs were lower for cases subject to arbitration:

- Indemnity amounts (the portion of the total claim cost paid to the claimant or plaintiff) were 31 percent lower for outcomes subject to arbitration compared to those that were not subject to arbitration. In cases where a payment was made, average indemnity amounts were $134,672 for arbitration claims, compared to $195,777 for non-arbitration claims.

- *Allocated loss adjustment expenses (ALAE)* amounts, that is, attorney fees and other costs incurred in investigating and defending claims, were 20 percent lower for claims that were subject to arbitration.

- On average, claims subject to arbitration were resolved 67 days sooner than claims that were not.

- 32.7 percent of arbitration claims resulted in no payment, compared with 26.9 percent of non-arbitration claims.

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