LIABILITY INSURANCE
FOR NURSING HOME OPERATORS

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Strategically Uninsured: An Unwise Course of Action

In these challenging economic times, health care providers are trying to trim their costs as much as possible, including – in extreme cases – operating without liability insurance and relying on corporate structure to shield against substantial payouts to successful tort plaintiffs. While some providers have argued that they are less likely to be sued if they have no insurance and consequently "shallow pockets", my experience is that nothing could be further from the truth.

My practice has focused on counseling long-term care providers for more than 15 years. Over this time I've handled hundreds of nursing home cases to resolution. I've also worked with nursing homes as outside general counsel, providing guidance on operations, regulation and liability issues. Not a month goes by when I am not asked: *"Won't they go away if I don't have insurance?"* It seems intuitive that if the money to pay a judgment or settlement is not *guaranteed* (i.e. insured) then plaintiff attorneys will move on to an easier target. I can't deny that in the past *some* lazy plaintiff attorneys have passed on uninsured cases. Others, however, have dug in and sought the personal assets of the corporate owners and professional employees. My experience in defending cases brought against *strategically uninsured* operators suggests that the substantial risks of being without insurance make it an unwise and dangerous course for both owners and professional employees. I have seen operators lose personal assets and face personal bankruptcy, spend hundreds of thousands of dollars in defense costs, and be investigated by enforcement agencies all as a direct consequence of being *strategically uninsured*. In addition, many face difficulty in staffing the facility where nurses know that the company won't stand behind them if a lawsuit is filed. Former nursing home administrator turned risk management consultant Ric Henry[1] believes that the quality of facility administration may be compromised in a strategically uninsured home. Since most state laws allow independent claims against the administrator individually, those homes without insurance will leave their high level manager's personal assets exposed: *"I wouldn't work in an strategically uninsured building – the risks are too high."*

Even with shallow pockets, you still must defend yourself.

Corporate health care providers without liability insurance still must retain counsel and defend every lawsuit filed against them. In our system, failing to defend acts as an admission of liability. Our courts typically won't allow a corporation to be defended by a non-lawyer. So, in each and every case where a lawsuit is filed, counsel must be retained, and paid. My typical retainer for this type of engagement (assuming a history of good corporate credit) is $100,000.

[1] http://www.WeArePendulum.com

I've been burned too many times by strategically uninsured operators caught in litigation who become unable to pay legal fees. Frequently, they could have obtained insurance for the price it costs to defend a single case.

Most lawsuits against uninsured facilities are brought by experienced attorneys, not those looking for an easy payout. As a result, the lawsuits will undoubtedly contain allegations necessary to gain access to the personal assets of the facility owners and staff. In order to use the corporate form to protect personal assets, and get to the point that an owner can "hand over the keys," the case must be at least *initially* defended. More often than not, if the shareholders have personal assets, they must continue to provide legal responses to motions, interrogatories, and depositions. Even then, after thousands of dollars in legal fees, a strategically uninsured defendant might still remain liable under tricky "piercing the corporate veil" laws.

Protection of personal assets is one thing, fraud is another.

In addition to traditional corporate veil issues, uninsured owners might be held liable for fraud as courts across the country are increasingly finding that the corporation was used improperly and allow the use of owner's personal assets to satisfy judgments. In addition, uninsured companies are typically viewed by courts as "irresponsible" or "poor corporate citizens" – determinations that could result in extensive pretrial discovery and substantial awards at trial.

The new Nursing Home Transparency Act prohibits walking away.

Potential new federal legislation will also require much greater corporate transparency and responsibility -- making uninsured operators *even more vulnerable* than they currently are. Under this new regulatory scheme, owners can be liable for criminal fraud and abuse if they walk away from a facility to avoid paying a judgment. The facility's responsibility to its residents upon facility closure has been dramatically altered to block an owner's "walk away" opportunity.

Piercing the Corporate Veil – a Tricky Area of Law

Some providers who consider forgoing liability insurance assume that they'll be protected by their corporate structure. Those high-risk gamblers believe that potential plaintiffs will never be able to "pierce the corporate veil", to get within the corporate structure to reach the assets of subsidiary corporations or individual shareholders. In reality, though, corporate veil law is extremely complex, making it a risky and expensive shield for protecting assets.

Does the corporate veil always protect personal assets?

Generally, shareholders, officers, and subsidiary corporations are "shielded by the corporate veil" unless they have committed fraud or abused the corporate form. In general terms, the corporate veil can be pierced, though, when three conditions are met:

- Shareholders disregard of the corporate entity makes it a **"mere instrumentality"** for transacting their own business; and
- There is such **unity of interest and ownership** that separate "personalities" of the corporation and owners no longer exist (e.g., record-keeping between the entities is confused); and
- Protecting the corporate entity would **promote injustice or protect fraud**.

When considering whether to shield the corporate veil, judges look closely at many facts. They must analyze the precise nature of corporate communications. They must scrutinize all the financial records of all corporate players, often applying techniques of forensic accounting. They must review all evidence of "control". In short, the judge must make a detailed analysis of all aspects of a corporation's operation.

What does it cost to defend personal assets?

In order to provide the judge with information to make this determination, extensive legal work is required. In my experience defending uninsured facilities, mounting an effective defense on these issues can cost at a minimum $100,000 or $200,000 in legal fees and expenses. In addition, depositions of all corporate owners are typically required before the judge can make any determination about the corporate structure. These depositions routinely involve hours of testimony about the owner's personal finances, assets and behaviors. While laws exist to protect this type of abusive discovery, judges don't like strategically uninsured operators. When a strategically uninsured operator moves the court for protection from invasive questioning, they usually don't do well.

The complexity of such an analysis makes it inherently difficult to predict how any specific court will rule on any individual corporate veil issue. As a result, most strategically uninsured providers will have *no choice* but to participate in fact-intensive litigation that *always* proves very costly, as attorneys and accountants invest time and effort to structure prevailing legal and factual arguments. While it can be very effective for providing protections in excess of traditional insurance limits, the corporate veil can be a costly and untrustworthy replacement for traditional insurance – one that can be avoided by obtaining and maintaining complete liability coverage.

Special Danger of Fraud

Fraud, one element of corporate veil cases but a separate legal count on its own, is a particularly dangerous charge because successful plaintiffs often recover punitive damages, in addition to other money awards.

Claims of fraud arise because providers typically present themselves as properly capitalized business entities with appropriate insurance to make plaintiffs whole in the unlikely event that liability is found. When such providers knowingly fail to obtain proper insurance, they commit fraud. Fraud, a legal cause of action by itself, might bolster plaintiffs' claims under many theories of state and federal law, including conspiracy or RICO (the Racketeer Influenced and Corrupt Organizations Act, which contains very broad definitions of "racketeering"). Substantial money damages – far greater than the cost of insurance premiums – may result.

Courts – and Public Policy – Favor Insured Parties

The primary goal of tort litigation is to make deserving plaintiffs whole for injuries they have suffered. Therefore, tort law has developed its extensive system of damages – compensatory, consequential (or "special"), and punitive. Public policy, striving to achieve the courts' "make whole" goal, favors full insurance or self-insurance programs, so that defendants found responsible for injury have pockets deep enough to pay.

While health care liability insurance is not yet mandated by statute in most states, judges have considered the issue of being intentionally uninsured in other contexts, and always favor the victim over the intentionally uninsured. Similar cases have been considered for decades in the area of auto insurance. States regularly mandate insurance coverage for all drivers, so that injured plaintiffs can be made whole. While the specific injuries differ between auto accidents and tortuous action in a long-term care setting, the public policy remains the same: courts want to protect innocent victims. Courts are likely to view with disfavor any defendant that purposely makes itself strategically unable to compensate plaintiffs after injury has been found. In fact, voluntarily choosing to go without the generally accepted standard of liability insurance raises the specter of substantial punitive damages – high dollar payouts designed to punish wrongdoers so that they change their behavior.

Pending Federal Legislation Ups the Ante Even Further

Following the money just got easier.

The Nursing Home Transparency and Improvement Act of 2009 (S. 647) was introduced by Senator Chuck Grassley on March 19, 2009 after advocacy groups and the media identified long term care providers who were attempting to exploit the rules of good corporate behavior. The Act is being considered as part of the overall health care bill making its way through Congress, and has already been passed by the House of Representatives. My

contacts in Washington tell me that it is widely supported on a bi-partisan basis and, if not passed as a part of healthcare reform, will undoubtedly resurface as another stand-alone bill.

When enacted as law, the Transparency Act will require the nursing home industry to disclose information about:

- The **identity of entities that own and operate** nursing homes;
- How facility profits are distributed, and to whom; and,
- Which corporations benefit financially from the operation of a facility.

If passed without amendment, the Transparency Act will substantially weaken the strength of corporate shields for nursing homes. By making all ownership information public as a condition of basic operation, the Transparency Act will create a roadmap for plaintiffs, pointing them toward all existing corporate assets. The Act will essentially define which corporate veils are available to be pierced. Combined with the strong public policy of making innocent tort victims whole after injury, the Transparency Act represents a substantial vulnerability for uninsured defendants.

I'll just give them the keys.

In addition to the well-publicized aspects of increased transparency, the pending legislation makes a provider liable for regulatory, civil and criminal liability if they walk away from a facility without giving at least 60 days notice, and making proper arrangements for safe transfer and placement of residents. While there have always been problems with walking away, this act makes it a regulatory problem with potential criminal implications. When counseling clients, advise them that the cost of a judgment-forced wind down of operations could last months, cost hundreds of thousands of dollars, and will not be reimbursed by Medicare or Medicaid.

Conclusion

While going without insurance may deter some smaller lawsuits, the legal landscape substantially favors the acquisition and maintenance of liability insurance for all corporate entities involved in health care. We strongly recommend that all of our clients operate as fully insured entities with *specifically tailored* insurance programs. We recommend retaining a full service retail insurance broker with at least 5 years experience working with long term care operators. Once that broker is on board, we counsel clients and their brokers to investigate all available insurance markets for the coverage that meets their needs. Since much is at stake, cost should not always be the primary driver. Some providers can offer greater control over defense, and increased long-term loyalty. Others offer turn-key defense with minimal impact on facility operations, but may not be a long term partner of the facility. An experienced LTC brokers can put together an insurance program that meets the needs of your operation.

As always, we are available to discuss the specifics of your company's needs in this challenging economic and legal environment. For more information, contact:

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