

**THE NEXT FRONTIER IN TORT REFORM:
PROMOTING THE FINANCIAL SOLVENCY
OF NURSING HOMES**

R. Patrick Bedell

Nursing homes provide a vital function in the American health care system, but the nursing home system has been plagued by abuse and neglect for decades. As a result of the abuses, states provided a right of action against nursing homes for insufficient quality of care. Litigation has been on the rise in recent years due to a greater influx of patients and a desire by the plaintiffs' bar to recover portions of ever-increasing jury awards. Unfortunately, the litigation costs along with the underfunding of nursing home facilities threaten the financial solvency of the nursing home industry. The increasing elderly population in the United States has only heightened the precariousness of the situation. In this note, Mr. Bedell propounds that enacting and strengthening existing tort reform with regard to nursing home litigation may alleviate some of the financial difficulties facing the American nursing home industry.

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The author would like to thank his grandparents, Leo and Mary Jo Bedell and Walter and Selina McGuire, for their constant support.

I. Introduction

Nursing homes serve a vital function within the American health care system: “they provide skilled nursing care and support to individuals who are not well enough to live at home, but not sick enough to require hospitalization.”¹ However, the problem of nursing home abuse has plagued the long-term care industry for decades.² States have responded to this problem by providing for a right of action in nursing home patients against nursing homes that do not provide sufficient quality care, but some states have recently made it harder to sue nursing home facilities.³

This note argues that such tort reform is desirable because the current nursing home tort regime imposes costs on the financially strained long-term care industry, while providing questionable benefits to patient care. Part II will illustrate legislative responses to litigation against nursing homes, demonstrated notably in tort reform legislation that strives to make it harder to bring a claim against a nursing home. Part III will outline the inspiration for recent tort reform in the nursing home tort regime, particularly the increased insurance costs attendant to tort liability and the underfunding of Medicaid programs that supply nursing homes with financial resources. Part IV argues for the implementation of tort reform, in light of the failure of the medical malpractice system to achieve its purported ends of deterrence and compensation, and considers the benefits of a national solution to problems that face the tort regime. Part V argues that Congress can address the financial problems that face the long-term care industry, while avoiding a corresponding sacrifice in patient care, by encouraging national tort reform on the state level through the financial incentive of increased Medicaid funding.

1. Angela Snellenberger Quinn, *Imposing Federal Criminal Liability on Nursing Homes: A Way of Deterring Inadequate Health Care and Improving the Quality of Care Delivered?*, 43 ST. LOUIS U. L.J. 653, 653 (1999).

2. Seymour Moskowitz, *Saving Granny from the Wolf: Elder Abuse and Neglect—The Legal Framework*, 31 CONN. L. REV. 77, 82–89 (1998).

3. See, e.g., FLA. STAT. ANN. § 400 (West 2002); 29 FLA. JUR. 2D *Hospitals, Nursing Homes and Related Health Care Facilities* § 45 (2003); Quinn, *supra* note 1, at 679; Armond Budish, *Lawmakers Make It Tougher to Sue Nursing-Home Operators*, THE PLAIN DEALER (Cleveland), Aug. 25, 2002, at L6, 2002 WL 6376466.

II. Background

A. The Rights of Nursing Home Patients

One of the problems that face the nursing home industry today is the negligent care for, or abuse of, nursing home patients.⁴ In response to problems of nursing home abuse, Congress passed the Nursing Home Bill of Rights in 1974 (NHBR) which conditioned Medicaid and Medicare funds on meeting federal standards.⁵ The NHBR promotes quality of resident care by providing that every resident “has the same right to a dignified existence in the home,” and that “every home is responsible to ensure that each resident is accorded this right.”⁶ In 1987, Congress passed the Federal Omnibus Budget Reconciliation Act (OBRA 1987) to further expand federal regulation of nursing homes.⁷ OBRA 1987 requires that long-term care facilities provide quality care for their residents.⁸ OBRA 1987 also provides a number of rights for nursing home patients that promote the patients’ well-being, such as the right to “reasonable accommodation of individual needs,” a “right to be free from restraints,” and a “right to voice grievances.”⁹

Congress has also imposed monetary penalties for noncompliance with federal standards.¹⁰ However, these amendments have not deterred deficient care as Congress had intended them to do, as at least 40% of nursing homes found noncompliant with federal standards still have not met federal standards of care.¹¹ The Health Care Financing Administration (HCFA), a division of the Department of Health and Human Services, found in a 1998 report that nursing home

4. INST. OF MED., IMPROVING THE QUALITY OF LONG-TERM CARE 76–77 (Gooloo S. Wunderlich & Peter Kohler eds., 2001). While evidence dictates that the quality of care in nursing homes has improved over the last ten years, quality of care problems are persistent, such as “insufficient attention to rehabilitation and restorative nursing.” *Id.* at 77. There are increasing problems in quality of care, “including lack of supervision to prevent accidents, improper care for pressure sores, and inadequate assistance with activities of daily living.” *Id.*

5. Kevin B. Dreher, *Enforcement of Standards of Care in the Long-Term Care Industry: How Far Have We Come and Where Do We Go from Here?*, 10 ELDER L.J. 119, 125–26 (2002).

6. *Id.* at 126.

7. *Id.* at 125.

8. *Id.*

9. *Id.* at 125–27.

10. Ellen J. Scott, *Punitive Damages in Lawsuits Against Nursing Homes*, 23 J. LEGAL MED. 115, 121 (2002).

11. *Id.* at 121–22.

patients “continued to suffer from both verbal and physical abuse as well as neglect.”¹² As federal regulations have attempted to ensure quality medical care, nursing homes are faced with the problem of improving the quality of their care.

State governments have supplemented the federal effort to improve nursing home quality of care with regulations of their own. OBRA 1987 explicitly stated that the enforcement of federal nursing home standards did not limit the imposition of state remedies.¹³ State governments, “realizing that the federal [government] enforcement sanctions provided for in OBRA [1987] and HCFA regulations simply are not enough to ensure that nursing home residents are free from abuse and neglect and provided with quality care, have enacted various state statutes to encourage private litigation.”¹⁴ For instance, the Alabama Supreme Court has upheld a common-law right of action against nursing homes even where a statutory cause of action is not supplied, noting that “in light of the large number of nursing home residents vulnerable to neglect, ‘the verdict would further the goal of discouraging others from similar conduct in the future.’”¹⁵ The State of Florida provides a right “to receive adequate and appropriate health care and protective support services,” “to be treated courteously, fairly, and with the fullest measure of dignity,” and “to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints.”¹⁶ If any of these rights are violated, Florida law provides a cause of action against the long-term care facility.¹⁷

B. Movement Toward Reform

Thus, while the federal government has tried to protect nursing home patients through regulation, states and patients have turned to the civil litigation system to achieve effective monitoring of the long-term care industry. However, states recently have considered the effects of litigation upon the nursing home industry. Over the last cou-

12. *Id.* at 118.

13. Quinn, *supra* note 1, at 673.

14. *Id.*

15. *Id.* at 679 (quoting *Montgomery Health Care Facility, Inc. v. Ballard*, 565 So. 2d 221, 226 (Ala. 1990)).

16. 29 FLA. JUR. 2D *Hospitals, Nursing Homes and Related Health Care Facilities* § 45 (2003).

17. *Id.*

ple of years, tort reform proposals aimed at reducing nursing home litigation have advanced in state legislatures.¹⁸ The Florida legislature passed nursing home tort reform in 2001, and Ohio enacted a nursing home tort reform statute in August of 2002.¹⁹ Nursing home tort reform was also proposed in the legislatures of Mississippi and Arkansas in 2001.²⁰

The Florida legislature amended its nursing home law to protect nursing homes from excessive litigation costs.²¹ The amendment eliminated the recovery of attorneys' fees whenever a plaintiff brought a successful suit, and allowed a defendant to recover fees only when the plaintiff's claim was proven frivolous.²² The new law restricts the award of such fees to cases where injunctive relief or administrative remedy is sought, and such fees are capped at \$25,000.²³ The law also makes it more difficult for a plaintiff to prove that a nursing home was negligent.²⁴ Previously, plaintiffs would argue that a nursing home was proven negligent when it did not meet the requirements of the Florida Administrative Code and the Federal Nursing Home Reform Amendments Act.²⁵ The new law places the burden on the plaintiff to prove that the defendant's breach of duty was the legal cause of "loss, injury, or death or damage to the resident," and that the "resident sustained loss, injury, death or damage as a result of

18. See, e.g., FLA. STAT. ANN. § 400 (West 2002); Reed Branson, *Panel OK's Tort Reform Bills; Doctors, Nursing Homes Cheer*, COM. APPEAL (Memphis), Feb. 6, 2002, at D58, 2002 WL 3461739 (reporting approval of tort reform proposal by Mississippi Senate Judiciary Committee); Budish, *supra* note 3; David Pilla, *Arkansas Lawmakers Seek to Limit Nursing Home Liability*, BEST'S INS. NEWS, Jan. 25, 2001, 2001 WL 4365145 (reporting that Arkansas legislature will consider nursing home tort reform House Bill 1382). Of course, tort reform proposals are not universally supported. See, e.g., Gregory Nathan Hoole, *In the Wake of Seemingly Exorbitant Punitive Damage Awards America Demands Caps on Punitive Damages—Are We Barking Up the Wrong Tree?*, 22 J. CONTEMP. L. 459 (1996) (criticizing congressional proposal to place caps on punitive damages); Neil Vidmar & Mary R. Rose, *Punitive Damages by Juries in Florida: In Terrorem and In Reality*, 38 HARV. J. ON LEGIS. 487, 511 (2001) (arguing that proposals in Florida for punitive damage reform unfounded, though neutral on whether tort reform is needed in that state).

19. FLA. STAT. ANN. § 400; Budish, *supra* note 3.

20. Branson, *supra* note 18 (reporting approval of tort reform proposal by Mississippi Senate Judiciary Committee); Pilla, *supra* note 18 (reporting that Arkansas legislature will consider nursing home tort reform House Bill 1382).

21. Tom J. Manos, *Florida's Nursing Home Reform and Its Anticipated Effect on Litigation*, FLA. B.J., Dec. 2001, at 1, 18.

22. *Id.* at 22.

23. FLA. STAT. ANN. § 400.023; Manos, *supra* note 21, at 22.

24. Manos, *supra* note 21, at 24, 25.

25. *Id.* at 24.

the breach,” before damages can be awarded.²⁶ The Florida law resolves prior uncertainty over whether the four-year statute of limitations provided in state negligence and statutory liability law or the two-year statute of limitations for medical malpractice and wrongful death is applicable in favor of the latter.²⁷ The statute also limits the award of punitive damages to instances where intentional transgression or gross negligence is proven by clear and convincing evidence.²⁸ Even if this is shown, the law limits the amount of damages that can be recovered to a tiered approach.²⁹ Under the first tier of the damages structure, if the plaintiff shows punitive damages are recoverable, she is eligible for the greater of “three times the amount of compensatory damages or \$1 million.”³⁰ The plaintiff is eligible for the second tier when “the fact finder determines that the wrongful conduct was motivated primarily by unreasonable financial gain *and* determines that the unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct” was known by managing staff.³¹ Under this tier, the jury may award the greater of “four times the amount of compensatory damages or \$4 million.”³² Furthermore, if the plaintiff proves the “defendant had *a specific intent to harm*,” and the fact finder determines the defendant’s conduct harmed the plaintiff, there is no cap on punitive damages.³³

The new Ohio statute similarly protects nursing homes from tort litigation.³⁴ The law limits punitive damages, and allows a jury to consider the nursing home’s ability to pay punitive awards and the impact such a payout would have upon its ability to provide services.³⁵ The statute provides that the conditions of a nursing home learned through state inspection, survey, or investigation cannot be used as evidence in a patient’s suit against his or her nursing facility.³⁶ Only the nursing home resident, his or her legal guardian or legally authorized representative, or specified family members may bring

26. FLA. STAT. ANN. § 400.023; Manos, *supra* note 21, at 24.

27. Manos, *supra* note 21, at 26.

28. *Id.* at 27.

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.*

34. Budish, *supra* note 3.

35. OHIO REV. CODE ANN. § 2315.21(E) (Anderson 2003); Budish, *supra* note 3.

36. OHIO REV. CODE ANN. § 3721.02(E)(1); Budish, *supra* note 3.

suit against the patient's nursing facility.³⁷ The law shortens the statute of limitations to file a claim against a nursing home from two years to one, and eliminates the award of attorneys' fees in abuse and neglect claims.³⁸ This law comes on the heels of a 1998 amendment to Ohio's Nursing Home Patients' Rights law that amended the provision for plaintiff recovery when the patient "received inappropriate or inadequate medical treatment or nursing care"³⁹ to permit recovery only when the nursing home workers exhibited "malice, aggravated or egregious fraud, oppression, or insult."⁴⁰ This standard of proof is very high.⁴¹

The tort reform proposed in Mississippi, which ultimately failed to pass,⁴² was introduced by the Senate Judiciary Committee to protect nursing homes by reducing the statute of limitations from three years to two and by designating patient records filed with Mississippi regulatory agencies confidential,⁴³ preventing residents' information to be given to anyone other than the resident.⁴⁴ Arkansas legislators have also proposed legislation that would reduce the statute of limitations on claims against nursing homes from a three- to five-year limit to a two-year limit, cap compensatory damages for noneconomic losses such as pain and suffering at \$250,000, and not allow a separate award for attorneys' fees.⁴⁵ It is evident that over the last two years state legislatures have considered bills and enacted laws designed to protect nursing homes from tort litigation. This note attempts to explain why tort reform legislation has recently been considered, and in some cases enacted, in various state legislatures.

III. The Causes of Tort Reform

Tort reform in claims against nursing homes has a number of causes. Recently, the nursing home industry has experienced financial strains. Between the fall of 1999 and April of 2000, "nationally,

37. OHIO REV. CODE ANN. § 3721.17(I)(b); Budish, *supra* note 3.

38. Budish, *supra* note 3.

39. Scott, *supra* note 10, at 123 (quoting *Blancett v. Nationwide Care, Inc.*, 1999 WL 3958, at *5 (Ohio App. Dec. 16, 1998)).

40. *Id.* (quoting OHIO REV. CODE ANN. § 2315.21(B)(1) & (2) (West 2000)).

41. *Id.*

42. Patrice Sawyer, *Nursing Home Records Bill Dies*, CLARION-LEDGER (Jackson, Miss.), Mar. 5, 2002, at 1B, 2002 WL 7615176.

43. *Id.*

44. *Id.*

45. Pilla, *supra* note 18.

more than 1,600 of the nation's 17,000 nursing homes . . . filed for bankruptcy."⁴⁶ Moreover, the nursing home industry is underfunded,⁴⁷ so litigation has placed a financial stress upon an already financially strapped industry. Therefore, states have turned to tort reform as a means of limiting costs upon nursing homes.⁴⁸

A. The Costs of Tort Litigation: Impact on Insurance

1. INSURANCE RATES ARE INCREASING

Nursing homes are faced with increasing liability insurance costs.⁴⁹ In Florida, increasing insurance costs have caused at least ten insurance carriers to leave the Florida market or to stop underwriting new business.⁵⁰ An actuarial study performed by Aon Worldwide Actuarial Solutions found that "loss costs" in the nursing home industry "have increased at an unprecedented annual rate of 20% in most states over the past five years and 37% in Florida."⁵¹ In 1999, the average loss costs per patient in Florida was \$6,283, in Texas, \$2,456, and in all other states, \$514.⁵² These costs "have driven most admitted writers from the market."⁵³ The Aon study surveyed nursing homes in the Florida market and determined that while 40% of their losses were attributable to their Florida operations, Florida only represented 10% of

46. Vickie Chachere, *Florida Nursing Homes Struggle with Lawsuits—Industry Officials Warn Increasing Insurance Costs May Force Care Centers to Close Doors*, STARLEDGER (Newark, N.J.), Apr. 23, 2000, at 025, 2000 WL 18943137.

47. See *Long-Term Care Financing: Blueprints for Reform: Hearings Before the Senate Special Comm. on Aging*, 107th Cong. 116 (2001) [hereinafter *Blueprints for Reform*] (statement of Steven Chies, Vice Chair, American Health Care Association).

48. There has been a significant increase in tort liability since the 1950s, which has resulted in calls for reform of the tort system and to reduce the scope of liability. ELEANOR DEARMAN KINNEY, *PROTECTING AMERICAN HEALTH CARE CONSUMERS* 64 (2002). Most tort reform efforts have attempted to limit the "frequency and severity of tort claims" by limiting the ability of plaintiffs to be awarded large damages from defendants. *Id.* Tort reform has also been justified on the grounds that tort law has failed to achieve its objectives of compensation for losses stemming from an injury and the deterrence of injury-causing conduct. *Id.*; see Jennifer Gimler Brady, *Long-Term Care Under Fire: A Case for Rational Enforcement*, 18 J. CONTEMP. HEALTH L. & POL'Y 1, 42 (2001).

49. Leslie Werstein Hann, *As Nursing Home Liability Losses Soar, Carriers Stop Writing Business*, BESTWIRE, Feb. 7, 2000, at http://www.lexis.com/research/retrieve/frames?_m=fc69bd466812a43f51ab106b752489fa&csvc=bl&cform=bool&fmtstr=FULL&docnum=1&_startdoc=1&wchp=dGLbVlb-zSkAb&_md5=15089e9c0eeb4393a0bab6d9e728cb1e.

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

their business.⁵⁴ Nationally, the cost for a nursing home to insure itself against malpractice rose from \$150 a bed in 1992, to \$700 a bed in 1998.⁵⁵

Insurers have responded to the increased costs of funding long-term care facilities by raising premiums (thus, increasing the risk that nursing homes must bear on their own), exiting markets, and not renewing operations with clients.⁵⁶ In 2000, the nursing home operator Eskaton paid \$100,000 for liability insurance, but in 2002 it paid \$700,000 for less coverage.⁵⁷ In 2000, the “average cost of liability insurance in California was about \$125 per bed for \$1 million in coverage. In 2001, it averaged about \$650 per bed.”⁵⁸ In 2002, the price of liability insurance in California averaged \$1,100 a bed.⁵⁹ The cost of liability insurance in Florida rose to \$7,000 a bed in 2002.⁶⁰ By 2000, insurance premiums rose nationally by 150% over premiums twelve to eighteen months earlier.⁶¹ As a result of increasing premiums, some nursing homes have opted to simply go without insurance coverage.⁶² The president of the Texas Health Care Association, an association that represents for-profit nursing homes, reported that 430 Texas nursing homes, close to 40% of the nursing homes in that state, do not have insurance.⁶³ Without liability insurance, a nursing home is exposed to bankruptcy if a large monetary judgment is rendered against it, possibly leaving some patients without care.⁶⁴ Other nursing home operators cut costs by ceasing operation of some facilities.⁶⁵

2. JURY AWARDS ARE BLAMED FOR INCREASED INSURANCE RATES

The nursing home industry has blamed rising liability insurance costs and financial difficulties faced by nursing homes on excessive

54. *Id.*

55. Brady, *supra* note 48, at 42.

56. Hann, *supra* note 49.

57. Kathy Robertson, *Nursing Homes Priced Out of Insurance*, E. BAY BUS. TIMES (Pleasanton, Cal.), Mar. 15, 2002, <http://philadelphia.bizjournals.com/eastbay/stories/2002/03/18/>.

58. *Id.*

59. *Id.*

60. *Id.*

61. Hann, *supra* note 49.

62. Naomi Snyder, *Insurance Costs Soar, State Law Will Require Facilities to Buy Coverage Next Year*, CORPUS CHRISTI CALLER-TIMES, July 21, 2002, at D1.

63. *Id.*

64. *Id.*

65. *Id.*

jury awards to plaintiffs who sue nursing homes.⁶⁶ The industry has attributed this to the ease with which plaintiffs can sue, and win claims against, nursing homes.⁶⁷ Nursing homes have cited the Florida plaintiffs' bar as responsible for the litigation costs nursing homes must incur.⁶⁸ Their argument is supported by the Aon study, which concluded that "[i]nsurance companies continue to exit [Florida] and cannot provide coverage when faced with this magnitude of losses, explosion in growth of claims, and extreme unpredictability of results."⁶⁹ The report also found that "[t]he increase in the average Florida Medicaid reimbursement rate from \$86 per day in 1995 to \$114 per day in 2000 has been entirely offset by rising liability costs."⁷⁰ Increased litigation has also made it more difficult to obtain insurance coverage.⁷¹ The Florida Department of Insurance found an inverse relationship between the reduction in insurance coverage, and the rise in damage awards to plaintiffs.⁷² The great rise in Florida "loss costs"⁷³ has "made it nearly impossible for insurers to predict results, thus curtailing insurer willingness to write policies for Florida long-term care providers."⁷⁴

This view has been considered by state legislatures that have recently debated tort reform and adopted by those that have enacted such reform. The costs imposed upon nursing homes by jury awards to patients is explicitly cited within Arkansas House Bill 1382 as the

66. Chachere, *supra* note 46.

67. *Id.*

68. *Id.*; Robertson, *supra* note 57.

69. THERESA W. BOURDON & SHARON C. DUBIN, AON RISK CONSULTANTS, FLORIDA LONG TERM CARE, GENERAL LIABILITY AND PROFESSIONAL LIABILITY ACTUARIAL ANALYSIS 3, <http://www.fhca.org/fhca/reimb/pdf/aonstudy2.pdf> (last visited Aug. 20, 2003). Florida's long-term care has been particularly burdened by increased costs. Florida "has an annual cost per nursing home bed 12 times the national average," and "nursing home operators in Florida withstand over four claims to every one in the rest of the nation." Terrance J. Shanahan, *Statutory Limits on Punitive Damages in Nursing Home Negligence Tort Actions: Preventing the Collapse of the Private Nursing Home*, 4 J. HEALTH CARE L. & POL'Y 373, 384 (2001).

70. BOURDON & DUBIN, *supra* note 69, at 3.

71. See Shanahan, *supra* note 69, at 384-85.

72. *Id.* at 383.

73. The Aon Risk Consultants study defines "loss cost" as "the cost per exposure of settling and defending claims. Loss cost is calculated as the ratio of total dollars of losses . . . to total exposures for a given period of time." BOURDON & DUBIN, *supra* note 69, at 25.

74. Shanahan, *supra* note 69, at 385.

basis for making it more difficult to sue nursing homes.⁷⁵ This bill argues that

the cost of claims by residents of long-term care facilities is a significant cost for long-term care facilities; that under the present law there is no reasonable limitation upon either the amount of recoveries under such claims, or the procedure utilized or evidence considered in respect to the recoveries . . . and that it is necessary to have a reasonable limitation on these matters in order to provide affordable and accessible care for long-term care facility residents.⁷⁶

In Florida, industry analysts feared that the increase in litigation against nursing homes would lead insurance providers to leave the state.⁷⁷ The rise in jury awards caused “either doubled insurance rates” or “liability insurers to leave the state altogether.”⁷⁸ In response to excessive verdicts, Florida nursing homes must face the prospect of closing down.⁷⁹ Excessive awards would “be devastating to the provider market,” which in turn would harm patients because “excessive closings could cause transfer trauma and a shortage of providers, analogous to the obstetrician shortage caused by rising malpractice premiums in the late 1980s.”⁸⁰

The Department of Health and Human Services also attributes rising insurance costs to litigation against nursing homes.⁸¹ The Department found that

nursing home malpractice costs are rising rapidly because of dramatic increases in both the number of lawsuits and the size of awards. Nursing homes are a new target of the litigation system. Between 1995 and 2001, the national average of insurance costs increased from \$240 per occupied skilled nursing bed per year to \$2,360. From 1990 to 2001, the average size of claims tripled, and the number of claims increased from 3.6 to 11 per 1,000 beds.⁸²

The Department notes that Florida had one of the highest costs per bed in 2001 at \$11,000, and that recently, nursing homes in Mississippi have faced liability cost increases up to 900%.⁸³ Although litigation has driven liability costs to crisis levels, this crisis is less pronounced

75. Pilla, *supra* note 18.

76. *Id.*

77. Jennifer L. Williamson, *The Siren Song of the Elderly: Florida's Nursing Homes and the Dark Side of Chapter 400*, 25 AM. J.L. & MED. 423, 440 (1999).

78. *Id.*

79. *Id.*

80. *Id.* at 440–41.

81. H.R. REP. NO. 107-693, pt. 1, at 16 (2002).

82. *Id.*

83. *Id.*

in states that have passed tort reform.⁸⁴ The Department observes that “[s]tates with limits of \$250,000 or \$350,000 on non-economic damages have average combined highest premium increases of 12–15%, compared to 44% in states without caps on non-economic damages.”⁸⁵

When insurance companies are no longer willing to insure nursing homes, the long-term care providers are deprived of an important means of insulating themselves from the high costs of health care. Insurance provides an opportunity for “risk-averse individuals to accept a small *certain* loss in preference to a large *uncertain* loss. An insurance system effectively *transfers* accumulated premiums from the insured, for whom the insured-against event did not occur to the insured for whom the insured-against event did occur.”⁸⁶ Insurance is, therefore, a financial mechanism that allows risks of financial loss to be spread across a large group of individuals.⁸⁷ The risks attendant to long-term care can and should be spread through insurance.⁸⁸ The primary methods of funding long-term care, private payments (which constitutes almost half of long-term care funding) and Medicaid, lack the risk-pooling provided by insurance.⁸⁹ Such funding leaves nursing homes exposed to substantial financial risk if insurance companies are unwilling to underwrite them.

B. Medicaid: An Important Source of Nursing Home Funding

As the elderly population in this country increases, there will be a corresponding “increase in demand for long term care services.”⁹⁰ Because Medicaid covers long-term care when a patient “spends down to her last \$2,000 in non-exempt assets,” the pending increase in demand for long-term care has governments, along with individuals and families, “expressing alarm at the prospect of going bankrupt in an attempt to meet and finance” this growing demand.⁹¹ While the

84. *Id.*

85. *Id.*

86. Yung-Ping Chen, *A “Three-Legged Stool” for Financing Long-Term Care*, in *A SECURE OLD AGE, APPROACHES TO LONG-TERM CARE FINANCING* 85, 87 (Kathleen H. Wilber et al. eds., 1997).

87. *Id.*

88. *Id.* at 88.

89. *Id.*

90. Jason A. Frank, *The Necessity of Medicaid Planning*, 30 U. BALT. L.F. 29, 29 (1999).

91. Jan Ellen Rein, *Misinformation and Self-Deception in Recent Long-Term Care Policy Trends*, 12 J.L. & POL. 195, 210 (1996).

government does not provide the sole financing for long-term care, public funding is the primary financial support for the industry.⁹² Long-term care is expensive; in 2000, total spending on long-term care was about \$137 billion.⁹³ Nationally, the average annual cost for a stay at a nursing home is \$50,000.⁹⁴ Medicaid, which is funded jointly by federal and state governments and given to individuals with low income, is the largest source of funding for long-term care.⁹⁵ In 2000, Medicaid provided \$63 billion in funding towards the long-term care industry, which is 46% of all long-term care spending.⁹⁶ Indeed, Medicaid remains a vital source of funding for nursing homes, as individual nursing home patients are not in a financial position to fund all of their care themselves.⁹⁷

Demand for long-term care will increase as individuals live longer and the elderly compose a greater percentage of the nation's

92. U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, SPECIAL COMMITTEE ON AGING, U.S. SENATE, LONG-TERM CARE, AVAILABILITY OF MEDICAID HOME AND COMMUNITY SERVICES FOR ELDERLY INDIVIDUALS VARIES CONSIDERABLY 1 (2002) [hereinafter GAO REPORT].

93. *Id.* at 7.

94. *Blueprints for Reform*, *supra* note 47, at 116 (statement of Steven Chies, Vice Chair, American Health Care Association).

95. GAO REPORT, *supra* note 92, at 1. An individual qualifies for Medicaid coverage for nursing home care when the patient is at least age sixty-five, meets the state's definition of a disabled individual or suffers from blindness, is a U.S. citizen or permanent resident alien who requires a type of care that can be provided only in nursing homes, and meets an income and asset requirement. JOSEPH A. GIACALONE, THE U.S. NURSING HOME INDUSTRY 94 (2001). The fourth requirement necessitates a government evaluation of the patient's ability to fund his or her long-term care. *Id.*

96. GAO REPORT, *supra* note 92, at 7. "For most nursing homes, Medicaid resident days comprise more than two-thirds of the total resident days." GIACALONE, *supra* note 95, at 96.

97. The cost of a month's stay at a nursing home is \$4,500, which can present too great a cost for many individuals, especially if they can no longer obtain employment. *Long-Term Care: Who Will Care for the Aging Baby Boomers: Hearing Before the Senate Special Comm. on Aging*, 107th Cong. 28 (2001) [hereinafter *Aging Baby Boomers*] (statement of David F. Durenberger, Chairman, Citizens for Long-Term Care). A protracted stay has the potential to "consume a lifetime of financial resources." *Id.* A patient is not eligible for Medicaid assistance, the primary supplier of public assistance to nursing home patients, until the patient has reached a certain level of financial impoverishment. *Id.* With an aging population, the costs of long-term care, already high, will become increasingly more expensive. *Id.* at 29. Moreover, "other demographic changes, including families living farther apart, two-wage earner families, and smaller families indicate there will be relatively fewer adult children upon which elderly parents or siblings in need of long-term care will be able to depend." *Id.*

population.⁹⁸ The U.S. Bureau of the Census determined that individuals aged eighty-five or older are most likely to require nursing home care.⁹⁹ By the year 2020, the number of individuals aged eighty-five or older will have doubled from its predicted 2010 level of 3.5 million people.¹⁰⁰ This number will double again by 2040, with a population of 14 million over eighty-five.¹⁰¹ As the number of elderly increases during this time period, the number of workers per retiree who supply the tax dollars for long-term care public funding will decrease from approximately 4.75 workers in 2010, “to about 2.75 workers per retiree in 2040.”¹⁰² As a result of these demographic changes, “Medicaid spending for long term care will continue to consume increasingly greater portions of the gross domestic product and of state budgets while the revenue base in states shrinks during the first half of this century.”¹⁰³ In the fiscal year 2002, rising Medicaid costs attributable to rising long-term care expenses contributed to state budget problems in forty states.¹⁰⁴ In response to this trend, American taxpayers will either be faced with an increasingly onerous tax burden¹⁰⁵ or public funding per patient in need of long-term care will necessarily decline.

1. UNDERFUNDING

Long-term care has historically suffered from underfunding relative to the public funds granted acute care.¹⁰⁶ One reason for historic underfunding is that long-term care is not perceived by Americans as a pressing need.¹⁰⁷ Many Americans view the long-term care industry

98. *Blueprints for Reform*, *supra* note 47, at 95 (statement of Carol O’Shaughnessy, Specialist in Social Legislation, Congressional Research Service, noting the anticipated dramatic increase in world elderly population).

99. *Id.* at 115 (statement of Steven Chies, Vice Chair, American Health Care Association).

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.* at 117.

104. *Aging Baby Boomers*, *supra* note 97, at 56 (statement of David F. Durenberger, Chairman, Citizens for Long-Term Care).

105. See *Blueprints for Reform*, *supra* note 47, at 118 (statement of Steven Chies, Vice Chair, American Health Care Association) (finding that “the number of workers per retiree is declining; the tax base is simply not there to financially sustain programs for the elderly including long term care”).

106. Kathleen H. Wilber et al., *Long-Term Care Financing: Challenges and Choices Confronting Decision Makers*, in *A SECURE OLD AGE, APPROACHES TO LONG-TERM CARE FINANCING*, *supra* note 86, at 17.

107. *Id.* at 17.

with a “combination of fear and denial grounded in our cultural aversion to dependency.”¹⁰⁸ Most Americans have little contact with nursing home patients and nursing homes are not noticed or well understood by the general population.¹⁰⁹ Current workers and their employers, normally very influential in the development of health care benefits, are not likely to view long-term care as a significant problem, and consequently it is rare that health benefits provided by an employer will include long-term care coverage.¹¹⁰

As the demand for long-term care has increased, the public funding that is provided for it has been reduced. Recent budget cuts have contributed to the financial problems facing nursing homes.¹¹¹ In 1997, Medicaid was responsible for 50% of nursing home funding, and Medicare provided 9% of their funding.¹¹² However, this funding has left the nursing home industry vulnerable to federal budget cuts. The Balanced Budget Act of 1997 “cut \$115 billion from entitlement programs, particularly Medicaid and Medicare, to balance the budget.”¹¹³ The Balanced Budget Act provided that nursing homes would no longer be funded under a “cost-based reimbursement” system, and supplied their funding through a “prospective payment system.”¹¹⁴ As a result of this Act, caps are placed on the amount of reimbursement nursing homes receive for the costs incurred in the care of a spe-

108. *Id.*

109. *Id.* at 18.

110. *Id.*

111. Hann, *supra* note 49.

112. *Id.* Until the early 1980s, Medicare was operated under a “fee-for-service” system in which the provider was reimbursed for hospital stays under retrospective costs. GIACALONE, *supra* note 95, at 92. However, in response to rapidly rising costs, the federal government introduced a new system of payment under Diagnosis-Related Groups (DRGs) and a prospective payment system (PPS), in which “diagnoses are classified into 23 major categories that are further divided into 477 subcategories.” *Id.* The DRG is determined by a doctor’s diagnosis, which determines the amount of payment to providers. *Id.* Each DRG has a PPS. *Id.* The DRG payment system provides an incentive to reduce the time of stay when the patient receives expensive care, and in order to be profitable the care is kept “at or below the preestablished payment for the procedure.” *Id.* The 1983 Medicaid reimbursement system has controlled costs in the hospital setting, but has also resulted in premature discharges from the hospital while requiring further recovery in nursing homes. *Id.* “The introduction of prospective payments to hospitals in 1983 was the cause of a significant rise in the utilization of home health care and nursing facilities.” *Id.* Thus, the Medicare system itself has made nursing homes an important source of care for patients who are eligible for public insurance benefits.

113. Brady, *supra* note 48, at 39.

114. *Id.*

cific patient.¹¹⁵ This change was at first welcomed by the nursing home industry, “but it soon became apparent that the payment rate schedule and inflation adjuster . . . was too low.”¹¹⁶ While the Medicare reforms of the Balanced Budget Act were intended to cut federal aid to skilled nursing facilities by one out of every six dollars previously granted, the reductions are projected to be twice that amount.¹¹⁷

As a result, the financial stability of the long-term care industry has been impaired.¹¹⁸ Several of the largest long-term care corporations, such as Vencor Inc. (the country’s single largest nursing home operator), Mariner Post Acute Network Inc., Lenox Healthcare Inc., Integrated Health Services Inc., and Sun Healthcare Group Inc., in addition to a number of regional corporations, have filed for Chapter 11 bankruptcy protection since the enactment of the Balanced Budget Act.¹¹⁹ A report by BDO Seidman found that Medicaid underfunded “skilled nursing care” by about \$3.3 billion in 1999, and by \$4 billion in 2000.¹²⁰

Thus, over the past several years, cuts in federal spending have contributed to the financial difficulties of the long-term care industry. These Medicaid cuts, when coupled with the failure of private long-term care insurance to catch on with Americans, “color darkly the financial climate within which the nursing home industry operates.”¹²¹ Although Congress attempted to mitigate the underfunding of nursing homes in the Balanced Budget Refinement Act of 1999 by increasing the funding rate for the “frailest older skilled nursing facility” patients, the impact of that act remains uncertain.¹²²

115. Nathalie D. Martin & Elizabeth Rourke, *Les Jeux Ne Sont Pas Faits: The Right to Dignified Long-Term Care in the Face of Industry-Wide Financial Failure*, 10 CORNELL J.L. & PUB. POL’Y 129, 135 (2000).

116. Brady, *supra* note 48, at 39.

117. *Nursing Home Bankruptcies: What Caused Them?: Hearing Before the Senate Special Comm. on Aging*, 106th Cong. 31 (2000) (testimony of Dr. Charles Roadman, President, American Health Care Association), <http://aging.senate.gov/oas/hr57cr.htm>.

118. Brady, *supra* note 48, at 39.

119. *Id.*

120. *Blueprints for Reform*, *supra* note 47, at 117 (statement of Steven Chies, Vice Chair, American Health Care Association).

121. Marshall B. Kapp, *The Nursing Home Crisis: Views from a Trustee in the Non-profit Sector*, J. HEALTH CARE L. & POL’Y 308, 316 (2001).

122. *Id.* at 316–17.

2. STATES EXPEND MEDICAID LONG-TERM CARE FUNDS

Medicaid was not designed to serve as the primary funding of long-term care services.¹²³ However, in spite of low enrollment increases, long-term care costs have increased starkly.¹²⁴ The significant annual increase in Medicaid long-term care payouts “have had an unintended and unfortunate impact on state budgets resulting in dramatic increases in state Medicaid expenditures.”¹²⁵ As a result, Medicaid is the fastest growing state expenditure, increasing from a 3% state budget average in the mid 1960s¹²⁶ to constitute an expected 20% of state budgets in 1999, at a total expenditure of \$243 billion a year.¹²⁷ States “use substantial amounts of their own money for long-term care without federal matching dollars or federal grants.”¹²⁸ States also expend their own money to fund residents who are not financially eligible for Medicaid.¹²⁹

Given the states’ financial contribution to long-term care funding, it is in the interests of states to address the costs tort litigation imposes on nursing homes. One possible solution is to limit recovery against nursing homes in order to alleviate the financial liability such a regime imposes.¹³⁰ Therefore, a consideration of the merits of tort reform as a solution to rising costs upon the long-term care industry is in order.

IV. Tort Reform Is Needed

A. Tort Litigation Is a Costly Means of Protecting Patients

The use of litigation to enforce the rights of patients comes with certain costs. The costs of medical litigation are borne by the patient it is meant to protect and by society.¹³¹ Evidence suggests excessive litigation does not improve the quality of patient care¹³² and may impose

123. Wilber, *supra* note 106, at 15.

124. *Id.*

125. *Id.* at 16.

126. *Id.*

127. Stacy Rummel, *Missouri Children’s Health Initiative: Politics and the Push Towards Universal Access*, 43 ST. LOUIS U. L.J. 1511, 1516 (1999).

128. INST. OF MED., *supra* note 4, at 69.

129. *Id.*

130. See Pilla, *supra* note 18.

131. David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (if Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1644 (2002).

132. Brady, *supra* note 48, at 42.

costs on nursing homes that make it harder for nursing homes to provide funds necessary for adequate care.¹³³ Tort litigation sometimes imposes costs on nonculpable actors, as it is subject to a rate of error.¹³⁴ Moreover, nursing home tort litigation may not achieve the quality patient care protection that could justify the costs of the tort system: nursing home litigation can lead to a downward spiral in quality of care¹³⁵ that is uniquely subject to error.¹³⁶ Additionally, the medical negligence regime does not always achieve its purported ends of compensation¹³⁷ and appropriate deterrence.¹³⁸

1. MEDICAL LITIGATION IS EXPENSIVE

The use of litigation as a means of enforcing nursing home patients' rights can be costly. The costs incurred by nursing homes in the form of increased insurance rates as a result of defending claims was demonstrated above.¹³⁹ However, patients also carry the cost of medical litigation, because most of the expense of litigation "is ultimately borne by patients in the form of higher medical fees."¹⁴⁰ The litigation system also produces social costs, because for "every dollar that reaches an injured patient, almost two additional dollars are spent getting it there."¹⁴¹ Thus inefficiency in the tort system makes it an expensive enforcement vehicle to society as well.

2. NURSING HOME LITIGATION CAN LEAD TO A DOWNWARD SPIRAL IN QUALITY OF CARE

While nursing homes have incurred the costs of tort litigation in the form of increased liability insurance and financial pressure on long-term care facilities, "[t]he value of tort litigation as a means of resolving nursing home quality of care and quality of life issues is dubious at best."¹⁴² Litigation itself requires nursing facilities to allocate limited resources to litigation at the expense of patient care.¹⁴³ The tort system is a flawed means of protecting patients because although

133. Brady, *supra* note 48, at 42; Williamson, *supra* note 77, at 439.

134. Moskowitz, *supra* note 2, at 148-49.

135. Williamson, *supra* note 77, at 439.

136. Moskowitz, *supra* note 2, at 148.

137. See, e.g., Hyman, *supra* note 131, at 1644.

138. See, e.g., *id.* at 1645.

139. See *supra* text accompanying notes 61-79.

140. Hyman, *supra* note 131, at 1644.

141. *Id.*

142. Brady, *supra* note 48, at 43.

143. *Id.*

legitimate claims are filed against nursing homes, nursing facilities must also expend resources to defend frivolous lawsuits.¹⁴⁴ Every year “many claims of abuse and neglect are proven to be completely false.”¹⁴⁵ Thus, the money spent on defending such claims does not promote the end of patient care, rather, that money is wasted. Moreover, a nursing care industry overborne with frivolous claims can lead to a “vicious cycle: a nursing home functions at a standard level; gets sued under Chapter 400 for minor violations; pays out in settlement or verdict, reducing the facility’s operating resources; thereby causing care to suffer as a result. As a consequence, the facility receives a poor rating and additional suits follow.”¹⁴⁶

Additionally, nursing home litigation can encourage staffing problems at long-term care facilities.¹⁴⁷ The Health Care Financing Administration reports a strong correlation between nursing home staffing levels and the quality of care at nursing homes.¹⁴⁸ Their report indicates that 54% of nursing homes were below the suggested nurses aides minimum staffing level, 31% were below the registered nurses suggested minimum level, and 23% were below the minimum for total suggested licensed staff.¹⁴⁹ Even when the employees in an understaffed nursing facility work at unrealistically high levels of production, most residents do not receive an appropriate quality of care.¹⁵⁰ As nursing homes are in need of increased staffing levels, the threat of large punitive damages may inhibit prospective employees from entering into an industry saddled with costly litigation.¹⁵¹ Also, an overly burdensome tort liability can encourage excessive caution on behalf of the nursing homes.¹⁵² The onus of tort litigation could encourage nursing facilities to restrict the mobility of its patients, because it may be cheaper for a facility to be fined for noncompliance

144. *Id.*

145. *Id.* at 45.

146. Williamson, *supra* note 77, at 439.

147. See Brady, *supra* note 48, at 42.

148. *Nursing Home Residents: Shortchanged by Staff Shortages, Part II: Hearing Before the Senate Special Comm. on Aging*, 106th Cong. 6 (2000) (testimony of Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration), <http://aging.senate.gov/oas/hr55sum.htm>.

149. *Id.* at 13.

150. *Id.* at 37 (testimony of John F. Schnelle, Borum Center for Gerontological Research, Los Angeles Jewish Home for the Aging, UCLA School of Medicine).

151. Brady, *supra* note 48, at 43.

152. See *id.* at 45.

with quality of life standards than to incur the risk and litigation costs that arise when a patient suffers an injury from a fall.¹⁵³

3. NURSING HOME LITIGATION IS SUBJECT TO ERROR

Litigation does not automatically secure the protection of the rights of all nursing home patients because suits on behalf of the elderly present special litigation problems.¹⁵⁴ The elderly are more likely to suffer from physical disabilities and impairments that “diminish their health, strength, and mobility.”¹⁵⁵ The predilection of the elderly to such injury can be cited by defendant nursing homes as the true cause of a patient’s injury, rather than abuse or neglect.¹⁵⁶ The fact finder could become confused as to whether an injury is owed to such propensity or to the nursing home’s violation of its duty of care.¹⁵⁷ Furthermore, with litigation comes delay, and it is an unfortunate reality that elderly patients may not survive the duration of their claim.¹⁵⁸ The elderly may make poor witnesses “because of speech, hearing, or other physical impairments.”¹⁵⁹ The testimony of nursing home patients is also complicated by poor memory or intimidation.¹⁶⁰ Nursing home litigation thus presents substantial costs in the form of a “downward spiral” created by the increasing pressure litigation costs place upon the nursing home industry, as well as a chance of error in claims filed against nursing homes.

4. HEALTH CARE LITIGATION FAILS TO ACHIEVE REDISTRIBUTION

One of the purported goals of the civil liability regime is to compensate injured plaintiffs for injuries suffered as a result of the defendant’s negligence.¹⁶¹ However, the benefits of tort litigation are arbitrarily distributed to plaintiffs that merit compensation.¹⁶² The Mello-

153. *Id.* Patient mobility is promoted as part of federal requirements that nursing homes “maintain the highest practicable physical, mental, and psychosocial well-being.” 42 C.F.R. § 483.25 (2002).

154. Moskowitz, *supra* note 2, at 148.

155. *Id.*

156. Brady, *supra* note 48, at 44; Moskowitz, *supra* note 2, at 148.

157. Moskowitz, *supra* note 2, at 148.

158. *See id.* at 149.

159. *Id.*

160. *Id.*

161. *See* Jeffrey O’Connell & James F. Neale, *HMO’s, Cost Containment, and Early Offers: New Malpractice Threats and a Proposed Reform*, 14 J. CONTEMP. HEALTH L. & POL’Y 287, 294 (1998).

162. *Id.* at 295. O’Connell and Neale cite Paul C. Weiler, who notes:

Brennan study, conducted over the course of more than ten years,¹⁶³ looked at the effects of medical malpractice litigation upon the health care industry and revealed that only approximately 2% of patients who were injured as a result of negligent medical care filed a claim.¹⁶⁴ Further, “[f]or every doctor or hospital against whom an invalid claim is filed, there are seven valid claims that go unfiled.”¹⁶⁵ A “substantial majority” of malpractice claims filed against a health care provider are cases in which no negligence was involved, and in many claims, no adverse event even occurred.¹⁶⁶ Therefore, the overwhelming majority of claims against health care providers will, even if the court finds for the plaintiff, not achieve a redistributive effect. The study also demonstrates that “in an appreciable percentage of cases,” the court found the defendant liable and awarded damages to the plaintiff “when there was no negligence or adverse event, and [did] not award[] damages when there was negligence.”¹⁶⁷ “Indeed, the best predictor of the size of an award is the severity of the disability, not whether there was negligence or an adverse event.”¹⁶⁸ Consequently, distribution of awards to injured plaintiffs is administered through a “lottery-like” civil justice system.¹⁶⁹ Moreover, because 47% of the costs imposed on nursing homes go to lawyers and other litigation costs, the aggrieved patient or family member receives little over

[T]ort benefits are doled out in a rather arbitrary manner to some—but not most—deserving victims, and also to those persons who are not “deserving” within tort law’s fault-based frame of reference. Even worse, to make payment to the relative handful of patients who do surmount the natural and legal barriers to demonstrating legal entitlement to damages, the malpractice system must spend an inordinate amount of both time . . . and money—nearly sixty cents of the malpractice insurance dollar—litigating whether the doctor was at fault so that the victim can be compensated.

Id. (quoting Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 915 (1993)).

163. Hyman, *supra* note 131, at 1641–42.

164. *Id.* at 1643.

165. *Id.* (quoting Michael J. Saks, *Medical Malpractice: Facing Real Problems and Finding Real Solutions*, 35 WM. & MARY L. REV. 693, 703 (1994)).

166. *Id.* at 1643.

167. *Id.*

168. *Id.* at 1643–44.

169. O’Connell & Neale, *supra* note 161, at 295 (citing David S. Starr, *The No-Fault Alternative to Medical Malpractice Litigation: Compensation, Deterrence, and Viability Aspects of a Patient Compensation Scheme*, 20 TEX. TECH L. REV. 803, 806 (1989)).

half their award.¹⁷⁰ The medical malpractice litigation system has struggled to achieve redistribution to injured plaintiffs.

5. **HEALTH CARE LITIGATION DOES NOT PROVIDE ADEQUATE DETERRENCE**

Another goal of the tort system is to deter negligent actors from repeated negligent behavior.¹⁷¹ In order for tort litigation to successfully deter negligent health care providers, it “must accurately and fairly assess liability in order to deter potential wrongdoers without affecting the behavior of non-negligent providers.”¹⁷² The health care litigation system is subject to problems of overdeterrence, where liability is imposed on health care providers even though the provider was not negligent.¹⁷³ Only a low number of patients who suffer injury as a result of negligent care file claims against their providers.¹⁷⁴ Further, studies report that “pain and suffering” damages are levied on the basis of whim and bias as much as by evidence.¹⁷⁵ As a result of overdeterrence caused through such whim and bias, health care practitioners believe they are vulnerable to irrational imposition of pain and suffering damages and, as a result, practice “defensive medicine” in order to protect themselves from liability.¹⁷⁶ The overdeterred health care provider will perform unnecessary medical tests to preclude legal liability¹⁷⁷ and will hesitate to perform more difficult medical procedures.¹⁷⁸ Even when a nonnegligent provider prevails at trial, it still must expend resources to defend itself against the plaintiff’s claim, leaving the deterrent effect of litigation murky because the provider had to expend resources even when it was not culpable.¹⁷⁹ The result is civil litigation that sends confusing signals, as “if the police regularly gave out more tickets to drivers who go through green lights than to those who go through red lights.”¹⁸⁰

170. Shanahan, *supra* note 69, at 385.

171. Hyman, *supra* note 131, at 1644.

172. O’Connell & Neale, *supra* note 161, at 296.

173. *Id.*

174. Hyman, *supra* note 131, at 1643.

175. O’Connell & Neale, *supra* note 161, at 297.

176. *Id.*

177. *Id.* at 297–98.

178. *Id.* at 298.

179. Hyman, *supra* note 131, at 1645.

180. *Id.* (quoting PAUL WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 75 (1993)).

B. Proposals for Increased Medicaid Funding on the State Level Are Impractical

The current budget climate in many states does not leave increased government funding as a viable solution to the financial pressures currently faced by nursing homes.¹⁸¹ In fiscal year 2002, forty-six states reported budget deficits, which combined reached \$37 billion, and states expected budget deficits to reach \$58 billion in fiscal year 2003.¹⁸² Increased Medicaid enrollment has significantly contributed to these state budget deficits.¹⁸³ As a result of increased costs and decreasing revenues in state budgets, “two-thirds of states plan to or have cut benefits, restricted eligibility, increased co-payments or dropped beneficiaries from their Medicaid programs” in the fiscal year 2003 budget.¹⁸⁴ Every state but Alabama prepared a Medicaid “cost-containment option” for fiscal year 2003.¹⁸⁵ It would be impractical to propose an increase in Medicaid funding to aid financially burdened nursing homes under such economic conditions. Because most states by law must have balanced budgets by the end of a fiscal year,¹⁸⁶ states cannot run deficits in order to fund Medicaid programs even in nonrecessionary years. Therefore, an increase in government spending is not a realistic solution to aid financially troubled nursing homes now, and may not be in the future.

C. Tort Reform Should Be Encouraged

Tort reform should be encouraged to make litigation a more efficient means of providing a right of action for nursing home abuse or negligence. Without the option of increased Medicaid funding, states

181. *Access-Medicaid: Nearly All States Reducing Program Spending in FY 2002, Survey Finds*, AM. HEALTH LINE, Jan. 14, 2003 at http://nationaljournal.com/cgi-bin/iftch4?ENG+ALL-_-ALL_PUBS+7-cr0199+1078410-DBSCORE+256+29+121+F+1+1+1+%22nearly+all+states+reducing+program+spending%22+AND+PD%2f01%2f13%2f2003%2d%3e01%2f15%2f2003 [hereinafter *Access-Medicaid*]; see *Politics & Policy Budget Deficits: Force States to Reduce Health Services*, AM. HEALTH LINE, Oct. 7, 2002 at http://nationaljournal.com/cgi-bin/iftch4?ENG+ALL-_-ALL_PUBS+7-cr0199+1078262-DBSCORE+256+28+3440+F+1+1+1+politics+AND+policy+AND+budget+AND+deficit+AND+PD%2f10%2f06%2f2002%2d%3e10%2f08%2f2002 [hereinafter *Politics & Policy*].

182. *Politics & Policy*, *supra* note 181.

183. *Id.*

184. *Access-Medicaid*, *supra* note 181.

185. *Id.*

186. *Politics & Policy*, *supra* note 181.

must consider an alternative solution to the financial problems currently faced by nursing homes. An actuarial analysis by Aon Risk Consultants, Inc. revealed a correlation between an increase in legislation that protects nursing home patients and an increase in liability costs.¹⁸⁷ The study determined that significant increases in liability costs are attributable to the minimum quality of care standards established for Medicaid and Medicare recipients in the 1987 Nursing Home Reform Act.¹⁸⁸ Moreover, the two states with the highest per bed "loss cost" ("the cost per exposure of settling and defending claims"),¹⁸⁹ Florida and Texas, have "very strong patient rights statutes."¹⁹⁰

In response to the insurance crisis of the 1970s, in which increased medical malpractice insurance rates and reduction in coverage led to "compromised" health care, state legislatures enacted reform legislation to combat this crisis.¹⁹¹ Medical malpractice tort reforms have been adopted in all fifty states and include efforts to cap punitive damages and shorten the statute of limitations on claims.¹⁹² Similar proposals are found in recent tort reform statutes aimed at claims against nursing homes, which studies have shown result in decreased claim and premium rates.¹⁹³ As a result of tort reform, claims have fallen nationwide, "with annual claims per 100 physicians decreasing from a high of nearly seventeen in 1987 to a low of eleven in 1991."¹⁹⁴ Evidence demonstrates that this reduction is not due to a reduced negligence or injury rate.¹⁹⁵

There is evidence to support the proposition that caps on punitive and noneconomic damages will curb rising insurance costs. A main objective of tort reform movements, shared in the Florida and

187. BOURDON & DUBIN, *supra* note 69, at 13.

188. *Id.*

189. *Id.* at 25.

190. *Id.* at 14. The study also notes that despite this correlation between high loss costs and strong nursing home patients' rights statutes, which is also evident in California, not all states with patients' rights laws have experienced this same trend. *Id.* Although more than half of states have some protection of patients' rights, "states vary on issues such as enforcement by lawsuit, reimbursement of attorney's fees, limits of liability, statute of limitations and damage caps." *Id.*

191. Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. WASH. L. REV. 181, 181-82 (1990).

192. David M. Studdert et al., *Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?*, 60 LAW & CONTEMP. PROBS. 1, 16 (1997).

193. *Id.*

194. *Id.*

195. *Id.*

Ohio reforms, is to limit punitive damages.¹⁹⁶ A limit on punitive damages will decrease the incentive to bring a frivolous lawsuit, because “the incentive to file frivolous lawsuits is increased by the prospect of a sizeable punitive damage award.”¹⁹⁷ Numerous studies demonstrate that California’s \$250,000 cap on noneconomic damages provided in its Medical Injury Compensation Reform Act of 1975 (MIRCA) “accounts for the principal difference between California’s stability and the chaos of other states in professional liability coverage costs.”¹⁹⁸ Today, the “average liability premium for an Ob/Gyn in California” is half the average of other large states, and while California’s premiums have risen 168% since the enactment of MIRCA, the national premium average has risen 420%.¹⁹⁹ Further, the cost of medical malpractice suits in California are 53% lower than the national average,²⁰⁰ and medical malpractice suits are settled 23% faster in California compared to the rest of the country.²⁰¹ A Stanford University study reveals that California’s liability reforms would, if enacted across the nation, save the health care system “\$50 billion a year in defensive medicine costs.”²⁰² Indeed a correlation exists between states that have adopted caps on noneconomic damages and lower insurance premiums.²⁰³ Thus, empirical evidence exists which demonstrates that some of the costs of the tort regime can be mitigated through reform. When such costs are reduced it becomes less expensive to insure nursing homes against litigation costs, and litigation becomes a more efficient means of protecting patients from abuse or negligence.

196. Dick Thornburgh, *America’s Civil Justice Dilemma: The Prospects for Reform*, 55 MD. L. REV. 1074, 1085 (1996).

197. *Id.*

198. *Health Care Litigation Reform: Does Limitless Litigation Restrict Access to Health Care?: Hearing Before the Subcomm. on Commercial & Admin. Law of the House Comm. on the Judiciary*, 107th Cong. 41 (2002) (declaration of Fred J. Hiestand).

199. *Id.*

200. *Id.*

201. *Id.*

202. *Id.*

203. See H.R. REP. NO. 107-693, pt. 1, at 16 (2002) (quoting Dep’t of Health & Human Servs., *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System* 12–13 (July 24, 2002)).

D. Should Tort Reform Be Engaged on the Federal Level?

Policy development at the federal level has been justified by the fact that states are not capable of advancing national policy goals.²⁰⁴ Some argue that federal regulations in certain policy arenas are needed to prevent states from competing with one another in a manner that leads to a “race to the bottom,”²⁰⁵ in which certain state interests suffer as a result of interstate competition.²⁰⁶ Concerns about a race to the bottom may be relevant in the context of long-term care policy and litigation. States may race to the bottom in providing Medicaid coverage to avoid becoming “welfare magnets”: attracting the neediest within its borders, and burdening its doles.²⁰⁷ This concern has been used to argue for tort reform at the federal, rather than state, level.²⁰⁸ Some commentators have even proposed federal tort law to promote “uniformity and protection of commercial interests.”²⁰⁹

The delegation of tort policy to state legislatures also subjects tort law to the undue influence of special interests that are able to exert control over state government.²¹⁰ State policymaking is subject to “more entrenched interests with [a] longer history of involvement in state policymaking” than that at the federal level,²¹¹ and consequently

204. Thomas A. Eaton & Susette M. Talarico, *Testing Two Assumptions About Federalism and Tort Reform*, 14 YALE J. ON REG. 371, 374 (1996).

205. *Id.*; Paul E. Peterson, *Devolution's Price*, 14 YALE J. ON REG. 111, 119 (1996). Long-term care policy indicated in financing, regulation, and services, is varied among the states. Phoebe S. Liebig, *Policy and Political Contexts of Financing Long-Term Care*, in A SECURE OLD AGE, APPROACHES TO LONG-TERM CARE FINANCING, *supra* note 86, at 147, 161–62. The federal government, through programs in cooperation with state governments, has attempted to mitigate variation in policy among the states by “requiring Medicaid program eligibility to be linked to the receipt of cash assistance programs; requiring states to meet national standards for nursing homes and expanding coverage to women and children; and requiring a minimum of each state’s OAA dollars to be spent on special outreach programs for food stamps” or providing school meal services. *Id.* at 162. This policy has reduced interstate variation by nearly half. *Id.* Nevertheless, states still play a significant role in determining the scope of health care services provided. *Id.*

206. For instance, states that compete with one another to attract industry may do so through lax environmental regulations, thus externalizing the costs of the state’s industry and undermining a national environmental policy. See Eaton & Talarico, *supra* note 204, at 374.

207. Peterson, *supra* note 205, at 117–20.

208. Eaton & Talarico, *supra* note 204, at 374.

209. Betsy J. Grey, *The New Federalism Jurisprudence and National Tort Reform*, 59 WASH. & LEE L. REV. 475, 475–76 (2002).

210. Liebig, *supra* note 205, at 170–71.

211. *Id.* at 171.

state long-term care policy is influenced “by intense advocacy from a multitude of providers and consumers.”²¹² West Virginia Supreme Court Justice Richard Neely has argued that states tend to apply tort law in favor of the interests of resident plaintiffs at the expense of defendants.²¹³ To avoid this bias, a degree of federal regulation of tort law could be desirable, as “punitive damage verdicts implicate both interstate and foreign commerce in a manner that only the federal Congress can address.”²¹⁴ Federal tort reform may not present constitutional difficulties, as Congress could hold the power to regulate tort litigation under the Commerce Clause (though this power is uncertain after *United States v. Lopez*²¹⁵), or could influence state tort reform policies through its spending power.²¹⁶

Nevertheless, tort law should be largely controlled on the state level. Standing in the path of a federalized tort order is a constitutional commitment to federalism, represented in the Tenth Amendment and in cases such as *Erie Railroad v. Tompkins*,²¹⁷ *United States v. Lopez*,²¹⁸ and *United States v. Morrison*.²¹⁹ This commitment protects the sovereignty of states within the realm of local governance.²²⁰ In *Morrison*, the Supreme Court did not confine its consideration of the constitutionality of congressional legislation to whether it was sufficiently related to interstate commerce; the Court invalidated purported regulation of interstate commerce that infringed upon the states’ traditional role to regulate crime.²²¹ The Court affirmed that “[t]he Constitution requires a distinction between what is truly national and what is truly local.”²²² Although the Supreme Court has recently affirmed

212. *Id.* at 170–71.

213. Eaton & Talarico, *supra* note 204, at 374; *see also* Grey, *supra* note 209, at 478 (noting that some commentators claim that “state judges and juries unfairly favor in-state plaintiffs against out-of-state defendants”). Although Judge Neely referred to nonresident product distribution companies, Eaton & Talarico, *supra*, at 374, the bias in favor of in-state plaintiffs against out-of-state corporations would logically still apply to nonresident health care companies.

214. *Punitive Damage: Tort Reform and FDA Defenses: Hearing Before the Senate Comm. on the Judiciary*, 104th Cong. 93 (1995) (statement of George L. Priest, Professor, Yale Law School).

215. 514 U.S. 549 (1995).

216. Robert M. Ackerman, *Tort Law and Federalism: Whatever Happened to Devolution?*, 14 YALE J. ON REG. 429, 438–42 (1996).

217. 304 U.S. 64 (1938).

218. *Lopez*, 514 U.S. at 549.

219. 529 U.S. 598 (2000); Grey, *supra* note 209, at 479.

220. Grey, *supra* note 209, at 479.

221. *Morrison*, 529 U.S. at 616; *see also* Grey, *supra* note 209, at 495.

222. *Morrison*, 529 U.S. at 617–18.

state sovereignty over matters of local governance, the notion of “dual federalism” in which state authority over local matters is considered exclusive died around 1937.²²³ Therefore, there may still be some role for concurrent federal authority over traditionally local matters.²²⁴ Nonetheless, the Supreme Court views “tort law as a core state interest,”²²⁵ and, as such, tort law must be primarily promulgated by the state.

Moreover, tort policy should remain within state control because localized control realizes practical benefits. First, “common law has been woven over hundreds of years in response to perceived states’ interests and works as an integrated whole” within the state’s legal structure.²²⁶ The ability of states to formulate tort law allows states to uniquely tailor the law to their particular needs.²²⁷ Tort law has continued to develop distinctly among the states, most notably in “an extraordinarily . . . diffuse range of limitations that has been enacted in furtherance of a state tort reform agenda,” including caps on punitive

223. Grey, *supra* note 209, at 497.

224. *Id.*

225. *Id.* at 503.

226. *Id.* at 518.

227. Robert L. Rabin, *Federalism and the Tort System*, 50 RUTGERS L. REV. 1, 6 (1997). The advantages of tort policy development at the state level is demonstrated in history. *Id.* English tort principle, established in *Rylands v. Fletcher*, 3 L.R.-E. & I. App. 330, 335 (H.L. 1868), provided that a property owner was strictly liable for “water brought onto one’s land, which subsequently escaped and did damage to a neighbor’s land.” *Id.* This principle was selectively adopted in the American states according to local need. *Id.* Western states rejected the principle, as illustrated in *Turner v. Big Lake Oil Co.*, 96 S.W.2d 221, 226 (Tex. 1936), which set forth an alternative principle and provided that “in Texas we have conditions very different from those which obtain in England. A large portion of Texas is an arid or semi-arid region . . .” *Id.* The ability of local government to uniquely appreciate the particulars of its own problems has been summarized by Edward I. Koch, who served as a United States Congressman before becoming Mayor of New York City:

As a member of Congress I voted for many of the laws, . . . and did so with every confidence that we were enacting sensible permanent solutions to critical problems. It took a plunge into the Mayor’s job to drive home how misguided my congressional outlook had been. . . . [A]s I look back it is hard to believe I could have been taken in by the simplicity of what the Congress was doing and the flimsy empirical support—often no more than a carefully orchestrated hearing record or a single consultant’s report—offered to persuade the members that the proposed solution could work throughout the country.

JOSEPH F. ZIMMERMAN, *CONTEMPORARY AMERICAN FEDERALISM: THE GROWTH OF NATIONAL POWER* 59 (1992) (quoting Edward I. Koch, *The Mandate Millstone*, Address at the Mid-Winter Meeting of the United States Conference of Mayors (Jan. 24, 1980)).

damages.²²⁸ State tort reform has indeed exemplified the paradigm of states as laboratories able to experiment with alternative tort policies.²²⁹ Also, the institution of state authority over tort law and policy promotes a complex “doctrinal weave.”²³⁰ If Congress attempts to legislate a uniform tort code, it must overcome the reality that “it remains far removed from the synthetic character of judge-made tort law that has evolved over decades in response to perceived state interests.”²³¹

V. Rising Nursing Home Care Costs Will Be Curbed Through Congressional Conditional Encouragement of State Tort Reform

The nursing home industry is currently troubled by a tort system that imposes the cost of increased insurance premiums, but does not bestow a corresponding benefit in the redistribution of resources or deterrence of negligence. These problems can be resolved through cooperation in tort law between state governments and the federal government in a manner that respects the states’ traditional purview over tort claims. This cooperation can be realized if Congress creates an incentive for states to address their troubled tort regimes in exchange for an increase in Medicaid funding that will promote quality patient care. If Congress enacts legislation that provides for a meaningful increase in Medicaid funding in exchange for the adoption of tort reform legislation, the costs of the tort system as a protection of patients’ rights will be reduced.²³²

228. Rabin, *supra* note 227, at 10.

229. *Id.*

230. *Id.* at 11.

231. *Id.*

232. In addition to providing a more efficient means of protecting the rights of nursing home patients, federal aid promotes competition among state governments that in turn promotes economic efficiency. Therese J. McGuire, *Federal Aid to States and Localities and the Appropriate Competitive Framework*, in *COMPETITION AMONG STATES AND LOCAL GOVERNMENTS* 153, 161 (Daphne A. Kenyon & John Kincaid eds., 1991). If an increase in Medicaid funding was performed in the model of “the current federal aid structure, which is a mix of matching and block grants of a slightly redistributive nature . . . interjurisdictional tax and expenditure competition” is facilitated because “less-wealthy jurisdictions could offer lower tax rates and burdens to mobile residents without having to cut expenditures, or could provide more services without an increase in taxes.” *Id.* Assuming residents are mobile, this may, in turn, “enhance competition among jurisdictions” for residents. *Id.* If local governments are equalized in their ability to provide similar government services at comparably low tax rates, residents will no longer become mobile and the amount of nonresidents that take advantage of certain government benefits will be minimized. *Id.* at 159. “Allocative efficiency” is achieved when states

The creation of an incentive for state tort reform will also make the tort system a more efficient means to protect patients from nursing home abuse. With tort reform, the redistributive aims of tort liability will be more effectively realized because a reduction in frivolous suits will lead to a more efficient and less costly litigation process, as evidenced in the California tort reforms. The problem of overdeterrence, to which the current tort regime is subject, will be alleviated through limitation of punitive damages or reduction in the statute of limitations period, making it harder for frivolous suits to be filed, and thus reducing the need of long-term care providers to practice the defensive medicine that health care providers entertain when subject to excessive liability. Underdeterrence will also be alleviated as a reduction in frivolous suits will reduce the exposure of long-term care providers to costly litigation. Indeed, the evidence of past tort reform efforts in the health care industry indicate that tort reform in the context of long-term care is worthwhile.

A congressional conditional grant-in-aid to states in exchange for their adoption of tort reform legislation will promote the cooperation of state and federal governments in a joint effort to improve the financial conditions of nursing homes and the quality of patient care, while further insulating tort law from the undue influence of special interests. The shortcomings attendant to exclusive state control over tort policy will be overcome with a federal role in such policy. A shift in influence over tort policy from state government to the federal government may prevent a race to the bottom in the grant of Medicaid funding, because such funding will be widely available to all states. Thus, the states that accept the conditional grant will not become "magnets" of superior health care, because the same Medicaid funding will be available to all states. This will prevent the decrease in quality of care that can be attendant in a race to the bottom in patient protections. The infusion of increased Medicaid funding will also allow states to avoid cutting health care subsidization in an environment of budget deficits,²³³ shoring up an important financial resource

are provided funding that allows nonwealthy states to compete with wealthier states for residents because then "local governments or bureaucracies are constrained in the extent to which they can waste public funds." *Id.*

233. Although the federal government will be running a budget deficit for the foreseeable future, *White House Asks for Raise of Debt Limit*, CHI. TRIB., Feb. 20, 2003, at 16 [hereinafter *Debt Limit*], the federal government is not legally barred from incurring a deficit. Many state constitutions, however, mandate balanced budgets. James C. Cooper & Kathleen Madigan, *Whatever the Final Figure, Stimulus Is Still*

that funds patient care. Moreover, the conditional grant will alleviate state tort law's struggle with the influence of special interests. States will arguably be much more willing to enact legislation, even in contravention of a bias in favor of in-state plaintiffs and against out-of-state corporations, if a financial incentive is attached.

The contingent increase of Medicaid funding by Congress for states that adopt tort reform legislation is consistent with the constitutional recognition of states' sovereignty over matters of law traditionally entrusted to the states. Congress "exercises great influence over the exercise of many reserved powers by state and local governments through conditions attached to national grants-in-aid."²³⁴ The Supreme Court has upheld the constitutionality of conditional grants-in-aid in *Massachusetts v. Mellon*²³⁵ and in *South Dakota v. Dole*.²³⁶ While congressional grant funds "have helped many states to both inaugurate many new programs and to expand existing programs which would not otherwise have been undertaken,"²³⁷ some criticize grant-in-aid programs for allegedly limiting the discretionary authority of state governments and clouding accountability toward the particular government institution responsible for failed or successful programs.²³⁸ However, these concerns would not be implicated if states are given leeway in structuring their tort reform plans. For instance, if Congress conditioned increased Medicaid funding on some tort reform plan, and did not insist upon particular tort reform strategies, states could decide for themselves the elements of tort reform (one state could limit punitive damages, one could limit the statute of limitations period, another could do both). This discretion respects state autonomy and state voters will be able to hold state government accountable for the particular tort reform plan it chooses to adopt. Im-

Vital, BUS. WK., May 12, 2003, at 27, 2003 WL 8814272. The federal government, however, is subject to a debt ceiling of \$6.4 trillion. *Debt Limit*, *supra*. As of February 20, 2003, the national debt was \$6.392 trillion, only \$8 billion under the limit. *Id.* As of that time, Treasury Secretary John Snow urged Congress to raise the limit. *Id.* Although a raise in the limit would allow increased Medicaid funding, the current federal deficit may counsel some delay of this resolution.

234. ZIMMERMAN, *supra* note 227, at 113–14.

235. *Id.* at 114 (citing *Massachusetts v. Mellon*, 262 U.S. 447 (1923)).

236. 483 U.S. 203 (1987). In *Dole*, the Supreme Court affirmed the constitutionality of a congressional statute that tied a grant of federal highway funds to a state, contingent upon the state's maintenance of a minimum drinking age of twenty-one years old. *Id.* at 205, 210–12.

237. ZIMMERMAN, *supra* note 227, at 120 (quoting W. Brooke Graves, an expert on federalism).

238. *Id.* at 119.

portantly, this proposal leaves the decision over whether to accept conditional funding, and the nature of tort reform if the condition is accepted, up to individual states, leaving tort law firmly within its traditional sphere of state law. The congressional condition of increased Medicaid funding in exchange for state adoption of tort reform to address increasing nursing home costs will thus not encounter a constitutional barrier to its implementation. It will, however, provide a remedy to the financial problems now facing nursing homes, without sacrificing the care of the patients the tort system is meant to protect.

VI. Conclusion

Recently several state legislatures have considered, and some have adopted, "tort reform" measures that strive to protect nursing homes from the increasing liability insurance costs that nursing homes have blamed on exposure to excessive jury awards. Because nursing homes substantially rely on Medicaid funding, which is not only subject to underfunding, but will be increasingly burdened as the elderly compose a greater percentage of the American population, it is appropriate that states attempt to ameliorate the financial strains that face the long-term care industry. The tort system is a good place to start. Tort litigation imposes costs on the nursing home patient, but the trade-off for increased quality of care may be illusory. Tort liability can drain nursing homes of financial resources that could be used to improve quality of patient care. Nursing home litigation is particularly subject to error because the elderly are especially likely to suffer physical injuries that are not necessarily caused by negligent care. These difficulties compound the general shortcomings of a health care liability regime that fails to achieve its purported goals of redistribution and deterrence. In the past, medical malpractice reform has reduced the costs the liability system imposes, with a cap on non-economic damages having reduced liability costs.

If such reform is encouraged on a federal level, a decrease in patient protection concomitant with a reduction in liability exposure can be avoided through the encouragement of a uniform tort system that prevents a race to the bottom in patient care standards among states. Moreover, if such encouragement of uniform tort policy is achieved through the conditional increase of Medicaid funding, the additional funds could be used to improve patient care at a time when states are

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cutting Medicaid funding. Such cooperative reform among state and federal governments will ease the costs the current tort regime imposes on long-term care providers, while promoting greater quality of patient care.