PROTECTING NURSING HOME RESIDENTS FROM ATTACKS ON THEIR ABILITY TO RECOVER DAMAGES

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Despite the high cost of nursing home care, residents remain susceptible to personal injury, with approximately 14.5 legal claims per 1,000 occupied beds. Citing an increase in the frequency of lawsuits against nursing homes and Medicare reimbursement cuts, many large nursing home chains have resorted to filing bankruptcy to ease these burdens, thereby decreasing the likelihood of liability protection and the availability of needed nursing home rooms. With the aging of the baby-boom generation, this compelling issue is far from its crest.

Five themes provide structure for our discussion of legal issues surrounding the nursing home model as a means of meeting the high demand for commercial residential eldercare:

(1) a brief history of the nursing home in American society;

(2) an examination of recent developments in federal and state statutory and case law that address nursing homes capitalization requirements and corporate structuring;

(3) a discussion of the characteristics of the legal system that facilitate or hinder the bringing of claims on behalf of injured nursing home residents;

(4) an examination of trends in general and malpractice liability insurance as they affect the eldercare industry, including a review of case law on corporate veil piercing from a variety of jurisdictions; and

(5) proposed elements of a solution to the complex problem of nursing home viability in the context of corporate organization, liability insurance, and governmental regulation.

These elements include verdict guidelines, mandated minimum insurance liability coverage by a nursing home, corporate structuring constraints, conditional licensure, and a revised formula for determining Medicare and Medicaid payments to nursing homes.

I. INTRODUCTION

At the end of 2007, there were approximately 16,000 certified nursing homes in the United States and an additional 39,500 assisted-living facilities.[1] More than 1.6 million people reside in U.S. nursing homes; nearly one million more live in assisted living facilities.[2] Caring for these roughly 2.5 million people are 2.7 million

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1. *See* American Association of Homes and Services for the Aging, *Aging Services: The Facts*, http://www2.aahsa.org/aging_services/default.asp [hereinafter AAHSA] (last visited Mar. 25, 2009) (providing statistics on availability of elder housing).

2. *See* BETH BAKER, OLD AGE IN A NEW AGE: THE PROMISE OF TRANSFORMATIVE NURSING HOMES 7-8 (1st ed. 2007) (providing statistic that there were 17,000 nursing homes in the United States in 2006 and outlining U.S. nursing home resident population); COLLEEN L. JOHNSON & LESLIE A. GRANT, THE NURSING HOME IN AMERICAN SOCIETY 3 (1985) (detailing contemporary nursing home population); David

employees.[3] The aggregate annual cost of care for residents of nursing home facilities is approximately $111 billion,[4] with the United States facing a surge in elder population with the aging of the baby boomers.[5]

By 2030, the U.S. elderly population—defined as sixty-five years and older—is projected to double to 72 million persons.[6] This growing segment of the population will require a corresponding growth in nursing home housing and care.[7] Although recent alternatives to the traditional nursing home model have developed,[8] the combination of an increasing demand for housing and a shortfall of affordable housing will necessitate the continued existence of nursing homes. For example, there are currently "more than 300,000 Section 202

A. Bohm, *Striving for Quality Care in America's Nursing Homes: Tracing the History of Nursing homes and Noting the Effect of Recent Federal Government Initiatives to Ensure Quality Care in the Nursing Home Setting*, 4 DEPAUL J. HEALTH CARE L. 317, 322 (2001) (providing historical statistics of nursing home population and number of nursing homes in United States).

3. *See* BAKER, *supra* note 2 (stating that 2.7 million employees is roughly twice the number of U.S. Wal-Mart employees).

4. AAHSA, *supra* note 1 (estimating annual cost of U.S. nursing homes); *see also* DIANA K. HARRIS & MICHAEL L. BENSON, MALTREATMENT OF PATIENTS IN NURSING HOMES 6 (2006) ("It is estimated that the industry generates close to $80 billion in revenues each year."); Tim Dollar, *Nursing Home Litigation: Practical Considerations of Filing, Discovery, and Trial*, 2 ASS'N OF TRIAL LAWS. OF AM. ANNUAL CONVENTION REFERENCE MATERIALS: PROFESSIONAL NEGLIGENCE 2423 (2002) ("Last year, United States elder care generated revenue of about $115 [billion] with nursing homes accounting for $100 [billion] of the total revenue.").

5. *See* ALAN GREENSPAN, THE AGE OF TURBULENCE 412 (1st ed. 2007) ("The oldest baby boomers become eligible for Social Security in 2008.").

6. *See* BAKER, *supra* note 2, at 8 (stating anticipating growth in U.S. elderly population); *see also* Henry H. Drummonds, *The Aging of the Boomers and the Coming Crisis in America's Changing Retirement and Eldercare Systems*, 11 LEWIS & CLARK L. REV. 267, 272 (2007) (referencing U.S. Census Bureau statistic that anticipates population of sixty-five or over to "almost double – from 36.7 million Americans in 2005 to 63.5 million [in 2025].").

7. *See* BAKER, *supra* note 2, at 8 (citing National Center for Health Statistics data that predicts nursing home population will exceed 3 million by 2030); *see also* Laura D. Seng, *Legal and Regulatory Barriers to Adequate Pain Control for Elders in Long-Term Care Facilities*, 6 N.Y. CITY L. REV. 95, 95 (2003) ("By 2020, it is estimated that more than 40% of Americans will die in nursing homes.").

8. *See* Ann Bookman & Mona Harrington, *Family Caregivers: A Shadow Workforce in the Geriatric Health Care System?*, 32 J. HEALTH POL. POL'Y & L. 1005 (2007) (pointing out family caregivers as an overlooked segment of elder care); Marshall B. Kapp, *Making Patient Safety and a "Homelike" Environment Compatible: A Challenge for Long Term Care Regulation*, 12 WIDENER L. REV. 227 (2005) (advocating policy to make long term care facilities more "homelike"); Peggie R. Smith, *Home Sweet Home? Workplace Casualties of Consumer-Directed Home Care for the Elderly*, 21 NOTRE DAME J.L. ETHICS & PUB. POL'Y 537 (2007) (detailing growth in consumer-directed home care).

affordable senior housing" units in the United States,[9] yet for each such available unit, ten seniors remain on waitlists, with an average wait time of 13.4 months.[10] The average age of an individual at the time he or she moves into a nursing facility is seventy-nine, and women—due in part to their longer life expectancy—are three times more likely than men to live in a nursing home during their lifetime.[11]

The annual cost of housing to the elderly consumer is daunting—$68,985 for a semi-private nursing home room, and $35,628 for an assisted living facility.[12] Although the cost of private nursing home care varies significantly among states, the U.S. average daily cost for private care in a nursing home is $194, or just over $70,000 per year.[13]

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9. *See* 12 U.S.C. § 1701q (2000) (providing housing for impoverished elderly) The statute states:

> The purpose of this section is to enable elderly persons to live with dignity and independence by expanding the supply of supportive housing that -- (1) is designed to accommodate the special needs of elderly persons; and (2) provides a range of services that are tailored to the needs of elderly persons occupying such housing.

Id.; *see also* HUD – Multifamily Housing – Program Description, http://www.hud.gov/offices/hsg/mfh/progdesc/eld202.cfm (last visited May 7, 2009) (describing Section 202 housing).

10. *See* AAHSA, *supra* note 1 (describing shortfall of affordable elder housing).

11. *Id.* According to 2004 data, the life expectancy for a female at birth was 80.4 years, at age 65, was 20.0 years, and at age 85, was 7.2 years. National Center for Health Statistics – Trends in Health and Aging, http://www.cdc.gov/nchs/agingact.htm (follow "Mortality and Life Expectancy" hyperlink, then follow "Life Expectancy at Birth, 65..." chart hyperlink) (last visited Mar. 25, 2009) (providing national health data). In comparison, the same statistics for males are 75.2, 17.1, and 6.1, respectively. *Id.*

12. *See* AAHSA, *supra* note 1 (listing average annual costs of various forms of elder housing).

13. AARP Bulletin – Average Daily Cost for Nursing Home Care by State, 2006, http://www.aarp.org/family/caregiving/articles/dailycost.html (last visited Mar. 25, 2008) (summarizing results of 2006 survey that computed average daily cost of private nursing home care by state and by large metropolitan area). According to the survey, the least expensive state was Louisiana at a cost of $116 per day. *Id.* The most expensive: Alaska, at $524. *Id.* The national average of monthly nursing home care is approximately $4,600. HARRIS & BENSON, *supra* note 4, at 8 (describing costs of nursing home care). If the national average cost of care is $194 per day, then multiplying that number by 365 results in an annual figure of $70,810.

Interestingly, the cost per day or nursing home care may actually be less in "high quality" nursing homes compared to "lower quality" nursing home. *See* BAKER, *supra* note 2, at 189. A 2003 cost study conducted by a nursing researcher "concluded that high-quality care is actually *less* expensive to deliver than is low-quality care." *Id.* (citing Marilyn Rantz, *Does Good Quality Care in Nursing Homes Cost More or Less than Poor Quality Care?*, 51 NURSING OUTLOOK 93, 93-94 (2003)). The study found "that higher staff retention led to increased efficiency and better-quality outcomes that in turn led to lower costs." *Id.* In fact, the average cost per day was "$13,50 less in

The payment of these costs is complex. Sources of payment for long-term care can be generally separated into a 2-2-1 ratio: 40% is paid by private funds (such as out-of-pocket from the individual receiving the care or his or her supporting family members); 40% from Medicaid payments; and 20% from Medicare.[14] Medicare essentially acts as a federal program of health insurance program the elderly (age sixty-five or older) and the disabled.[15] In contrast, Medicaid pays for the medical care of those with limited income.[16]

Despite the high cost of nursing home care, residents remain susceptible to personal injury. A 2003 study conducted by the industry examined 108 nursing home operators and found that the number of injury claims rose each year to the point that there are now approximately "14.5 [legal] claims per 1,000 occupied beds."[17] Citing an increase in the frequency of lawsuits against nursing homes and Medicare reimbursement cuts, many large nursing home chains have resorted to filing bankruptcy to ease these burdens.[18] "The nursing home industry is reeling with problems and has been vigorously lobbying on many fronts in recent years to reverse the tide of bankruptcies, crippled profits, and ever decreasing shareholder and market capitalization values."[19]

With the aging of the baby-boom generation, this compelling issue is far from its crest. To provide equitable solutions, the stakeholders involved must be aligned with the goals of promoting quality eldercare and enabling responsible nursing home owners to profit financially.

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high-quality homes, for an annual savings of $440,000 in a home with ninety residents." *Id.*

14. *See* AAHSA, *supra* note 1 (detailing long-term care spending by payor).

15. *See* Kim Glaun, *Medicare*, *in* POVERTY LAW MANUAL FOR THE NEW LAWYER 84, 84 (2002) (defining Medicare).

16. *See* Jane Perkins, *Medicaid*, *in* POVERTY LAW MANUAL FOR THE NEW LAWYER 61, 61 (2002) (defining Medicaid).

17. *See* Michael L. Rustad, *Neglecting the Neglected: The Impact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits*, 14 ELDER L.J. 331, 342 (2006) (quoting Lisa Belloti, *Aon Risk Consultants Releases 2003 Long Term Care Study on Continuing Increases in Patient Care Litigation*, HEALTHLINE, July 2003, at 1-2, http://www.aon.com/about/publications/pdf/health-line/2003_ltc_study_july.pdf).

18. Andrews Publications, *In Re Lenox Healthcare, Inc.*, 9 ANDREWS CHAPTER 11 UPDATE 6 (1999).

19. John Elliott Leighton, *The Nursing Home Industry Versus Government and Advocates: Legislation, Litigation, and Bankruptcy*, 2001 ASS'N OF TRIAL LAWS. OF AM. WINTER CONVENTION REFERENCE MATERIALS 397.

(2) an examination of recent developments in federal and state statutory and case law that address nursing homes capitalization requirements and corporate structuring;

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II. BRIEF HISTORY OF ELDERCARE IN THE UNITED STATES

The quality of care for the U.S.'s elderly has changed dramatically over time. "[T]he social demographics of the typical [colonial] American family ensured the availability of long-term care for the elderly by their children."[20] Colonial life was more rural and agrarian than modern society, thus most elderly served a vocational function with mild labor tasks or assistance with child rearing.[21]

Inevitably, there were impoverished elderly without familial insulation.[22] "Based upon the English Poor Law of 1601, early American colonists took the view that government was responsible for giving public relief" to such unfortunate and isolated persons.[23] Local governments sheltered the impoverished with "almshouses, orphanages, poor farms, or poorhouses."[24] "Poorhouses sheltered a diverse cross section of society under one roof, becoming the location of last resort for mentally handicapped persons, orphans, the elderly,

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20. Patrick A. Bruce, Note, *The Ascendancy of Assisted Living: The Case for Federal Regulation*, 14 ELDER L.J. 61, 63 (2006).

21. *See id.* at 63-65 (describing colonial treatment of elderly); *see also* Bohm, *supra* note 2, at 324-25.

22. *See* Bruce, *supra* note 20, at 64.

23. Bohm, *supra* note 2, at 324; *see also* KERMIT L. HALL ET AL., AMERICAN LEGAL HISTORY: CASES AND MATERIALS 45-46 (3d ed. 1991) (describing English Poor Laws).

> Colonial laws were modeled on the Poor Laws of the reign of Elizabeth I. First enacted in 1598 and then reenacted in definitive form in 1601, the English Poor Laws provide for appointment of overseers of the poor in every parish. These officers had comprehensive authority to bind out the children of the poor as apprentices . . . raise taxes n money and in kind . . . build [housing] and in general to operate a parish-based welfare system vaguely resembling modern workfare experiments.

Id. at 45.

24. JOHNSON & GRANT, *supra* note 2, at 5; *see* Bruce, *supra* note 20, at 64 ("Indoor relief, or institutional care, was primarily provided through the poorhouse.").

and even criminals."[25] In the late nineteenth and early twentieth centuries, such institutions became predominantly populated by the elderly and, as the quality of living conditions in such facilities began to decline, a social movement advocating a more humane solution to the nation's impoverished elderly began to develop.[26]

When the Great Depression struck in the early twentieth century, the wealth and savings of America's elderly class was largely erased and, unlike the familial care pattern of prior generations, their children no longer had the means to support this "newly destitute" class of elderly.[27] In 1935, the Commission on Economic Security estimated that of the 7.5 million people aged sixty-five or older, roughly 50% were entirely dependent.[28]

It was against this backdrop of national economic hardship that the Social Security Act was introduced in 1935.[29] At the time the Act was passed, the focus was on Old Age Assistance (OAA), which was considered "'a temporary transitional measure [designed] to meet the income needs of the elderly until the contributory, nonmeans-tested system of old age insurance. . . could be fully implemented.'"[30] Old Age Assistance paid the elderly poor with cash, regardless of work history.[31] Federal requirements prohibited payment of Old Age Assistance to those elderly persons who lived in public institutions.[32] Proprietary convalescent homes emerged because of this prohibition.[33]

By the mid-1940s, "'[p]rivate entrepreneurs were offering nursing and personal care services over and above what boarding homes had traditionally provided.'"[34] Federal programs that

25. Bruce, *supra* note 20, at 64.

26. *See* Bohm, *supra* note 2, at 326-28 (describing transition from social belief that moral guidance could cure poverty to more humanistic view of the poor). "By the end of the 1800's, almshouses were becoming 'transformed' into public nursing institutions as a result of the aging American population and the institutional advances." *See id.* at 327-28.

27. Bruce, *supra* note 20, at 65 (describing effect of Great Depression on elderly).

28. *See id.*

29. *See* Pub. L. No. 74-271, 49 Stat. 620 (1935).

30. Bruce, *supra* note 20, at 65 (quoting BRUCE C. VLADECK, UNLOVING CARE: THE NURSING HOME TRAGEDY 86 (1980)).

31. See *id.* at 66 ("OAA provided 'cash payments to elderly poor people, regardless of their work record.'").

32. *See id.* (suggesting that "societal disfavor with public institutions" was behind legislative rationale to deny assistance payments to elderly living in institutions).

33. *See id.* at 65-66 (describing evolution of Social Security); *see also Nursing Homes*, TIME, Aug. 13, 1956, http://www.time.com/time/magazine/article/0,9171,86544,00.html (detailing rise in convalescent homes in United States). "Overall conclusion to be drawn: most U.S. convalescent homes are not medically oriented – or, indeed, safely oriented." *Id.*

34. Bruce, *supra* note 20, at 66 (quoting VLADECK, *supra* note 30, at 39).

reimbursed "particular types of facilities for the care and treatment of qualified elderly persons inadvertently shaped" nursing home facilities into a vital source of care for America's elderly.[35] The Social Security Act influenced the development of nursing homes because it provided older people with increased income, allowing them to afford nursing home care and services.[36] The Social Security Act thus unintentionally encouraged the development of the modern nursing home.[37]

Old Age Assistance prohibited government payments "if the elderly person was living in a public institution."[38] Therefore, this federal funding scheme "helped to encourage the expansion of private nursing homes, transforming the remaining public nursing intuitions and almshouses into the modern day nursing home."[39] This virtually instantaneous statutory transfer of purchasing power into the hands of the elderly shaped the scope of available services—even "proprietary convalescent homes" arose as private, cash-short homeowners opened their doors to the elderly.[40]

In 1950, Congress significantly amended the Social Security Act.[41] The 1950 amendments contained three major reforms: a lift on the prohibition of payments to public institutions, "federal matching of payments made by state and local welfare agencies to the suppliers of health services," and the requirement that states establish licensing regulations for public nursing homes.[42] These amendments opened the door for the modern nursing home.

Another key to the development of nursing homes was the advent of Medicare and Medicaid. If long-term care providers qualified for and utilized Medicare and Medicaid funds, they had to follow strict federally mandated regulations.[43] Medicare and Medicaid increased available public money for nursing homes that

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35. Bohm, *supra* note 2, at 329.

36. *See* Bruce, *supra* note 20, at 66 ("The driving force behind the rapidly developing nursing and personal care services was the Social Security Act, 'which had injected a substantial new flow of income into the hands of older people and those who sold services to them.'").

37. *See id.* at 66-67 (describing evolution from convalescent homes to nursing homes, with Social Security funds as a catalyst).

38. *Id.* at 66.

39. Bohm, *supra* note 2, at 329.

40. *See* Bruce, *supra* note 20, at 66 (describing marketplace changes occurring as result of capital inflow from Social Security Act); *see also* JOHNSON & GRANT, *supra* note 2, at 6 ("Although Social Security benefits could not be used for almshouses, they could be used for the expansion of services in private boarding houses.").

41. Pub. L. No. 734, 64 Stat. 477 (1950).

42. Bruce, *supra* note 20, at 66-67.

43. *See id.* at 67 (detailing influence of Medicare and Medicaid restrictions on nursing homes).

met certain federally mandated minimum standards.[44]

These minimum standards, however, were too stringent for many nursing homes to meet.[45] In response, "the government developed different methods, essentially classifications, whereupon a nursing facility could still receive Medicare and Medicaid funding without technically meeting the newly created hospital-like regulations."[46] Due to the constant changing labels, "classifications and certifications of nursing facilities, federal and state funding of nursing homes through the Medicare and Medicaid programs allowed a vast amount of money to be spent for elderly care."[47]

In the 1980s, the poor quality of care within many public and private nursing homes was gaining publicity.[48] Responding to public pressure for improved eldercare, Congress passed the Omnibus Reconciliation Act of 1987 (OBRA 87).[49] The Act was "aimed at curing some of the quality care downfalls of nursing home facilities, as well as enacting patients' rights."[50] OBRA 87 focused federal standards on care delivery and care results.[51] The Act strengthened sanction enforcement and created a federal penalty to compel nursing facilities to comply with the new standards.[52] The legislation added penalties "such as civil monetary penalties, the placement of a substitute manager in the nursing home, mandatory staff training on specific non-compliant issues, implementation of a correction plan and the placement of an on-site monitor at the nursing home."[53]

Because of OBRA 87 and related regulation, the government is increasingly involved in the conditions of care provided in nursing

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44. *See* Bohm, *supra* note 2, at 329-35 (discussing growth of modern nursing home through legislative incentives).

45. *Id.* at 330.

46. *Id.*

47. *Id.* at 331.

48. *See* BAKER, *supra* note 2, at 15 (describing social movement for improved elder housing and care conditions as beginning in mid-1970s and coming to fruition in late 1980s). "In 1975, members of the National Gray Panthers Long-Term Care Action Project organized the National Citizens' Coalition for Nursing Home Reform (NCCNHR), aimed at fighting for higher standards in nursing homes." *Id.* In 1985, NCCNHR organized small groups of nursing home residents in fifteen different states to speak out about quality of care standards in nursing home facilities. *See id.* In 1986, the Institute of Medicine "issued a landmark report, 'Improving the Quality of Care in Nursing Homes[,]'" which indirectly led to the passage of the Omnibus Reconciliation Act of 1987 shortly thereafter. *Id.*

49. *See id.* at 15-16 (providing investigative and social background to passage of OBRA in 1987).

50. Bohm, *supra* note 2, at 331.

51. *See id.* at 332 (detailing policies behind enactment of OBRA 87).

52. *See id.* (detailing federal role of nursing home regulation following implementation of OBRA 87).

53. *Id.*

home facilities. After OBRA 87 was enacted, the government created regulations that implemented the quality care standards for nursing homes.[54] Following the enactment of the statutory scheme, a prospective nursing home owner who wanted to open a nursing home had to agree to participate in Medicare and Medicaid as a condition of accepting any government money.[55] If the nursing home owner decided to participate in Medicare and Medicaid then he or she would be forced to comply with government regulations.[56]

III. CURRENT ELDERCARE STRUCTURE AND RISING NEED

The elder population is larger than ever before—due in part to longer life spans.[57] California and Florida have the most elderly residents in the United States, with Texas expected to be third by 2025.[58] "California [currently] has the largest number of nursing homes with 1,378, closely followed by Texas, [which has 1,251,] while Florida has 734 facilities."[59]

In 2008, "about nine million men and women over the age of 65 will need long-term care."[60] By 2020, the number in need will reach 12 million older Americans.[61] While most will be cared for at home, a study by the U.S. Department of Health and Human Services predicts that people who reach age sixty-five have a 40% chance of entering a nursing home.[62] "About 10 percent of the people who enter a nursing home will stay there five years or more."[63]

In courts of law, the elderly are not a suspect class under constitutional jurisprudence.[64] According to the U.S. Supreme Court

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54. *See id.* at 332 ("Several years later, the government developed compliance regulations for nursing facilities which finally implemented quality care standards for nursing facilities.").

55. *See id.* at 333 (detailing options for "a person owning a nursing home [who] wants to open that facility to the public").

56. *See id.* (illustrating the restrictive nature of regulations on operation of nursing home business).

57. *See* Drummonds, *supra* note 6, at 271-72 (detailing aging baby boomers and size of elder population).

58. *See* Texas Senate Research Center, *Nursing Home Liability Insurance Rates: Factors Contributing to the Rate Increases in Texas*, IN BRIEF, Feb. 2001, at 1, http://www.senate.state.tx.us/SRC/pdf/IN_BRIEF_Nursing.pdf (discussing Texas elder population forecasts).

59. HARRIS & BENSON, *supra* note 4, at 8.

60. *See* Medicare.gov, Long-Term Care, http://www.medicare.gov/LongTermCare/Static/Home.asp (last visited Mar. 25, 2009) [hereinafter Medicare – Long-Term] (detailing current and forecasted need for elder care).

61. *See id.* (forecasting growth in elder segment of population).

62. *See id.* (describing future trends in nursing home need).

63. *Id.*

64. *See* BLACK'S LAW DICTIONARY 1487 (8th ed. 2004) (defining suspect class as "[a] group identified or defined in a suspect classification"). Furthermore, Black's Law

in *Kimel v. Florida Board of Regents*, "[s]tates may discriminate on the basis of age without offending the Fourteenth Amendment if the age classification in question is rationally related to a legitimate state interest."[65] The Court reasoned that "[o]ld age also does not define a discrete and insular minority because all persons, if they live out their normal life spans, will experience it."[66] Thus, the elderly are "an unprotected class of citizens under the Equal Protection Clause of the Fourteenth Amendment."[67]

This lack of constitutional protection is particularly relevant in the modern context of legislative tort reform: an increasingly popular solution to the perceived excess of civil personal injury litigation is a cap on non-economic damages—such as pain and suffering, loss of enjoyment of life, or depression—as a disincentive to litigators and plaintiffs.[68] Because the elderly typically do not have significant or collectable economic damages (such as lost wages), non-economic damage limitations have an unequal impact on the elderly; yet, because of their constitutionally-unprotected class status, the elderly have no recourse to this seeming inequity. This lack of possible damages, in turn, acts as a disincentive to attorneys working on a contingent-fee basis. The difficulty in presenting high damage claims is the primary obstacle to large verdicts in most nursing home litigation.[69] Additionally, for those cases actually brought to trial, the lack of damages requires attorneys to employ emotional methods—such as detailing the plaintiff's life before becoming a resident at the nursing home and explaining the medical conditions and manner of death in vivid detail, often with visual recreations—in an effort to maximize jury verdicts.[70] This tactic, while it may simply be the attorney acting as a zealous advocate for his or her client, results in a publicly perceived need for further tort reform, thus driving up nursing home general and malpractice liability insurance.[71]

Dictionary defines suspect classification as "[a] statutory classification based on race, national origin, or alienage, and thereby subject to strict scrutiny under equal-protection analysis." *Id.*

65. 528 U.S. 62, 83 (2000); *see also* Victoria A. Schall, *The New Extreme Makeover: The Medical Malpractice Crisis, Noneconomic Damages, the Elderly, and the Courts*, 5 APPALACHIAN J.L. 151, 152 (2006) (describing constitutional treatment of elderly).

66. *Kimel*, 528 U.S. at 83.

67. Schall, *supra* note 65, at 152.

68. *See id.* at 153 (noting that twenty-one states had capped noneconomic damages by 2004).

69. *See* Dollar, *supra* note 4, at VII ("In most nursing home cases, damages have been seen as the major obstacle to large verdicts.").

70. *See id.* (noting need for creative courtroom tactics that pander to jury when procedural rules are ambiguous or lacking).

71. *See id.* (recommending courtroom methods for maximizing jury verdicts for elder clients against nursing home defendants).

IV. DYNAMIC PROBLEM: INCREASED LITIGATION, RISING LIABILITY INSURANCE PREMIUMS, AND UNDERCAPITALIZATION OF NURSING HOMES

Nursing homes have multiple sources of revenue. As of 2006, the average annual cost of nursing home care for a private pay resident was approximately "$71,000 for a private room, and $62,500 for a semiprivate room; a one-bedroom assisted-living unit cost more than $32,000 a year."[72] Approximately two-thirds of nursing homes are for-profit organizations whereas "26[%] are nonprofit, and 7[%] are government owned and operated."[73] Most nursing homes depend on a mixture of private and Medicaid payments.[74] Approximately 15% of nursing homes, however, are "almost entirely [dependent] on Medicaid for reimbursement."[75]

Despite the growing need for nursing home services, the industry is rife with bankruptcies and litigation.[76] By their very nature, nursing homes are high-risk ventures: they are inhabited by frail, unsteady residents who are often mentally compromised.[77] Risk and litigation go hand-in-hand, and litigation increases costs. Increased costs, especially when coupled with decreasing profit margins from reduced Medicare and Medicaid payments, lead to bankruptcies.

The quality of care received by nursing home residents is highly variable. As a result, nursing homes have become frequent targets for litigation. According to a St. Louis attorney who specializes in defending nursing homes, "nursing homes have big targets on their backs. It's the litigation *du jour* now and has been for a couple of years . . . ."[78]

With the litigation boom of the last decade,[79] nursing home

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72. BAKER, *supra* note 2, at 8.

73. HARRIS & BENSON, *supra* note 4, at 6; *see also* BAKER, *supra* note 2, at 9 ("Two-thirds of nursing homes are for-profit enterprises, most of them operated by large corporations such as Kindred Healthcare and HCR/ManorCare.").

74. BAKER, *supra* note 2, at 9 (detailing payers).

75. *Id.*

76. See Leighton, *supra* note 19 (describing current state of nursing home industry, fraught with bankruptcies and lower profit margins).

77. *See* Centers for Disease Control and Prevention, Falls Among Older Adults: An Overview, http://www.cdc.gov/ncipc/factsheets/adultfalls.htm (last visited May, 2009) ("In 2005, 15,800 people 65 years and older died" of fall-related injuries. Another 1.8 million were treated in emergency departments for nonfatal injuries related to falls.). The total cost for falls among older adults in 2000 was about $19 billion. *Id.* Given the growing population of this age group, this cost is expected to reach $54.9 billion by 2020. Centers for Disease Control and Prevention, Costs of Falls Among Older Adults, http://www.cdc.gov/ncipc/factsheets/fallcost.htm (last visited May 9, 2009).

78. John DeMoor, *Trends in Nursing Home Litigation*, KAN. CITY DAILY REC., Aug. 3, 2005 (referencing attorney Stephen Strum).

79. *See id.* ("[Handing over the keys] is just one of the latest trends . . . . Other

owners and operators face sharply escalating liability insurance premiums, heightened by increased risk of litigation.[80] Lack of sufficient insurance has led some nursing home defendants to use the tactic of "hand[ing] over the keys to the facility's front door" to dissuade plaintiffs from continuing litigation.[81]

Another increasingly common tactic of liability avoidance used by nursing home companies is corporate restructuring to insulate assets from plaintiffs executing judgments entered against defendant nursing homes or to dissuade litigation altogether.[82] That is, simultaneous with an increase in claims brought on behalf of nursing home residents, there is an increase in general and malpractice liability insurance premiums, leading to greater incentives for corporate structuring to insulate from liability. Although foregoing insurance or restructuring disincentivize litigation and effectively reduce legal liability, they do not remove the front-end problem of inadequately funded nursing home corporations.

The three main elements in the decrease of nursing home viability—a boom in litigation, rising nursing home insurance premiums, and the restructuring of nursing home ownership to avoid liability—create a mutually reinforcing negative cycle. As litigation increases, insurance premiums increase, leading to additional attempts to mitigate liability through corporate restructuring. Depleted assets, intentionally resulting from corporate restructuring, in turn raise insurance premiums still further, while serving as a counter-incentive to litigation.

Additionally, as insurance premiums increase and the size and frequency of legal claims increase, some insurers leave the nursing home market due to financial hardship. Thus, elder citizens with meritorious claims for damages are increasingly without a collectible monetary remedy even if their claims are brought to trial. Consequently, fewer potentially meritorious claims are brought to trial due to the infeasibility of collection.[83]

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trends attorneys cited include plaintiffs joining hospitals more regularly in the lawsuit; an increase in lawsuits related to resident-on-resident assaults and sexual assaults; and forcing perspective residents to sign binding-arbitration agreements.").

80. *See* Sara Hoffman Jurand, *Lack of Insurance Hinders Recovery in Nursing Home Cases*, TRIAL, Feb. 1, 2006, at 14 (discussing difficulty in recovery verdicts entered against nursing home defendants because of inadequate insurance).

81. DeMoor, *supra* note 78.

82. *See generally* Joseph E. Casson & Julia McMillen, *Protecting Nursing Home Companies: Limiting Liability Through Corporate Restructuring*, 36 J. HEALTH L. 577 (2003) (detailing trends in nursing home corporate structuring to maximize asset protection from creditor plaintiffs).

83. *See* Marshall B. Kapp, *Malpractice Liability in Long-Term Care: A Changing Environment*, 24 CREIGHTON L. REV. 1235, 1237 (1991) ("Older persons historically have been underrepresented statistically as plaintiffs in health care malpractice

A. *Litigation Boom*

Although receiving a disproportionately large amount of health care, the elderly have historically not been a highly represented class in civil litigation based on medical causes of action.[84] Several reasons drive the underrepresentation of the elderly. Monetary damages are low because elder plaintiffs typically do not have lost wages or out-of-pocket medical expense.[85] Proximate or direct causation may be difficult to prove for frail plaintiffs with a multitude of health problems.[86] Elder plaintiffs may not be credible witnesses before a jury.[87] Furthermore, elder plaintiffs may not outlive the long duration of legal proceedings.[88] Finally, the elderly may lack a voice to report their problems or contact a lawyer.[89]

Despite the difficulties unique to civil actions brought on behalf of elderly clients, the frequency of such actions has been increasing since the mid 1980s.[90] As a further reflection of this growing trend, the American Trial Lawyers Association (ATLA)—a national organization composed of the top 100 trial lawyers from each state—began a Nursing Home Litigation Group in the early 1990s.[91]

Certain courts have allowed more lenient and expedited procedures for elderly plaintiffs, and have relaxed restrictions on rules allowing relatives or decedents' estates to bring action.[92] Furthermore, publicity surrounding exorbitant verdicts for elder plaintiffs has directed the attention of trial lawyers to elder plaintiffs

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lawsuits.")

84. *See generally id.* at 1237-41 (explaining changing frequency in elder lawsuits).

85. *See id.* at 1238 ("Cases involving egregious patterns of patient abuse and neglect, thereby qualifying for the award of punitive or exemplary damages, have been the scenarios most likely to attract plaintiffs' attorneys working on a contingent fee arrangement, and thus to enter the legal system from the nursing home setting.").

86. *See id.* (noting difficulty of proving causation, necessary element in standard negligence claim).

87. *See id.* ("[A]n older plaintiff who is severely compromised physically and mentally may not make a persuasive or credible witness on his or her own behalf, and sufficient supportive evidence from other sources may be difficult to uncover and present.").

88. *See id.* ("[T]he lawsuit may outlive the older plaintiff.").

89. *See id.* at 1237-39 (detailing aspects of elderly plaintiffs that may explain, in part, seeming absence of elderly clients in law practice).

90. *See id.* at 1239-41 (noting increasing actions against nursing homes).

91. American Trial Lawyers Association, http://www.theatla.com/about.html (last visited Apr. 20, 2008); *see* Kapp, *supra* note 83, at 1239 (noting creation of ATLA's nursing home-specific group).

92. Julie A. Braun & Elizabeth A. Capezuti, *Nursing Home Litigation and the Elder Law Attorney*, 14 NAT'L ACAD. ELDER L. ATT'YS Q. 3, 4 (2001) (discussing whom may bring suit).

because of their perceived need for representation.[93]

As a result, litigation verdicts against nursing homes are increasingly larger.[94] In Texas, for example, there were 86 claims against nursing homes in 1997 with a total worth of $10.4 million.[95] Just two years later, there were 92 claims that cost nursing homes $26.1 million, a per-claim cost increase of nearly two-and-a-half times that of 1997.[96]

Nursing home lobbyists and interest groups point to the increase in litigation as the primary cause of the national nursing home shortage.[97] These groups claim that the diversion of funds from resident care, facility maintenance, and payroll to pay for a handful of large-verdict lawsuits has decreased the overall level of care for nursing home residents.[98] Nursing home advocates, especially in those states with liberal elder rights statutes and few limitations on damages, blame tort litigation as the cause of the nursing home financial problem.[99] In contrast, litigators note that "if nursing home

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93. *See* Kevin McVeigh, *Joe Louis' Sister Froze to Death at Nursing Home, Suit Says*, FINDLAW, July 25, 2008, http://news.lp.findlaw.com/Andrews/h/nlr/20080725/20080725_high.html (describing recent death of Joe Louis' elderly sister, who suffered from Alzheimer's, in Detroit nursing home); *see also* Kevin McVeigh, *La. Nursing Home Hit With $1 Million Verdict in Bedsore Death Case*, FINDLAW, Nov. 15, 2007, http://news.findlaw.com/andrews/h/nlr/20071115/20071115_king.html ("A Louisiana state court jury has awarded $1 million to the daughter of a nursing home resident who died from infected bedsores during his 26-day stay at the facility."); Mark Singletary, *Vioxx Trial Puts Louisiana in Top Ten Jury Awards List*, BNET, Feb. 12, 2007, http://findarticles.com/p/articles/mi_qn4200/is_20070212/ai_n1722418 ("In the third largest nursing home verdict in U.S. history, a Texas jury awarded $160 million to the family of an elderly man who was severely beaten by his violent and mentally ill roommate.").

94. *See* PENNSYLVANIA BAR INSTITUTE, NURSING HOME NEGLIGENCE LITIGATION, at iii (2006) ("Lawsuits against nursing homes are on the rise; in fact, nursing home litigation is one of the fastest growing areas of health care litigation today.").

95. *See* Texas Senate Research Center, *supra* note 58, at 5 (detailing 1997 claims).

96. *See id.* (detailing 1999 claims and contrasting 1999 claims with 1997 claims).

97. *See generally* Leighton, *supra* note 19 (describing actions of nursing home industry lobbyists).

98. *See id.* (summarizing arguments of lobbyists).

99. *See id.* at 403 ("The American Health Care Association (AHCA) and the National Medical Liability Reform Coalition have declared that nursing homes and assisted living facilities are plagued by a proliferation of lawsuits in states that have liberal patient rights provisions."). Nursing home industry interest groups propose the following steps to solve the national nursing home litigation problem:

> (1) Periodic payment of future damages over $100,000; (2) Limiting punitive damages to 3 times the amount of damages awarded for economic losses or $250,000; (3) Two-year statute of limitations; (4) Establishing joint and several liability; (5) Allowing defendants to introduce collateral source payments; and (6) Entitling prevailing parties to attorneys' fees from a non-prevailing party.

residents were not abused and neglected, there would be nothing to sue for."[100]

In fact, several studies have concluded that the increase in eldercare-related litigation is justified. In 2001, two Florida newspapers conducted a study of 924 lawsuits filed against nursing homes in south and central Florida over the prior five-year period.[101] The review led to the conclusion that the vast majority of the 924 suits were not frivolous.[102] Approximately half of the suits were related to deaths, half of the suits mentioned bedsores, one-third of the suits dealt with infection, and one-quarter of the suits were related to falls.[103] Affirming the findings of the newspapers' study, a 2001 Florida Task Force examined 225 lawsuits brought in Hillsborough County, Florida, and found zero frivolous claims.[104]

A 2002 study by the Americans for Insurance Reform—an alliance of more than 100 public interest groups—concluded that "over the past 30 years, insurance premium rates had been unrelated to payouts for lawsuits, but instead, had followed the ups and downs of the economy."[105] Nonetheless, "[i]n the late 1990s, large awards for pain and suffering, previously more common in medical malpractice claims against physicians, began to be awarded more frequently to injured nursing home residents as well. Punitive damage awards against nursing homes also became more common."[106]

Financial instability of a nursing home cannot be solely attributed to increased litigation. "The financial problems restricting services to seniors today in nursing homes is a direct result of the fusion between incurred debt from aggressive business growth practices, Medicare reimbursement cutbacks, and a chronically underfunded Medicaid system."[107]

Issues in the public discourse on the nursing home problem include the standard of care that nursing home residents receive and insurer refusal to sell liability policies to nursing homes. Yet, the strength of both of these issues hinges on the merit, or lack thereof,

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Id.

100. *Id.* at 404.

101. *See* BERNADETTE WRIGHT, NURSING HOME LIABILITY INSURANCE: AN OVERVIEW 13 (2003), http://assets.aarp.org/rgcenter/health/2003_08_nh_ins.pdf (detailing a 2001 study by *Sun-Sentinel* and *Orlando Sentinel*).

102. *See id.* (summarizing findings of study).

103. *See id.* (summarizing findings of study).

104. *See id.* at 12.

105. *Id.*

106. *Id.* at 14.

107. Leighton, *supra* note 19 (concluding that the scare tactic of nursing home industry blaming litigation for inadequacy of care is "clever, but the evidence shows it is without merit").

of lawsuits brought on behalf of nursing home plaintiffs.[108]

The number, frequency, and severity of claims brought on behalf of elder clients vary by region and are largely a product of the statutory rights recognized in the elder population in a given state.[109] As seen from the review of the above studies, most suits brought on behalf of nursing home residents are meritorious and based on actual injury or death.[110] To the extent that litigation has actually increased, the reason "may be that society has grown less tolerant of poor quality nursing home care."[111] Additionally, beyond the federal statutory amendments under the Omnibus Budget Reconciliation Act of 1987, "several states have enacted additional rights to provide further protections for nursing home residents. State residents' rights laws sometimes include a private right of action, which allows residents and their families to sue when a nursing home violates the residents' rights specified by the law."[112]

Although the amount of eldercare litigation is increasing in many jurisdictions,[113] it does not appear to be the result of a corresponding increase in frivolous claims.[114] Nursing home bills of

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108. *See id.* (describing dynamic problem of nursing home situation, which litigation remains easy scapegoat for). "Many issues are involved in the nursing homes' current dilemma such as its own financial mismanagement and financially reckless calculations." *Id.* The cause of litigation is also debated between "favorable laws or because too many homes provide substandard care inviting their own lawsuits." *Id.* Furthermore, the cause of insurer refusal to write policies is debated between "merit less lawsuits or the unpredictability that comes with even meritorious lawsuits." *Id.*

109. *See* Casson & McMillen, *supra* note 82, at 591-92 (describing varying nature of regulatory environments in different jurisdictions).

110. For a further discussion of the merit of Florida lawsuits brought on behalf of nursing home residents, see *supra* notes 101-04 and accompanying text.

111. *See* Wright, *supra* note 101, at 17.

112. *Id.*

113. *See* Casson & McMillen, *supra* note 82, at 584 (detailing rise in nursing home litigation). "Recent reports estimate the number and amount of nursing home liability claims to be on the rise. Claims against nursing homes have tripled from 4.6 claims per 1,000 beds in 1991 to 14.5 claims per 1,000 beds in 2002." *Id.* The average amount of each claim has more than tripled as well, "from $63,500 in 1991 to just under $200,000 in 2002." *Id.*

114. *See* Kapp, *supra* note 83, at 1241-52 (suggesting that increase in resident claims against nursing homes is not due to frivolous litigation, but from growing source of claims, such as admission agreements and bills of rights). "The largest single source of negligence claims against nursing homes is patient injury associated with falls or wandering." *Id.* at 1242. Furthermore, "[b]ad clinical outcomes, particularly where they are unexpected by the patient or family, are the most reliable leading indicator of eventual lawsuit initiation." *Id.* at 1248. Bedsores are another source of increasing litigation. *See id.* at 1249. "Another potential source of nursing home litigation is violation of the provisions contained in the written admission agreement routinely executed between the nursing home and the patient or his or her legal surrogate the time the patient enters into the facility." *Id.* at 1250.

rights,[115] recently passed in many U.S. states,[116] have made elder plaintiffs more profitable for attorneys working on a contingent-fee basis.[117] In conclusion, there is evidence that the increase in litigation is not reflective of a decrease in eldercare, but instead an acknowledgment of previously overlooked meritorious claims, changing social norms regarding eldercare standards, and recent legislation by various states.[118]

B. Rising Insurance Rates

"Nursing home liability insurance generally pays for the damages and defense expenses resulting from a negligent act, error, or omission in caring for a nursing home resident."[119] Although most large nursing home companies carry some form of liability insurance,

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115. This development has largely been the result of OBRA. Florida, for example, enacted an extensive nursing home residents' rights statute in 2007. FLA. STAT. ANN. § 400.022 (West 2006). Florida's statute protects a plethora of rights, including: "[t]he right to civil and religious liberties," "[t]he right to private and uncensored communication," "[t]he right to present grievances," "[t]he right to organize and participate in resident groups," "[t]he right to examine . . . the results of the most recent inspection of the facility," "[t]he right to manage his or her own financial affairs," "[t]he right to be fully informed . . . of services available," "[t]he right to be adequately informed of his or her medical condition," "[t]he right to refuse medication or treatment," "[t]he right to receive adequate and appropriate health care," "[t]he right to have privacy in treatment," "[t]he right to be treated courteously, fairly, and with the fullest measure of dignity," "[t]he right to be free from mental and physical abuse," "[t]he right to freedom of choice in selecting a personal physician," "[t]he right to retain and use personal clothing and possessions," and "[t]he right to have copies of the rules and regulations of the facility." *Id.* §§ 400.022(1)(a)–(s).

116. State statutes have largely been patterned off of the federally guaranteed nursing home residents' rights enacted in 1987. *See* NAT'L CITIZENS COALITION FOR NURSING HOME REFORM, RESIDENTS' RIGHTS: AN OVERVIEW 1-2 (2003), http://www.nccnhr.org/uploads/ResRights03.pdf (outlining federally enumerated rights). These rights include, generally, the right to be fully informed; the right to complain; the right to confidentiality and privacy; the right to participate in one's personal care; the right to respect, freedom, and dignity; and the right to make independent choices. *See id.*

117. Such Nursing Home Residents' Rights statutes typically create a cause of action for the violation of any enumerated statutory rights. In Florida's statute, for example, standing to bring a cause of action is given to a broad range of persons:

> Any resident whose rights as specified in this part are violated shall have a cause of action. The action may be brought by the resident or his or her guardian, by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death.

FLA. STAT. ANN. § 400.023(1) (West 2006)

118. *See* Kapp, *supra* note 83, at 1253-55 (describing rise of patient advocacy networks in response to changing social views of elderly as partial explanation for increased litigation).

119. Texas Senate Research Center, *supra* note 58, at 1.

many states do not require nursing homes to purchase liability insurance.[120] Skilled nursing facilities, which provide both housing and health care providers, typically carry both general and professional liability insurance.[121] "General liability insurance addresses the risk from accidents occurring on the property. Professional liability insurance addresses the occurrence of errors and omissions on behalf of the employees, that the employer . . . could be held responsible for."[122]

Nursing home liability insurance premiums are growing exponentially. In Texas, for example, the per-bed rate charged by regulated insurers grew from approximately $200 in 1998 to $900 in 2000.[123] In Ohio, premiums rose 30% in some facilities from 2000 to 2001.[124] Annual rates of Texas's unregulated insurers—not subject to the strict financial oversight from the state—were between $2,500 and $5,000 per bed in 2000.[125] One St. Louis attorney recently stated that one of his nursing home clients saw its "long-term care liability insurance premium jump from $50,000 to $500,000 a year."[126] In Florida, one non-profit nursing home saw an increase in its renewal price of liability insurance rise from $80,000 to $720,000 in one year for half the coverage.[127] As regulated rates increase, some nursing homes are pushed into the unregulated market, thus forcing the company to choose between exaggerated rates or forgoing liability insurance altogether.

Despite the increases in nursing home liability insurance premiums, the number of insurance companies offering nursing home liability insurance is declining.[128] Insurance companies profit from the law of large numbers. By spreading risk across a large pool of

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120. *See id.* (noting that Texas nursing homes are not legally required to purchase liability insurance).

121. *See* CAL. DEP'T OF HEALTH SERVS. LICENSING AND CERTIFICATION PROGRAM, LIABILITY INSURANCE FOR CALIFORNIA LONG-TERM CARE PROVIDERS: A REPORT TO THE CALIFORNIA LEGISLATURE 5 (2001) [hereinafter CAL. DEP'T OF HEALTH], http://www.dhs.ca.gov/LNC/ltcliab/default.htm (describing liability insurance of skilled nursing facilities).

122. *Id.*

123. *See* Texas Senate Research Center, *supra* note 58, at 1.

124. *See* Marshall B. Kapp, *Legal Anxieties and End-of-Life Care in Nursing Homes*, 19 ISSUES L. & MED. 111, 123 (2003) (detailing increase in Ohio premiums).

125. *See* Texas Senate Research Center, *supra* note 58, at 2 (noting drastically higher rates charged by unregulated insurers). Unregulated insurers must show proof that the nursing home client was unable to obtain regulated insurance. *See id.*

126. DeMoor, *supra* note 78.

127. *See* Kapp, *supra* note 124, at 123 (detailing the problem with the increase in nursing home premiums).

128. *See* Texas Senate Research Center, *supra* note 58, at 2 (detailing duality of insurance problem: increasing premiums and decreasing insurers in marketplace).

clients, insurers can withstand a certain amount of liability claims.[129] However, even as the demand for nursing home services increases, the marginal profits from accepting additional Medicaid patients may actually decrease. Therefore, many facilities attempt to lower costs by reducing staff, even though their facilities may become correspondingly more risky for patients.[130] In addition, insurer profitability declines because relatively safe nursing homes decide to self-insure or forego insurance in response to escalating premiums, producing a percentage increase in claim filings for the remaining insured nursing homes.[131] Insurers then must raise their rates, inevitably pricing certain nursing home clients out of the market.

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129. *See* JOHN F. DOBBYN, INSURANCE LAW IN A NUTSHELL 2-4 (4th ed. 2003) (introducing fundamental concepts of insurance). Insurance can be conceptualized as the distribution of risk across a group of substantial size. According to Professor Dobbyn:

> By paying a pre-determined amount (premium) into a general fund out of which payment will be made for an economic loss of the defined type, each member contributes to a small degree toward compensation for losses suffered by any member of the group. The member has no way of knowing in advance whether he will receive in compensation more than he contributes or whether he will merely be paying for the losses of others in the group; but his primary goal is to exchange the gamble of going it alone, whereby he could either escape all loss whatsoever or suffer a loss that might be devastating, for the opportunity to pay a fixed and certain amount into the fund, knowing that that amount is the maximum he will lose on account of the particular type of risk insured against.

Id. at 2-3.

130. *See* R. Patrick Bedell, Note, *The Next Frontier in Tort Reform: Promoting the Financial Solvency of Nursing Homes*, 11 ELDER L.J. 361, 379 (2003).

> Additionally, nursing home litigation can encourage staffing problems at long-term care facilities. The Health Care Financing Administration reports a strong correlation between nursing home staffing levels and the quality of care at nursing homes. Their report indicates that 54% of nursing homes were below the suggested nurses aides staffing level, 31% were below the registered nurses suggested minimum level, and 23% were below the minimum total suggested licensed staff.

Id.

131. *See* DOBBYN, *supra* note 128, at 3-4 (detailing concept of "substantial membership"). Professor Dobbyn explains:

> In fixing premium rates to be paid by each member to cover all losses for the period as well as administrative and other costs, the insurer is required to predict the number and size of losses that are likely to occur during that period. Just as in flipping a coin . . . the probability that the prediction of total losses will not be thrown off by an unanticipated number of losses increases as the number of insurance policies issued increases.

Id. Thus, if circumstances change that increase the collective risk of the pool of insureds (such as a pattern of nursing home understaffing) or if certain individual insureds, whose participation the group premiums are based, decide to leave the pool because they no longer value the service of insurance at the price of the premium charged, the proportionate risk and premiums of the remaining insureds will change.

Some nursing homes do not have insurance coverage because they are not able to self-insure, they cannot afford the premiums, or they perceive themselves as relatively low-risk and thus, from a cost-benefit standpoint, not in need of insurance. As a result, when liability insurance rates are increased in general to cover anticipated litigation costs, nursing homes owners who perceive low risk are prompted to drop their coverage, thereby increasing the exposure of their residents if the owners are unable to pay legitimate judgments against them. If insurance premiums rise to extremely high levels, and there is no regulatory requirement to carry insurance, the nursing homes' owners who continue to operate are likely to be the riskier clients.[132] Carried to its logical conclusion, this cycle will result in some insurers leaving the market altogether because of the extraordinary high-risk profile of the remaining client pool.

In Texas, for example, only three regulated nursing home insurance companies remained in the state as of 2000, significantly down from the eight regulated companies that were present in the state just four years earlier.[133] By 2001 just two regulated companies remained.[134] With decreases in the number of insurers in the market, the market share of the remaining firms increases, thus potentially leading to increased pricing power and selectivity of those remaining firms, which, in turn, drives up liability insurance rates even further and may exclude more nursing homes from the market.[135] Consequently, nursing home facilities, particularly smaller corporations, tend to carry the state required minimum liability insurance, or, if legal, foregoing insurance or self-insuring.[136]

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132. *See id.* (detailing concept of pool of insureds and substantial participation).

133. *See* Texas Senate Research Center, *supra* note 58, at 2 (detailing retreat of insurers from Texas marketplace).

134. *See id.* (detailing dwindling presence of insurers).

135. *See* N. GREGORY MANKIW, PRINCIPLES OF MICROECONOMICS 347-48 (3d ed. 2004) (describing pricing tensions of oligopoly market). Markets defined by a few number of sellers, or oligopolies, have a tension between acting collectively and acting self-interestedly. *See id.* at 347. In the nursing home insurance market, especially in a state with few remaining insurers, an increase in premiums initiated by one firm would likely be followed by the few remaining firms.

136. *See* Jurand, *supra* note 80, at 14 (describing trends in nursing home insurance). Laws requiring liability insurance coverage or reporting vary by state and are reflective of each state's particular circumstances, such as the size of the elder population, the rate of poverty within the elder population, and the cost of labor for skilled nursing and long-term care facilities, to name only a few factors. CAL. DEP'T OF HEALTH, *supra* note 121, at 69-81 (detailing various state minimum insurance laws). For example, Florida, Texas and Pennsylvania all require nursing homes to carry minimum liability insurance. *See id.* at 79. Mississippi, Ohio, Pennsylvania, and Florida have shortened statutes of limitations for elder abuse claims. *See id.* at 77. Florida and Ohio have statutory caps on punitive damages. *See id.* The Tennessee and Mississippi legislatures imposed statutory caps on pain and suffering damages. *See id.*

In California, where nursing homes are not required to carry liability insurance, a general trend of increasing premiums and fewer policy writers has been observed.[137] California represents a unique environment for eldercare because for-profit corporate chains have a large share of the eldercare market, while utilization rates among California's elderly are far below the national average.[138] A 2001 report from the California Department of Health Services found that many skilled nursing facilities "are choosing to self-insure, insure with a large deductible, or go bare, for the purpose of gaining more control over the potential response to a claim or lawsuit."[139]

In 2001, the California Department of Insurance "conducted a data call to determine the state of long-term care liability insurance availability for nursing homes and assisted living facilities in California."[140] From an initial sample of 448 insurers licensed to write policies for long-term care facilities, only eighteen insurers responded that they were accepting new business as of 2001 and sixteen insurers, a small but significant number had either stopped issuing policies to long-term care facilities altogether or were offering policy renewals only.[141]

When nursing homes are faced with increased liability insurance costs, they cannot easily pass costs onto patients because of Medicare and Medicaid regulations. "Medicaid is a [s]tate and [f]ederal [g]overnment program that pays for . . . nursing home care for older people with low incomes and limited assets" after the 100 days of Medicare coverage.[142]

Eligibility for services varies from state to state, usually based on individual income and personal resources.[143] If Medicare coverage requirements are met, the patient is entitled to coverage of the first

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at 78.

137. *See* CAL. DEP'T OF HEALTH, *supra* note 121, at 5 (describing general trends detected as result of the 2001 report).

138. *See* BRIAN BURWELL, EILEEN TELL & THOMSON MEDSTAT, U.S. OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY, THE NURSING HOME LIABILITY INSURANCE MARKET: A CASE STUDY OF CALIFORNIA 2 (2006), http://aspe.hhs.gov/daltcp/reports/2006/NHliab-CA.pdf (detailing specifics of California elder care). Of California's 1,303 nursing facilities, 79% are for-profit and 55% are owned by regional or national chains. *Id.* California "has 123,920 certified nursing home beds, 32 for every 1,000 people age 65 or older. This ratio is well below the national average of 46." *Id.*

139. CAL. DEP'T OF HEALTH, *supra* note 121, at 7.

140. *Id.* at 10.

141. *See id.* (reporting results of data call).

142. Medicare – Long-Term, *supra* note 60 (differentiating Medicare and Medicaid).

143. *Id.* ("Who is eligible and what services are covered vary from state to state. Most often, eligibility is based on your income and personal resources.").

twenty days of skilled nursing care.[144] For days 21 through 100, Medicare pays for all covered services up to an annually adjusted, daily co-insurance amount.[145] In 2008, for example, the co-insurance for days 21 through 100 was up to $128 per day.[146] To be accepted as a Medicare provider, a nursing home must accept the Medicare payment of $128 per day as payment in full.[147] As a result, increased costs, including increased insurance costs, cannot be added to a Medicare or Medicaid bill but must come from current profits or increases in patient co-pays.

Of major importance is the fact that Medicare typically does not pay for long-term care, but only for "medically necessary skilled nursing facility or home health care," and even then only under certain conditions.[148] Most significantly, Medicare does not pay for "custodial care," which refers to "activities of daily living like

144. 42 C.F.R. § 409.85(a)(1) (2007) (detailing coverage for care received in Skilled Nursing Facility (SNF) for first 20 days).

145. *See id.* § 409.85(a)(2) (detailing coverage for next 80 days).

146. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEPT. OF HEALTH AND HUMAN SERVS., MEDICARE COVERAGE OF SKILLED NURSING FACILITY CARE 3 (rev. 2007), http://www.medicare.gov/Publications/Pubs/pdf/10153.pdf (noting that 21-100 day copayment rose to $128 beginning January 1, 2008). "Daily coinsurance for the 21st through 100th day in a skilled nursing facility will be $133.50 in 2009, up from $128 in 2008." Press Release, Ctrs. for Medicare & Medicaid Servs., U.S. Dept. of Health and Human Servs., CMS Announces Medicare Premiums, Deductibles for 2009 (Sept. 19, 2008), http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3272.

147. *See* § 412.521(a)(1) ("Under the prospective payment system, long-term care hospitals receive a predetermined payment amount per discharge for inpatient services furnished to Medicare beneficiaries."); *see also* EARL DIRK HOFFMAN, JR., BARBARA S. KLEES & CATHERINE A. CURTIS, DEP'T OF HEALTH AND HUMAN SERVS., BRIEF SUMMARIES OF MEDICARE & MEDICAID: TITLE XVIII AND TITLE XIX OF THE SOCIAL SECURITY ACT 20-22 (2007), http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2007.pdf (discussing financing, liability, and payment for Medicare and Medicaid); U.S. Department of Health and Human Services, Paying for Long-Term Care, http://www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Costs_Of_Care/Costs_Of_Care.aspx (last visited Feb. 9, 2009) (describing payment coverage for nursing homes). According to the summary chart on the government website, for nursing homes, Medicare "[p]ays in full for days 0-20 if you are in a Skilled Nursing Facility following a recent hospital stay. If your need for skilled care continues, may pay for days 21 through 100 after you pay a $128/day co-payment." *Id.* Private Medigap insurance "[m]ay cover the $128/day copayment if your nursing home stay meets all other Medicare requirements." *Id.* Medicaid "[m]ay pay for care in a Medicaid-certified nursing home if you meet functional and financial eligibility criteria." *Id.* But, "[i]f you need only personal or supervisory care in a nursing home and/or have not had a prior hospital stay, or if you choose a nursing home that does not participate in Medicaid or is not Medicare-certified," then you must pay out of pocket. *Id.*

148. Medicare – Long-Term, *supra* note 60 (detailing nuances of Medicare in laymen's terms).

dressing, bathing, and using the bathroom," or "care that most people do for themselves, for example, diabetes monitoring."[149]

In the cases when nursing home day rates exceed Medicare and Medicaid rates, Medicare and Medicaid rates can be argued to be below profitable levels, contributing to the need for nursing homes to cut costs. Options for cost cutting include the decision not to carry adequate levels of liability insurance and the choice of a corporate structure that bleeds the books of a nursing home of its assets, making it an unattractive target for lawsuits.

To cover the shortfall created by low Medicare and Medicaid rates, nursing homes can raise their day rates even though only private-pay patients are affected. This tactic is theoretically possible—and done in practice—but with limits. If rates for self-financed patients became prohibitively high, they are forced to find other options—such as home care and Veterans Hospitals—and thus leave the nursing home with a higher percentage of "underpaying" Medicare and Medicaid patients, which may lead to the financial failure of the nursing home, because few nursing home residents have private long-term care insurance.[150] "Because the cost of nursing home care is so high, many middle-income people become Medicaid-eligible after several months of long-term care."[151] In response, "Congress enacted special protections for spouses of nursing home residents so that one spouse can become eligible for Medicaid long-term care without first spending down all the couple's income and resources."[152]

Proposed legislation in Connecticut is indicative of the financial gravity of eldercare financing.[153] In response to the financial mismanagement and subsequent bankruptcy of Haven Healthcare, the proposed legislation would allow the state broad discretion to protect nursing home residents.[154] It could conduct "forensic audits of

149. *Id.* ("Medicare doesn't pay for this type of care called "custodial care". Custodial care (non-skilled care) is care that helps you with activities of daily living.").

150. *See* Jeanne Finberg, Medicaid and the Elderly Poor, Resources for New Legal Aid Attorneys, http://povertylaw.pbworks.com/Medicaid-and-the-Elderly-Poor (last visited May 11, 2009) (describing insured status of elder population).

151. *Id.*

152. *Id.* (citing 42 U.S.C. § 1396r-5 (2006)).

153. *See* Attorney General's Office, *Blumenthal, Wyman Announce Sweeping Reforms in Nursing Home Regulation*, NORWALKPLUS.COM, Feb. 8, 2008, http://www.norwalkplus.com/nwk/information/nwsnwk/publish/News_1/BLUMENTHAL_WYMAN_ANNOUNCE_SWEEPING_REFORMS_IN_NURSING_HOME_REGULATION833.shtml (reviewing regulations proposed by Connecticut Attorney General Richard Blumenthal and Comptroller Nancy Wyman); *see also* S.B. 32, Gen. Assem., Feb. Sess. (Conn. 2008) (outlining statutory amendments to protect nursing home residents).

154. Attorney General's Office, *supra* note 153.

Connecticut nursing homes," ease the process for court-appointed receivership of financially mismanaged nursing home facilities, "[p]revent corporate bleeding of nursing home finances by establishing a statutory cap on management fees and rental payments," and set minimum insurance coverage requirements for malpractice and liability of at least $2 million per incident.[155] The state could also tighten property ownership requirements for repairs and maintenance and alter reporting requirements for certain significant changes in ownership.[156]

Haven Healthcare and its parent company Haven Eldercare were started in the late 1990s when two business partners began managing two nursing homes.[157] By 2003, Haven owned and operated fifteen facilities in Connecticut and twelve more in other New England states, with hopes to purchase an additional nine facilities in Connecticut.[158] By 2007, because of financial commingling, gross mismanagement, and several litigation settlements, Haven owed creditors—including pharmaceutical and utility companies—over $20 million, resulting in the heat being shut off in one Haven facility during December.[159]

Making the Haven scenario all the more egregious was Haven's response to creditor pressures resulting from its own financial mismanagement:

> [a]s creditors . . . lined up against Haven, the chain . . . stepped up its efforts to collect on its own unpaid bills, filing lawsuits against elderly residents [seeking] payments for care not covered by Medicare or Medicaid. In some cases, Haven [went] after the residents' only assets — their homes.[160]

The degree of Haven's financial mismanagement evidences the need for regulatory oversight and financial disclosure requirements within

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155. *Id.*

156. *Id.*

157. *See* Lisa Chedekel & Lynne Tuohy, *Haven Debt Woes*, HARTFORD COURANT, Nov. 20, 2007 (detailing Haven Eldercare company history). Haven's CEO, Raymond Termini, began purchasing and managing nursing homes in the 1990s with the help of his mentor and business partner Reverend Edward C. Doherty. *See id.*

158. *See id.* (describing expansion of Haven Eldercare within New England markets).

159. *See id.* ("The chain, which owns 15 nursing homes in Connecticut, has become mired in debt litigation, with at least a dozen creditors seeking more than $20 million in unpaid bills for medication, oxygen and other supplies, according to records.").

160. *Id.* Contemporaneous to the failed financial obligations of Haven Healthcare, Haven's CEO "launched a record label in Nashville to produce both little-known and established country musicians," an endeavor that he freely admitted funding with assets of Haven Eldercare. *Id.* Haven's CEO also built a lake house worth nearly $500,000 while Haven paid $7.3 million in management fees during the 2006 fiscal year. *See id.*

the nursing home industry. Connecticut's in-depth legislative response to the Haven situation is indicative of the potential heightened regulatory environment that could become commonplace if the market does not first provide solutions to the eldercare problem.

Additionally, nursing homes serve a high-risk population. Falls are the leading cause of fatal and nonfatal injuries for persons aged sixty-five years and older.[161] An estimated one-third of older adults fall each year, with a significant correlation between the likelihood of falling and age.[162] In 2003, approximately 13,700 persons aged 65 years or older died from fall-related injuries.[163]

To estimate the percentage of senior citizens who fall in a three-month period, the Centers for Disease Control analyzed data from the 2006 Behavioral Risk Factor Surveillance System survey.[164] The analysis indicated that approximately 5.8 million persons aged 65 years and older (15.9% of all U.S. adults) fell at least once during the three-month study period. It showed that 1.8 million of those who fell (31.3%), "sustained an injury that resulted in a doctor visit or restricted activity for at least 1 day."[165] The researchers also found that 31.8% of the senior citizens who sustained a fall-related injury needed help with daily activities as a result.[166] Of those needing assistance, 58.5% were expected to require help for six months or more.[167]

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161. J. A. Stevens, G. Ryan & M. Kresnow, *Fatalities and Injuries from Falls Among Older Adults—United States, 1993-2003 and 2001-2005*, 55 (45) MORBIDITY & MORTALITY WKLY. REP. 1221, 1221-24, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5545a1.htm (emphasizing relationship between elder falls and elder mortality); *see also* Falls Among Older Adults: An Overview, http://www.cdc.gov/ncipc/factsheets/adultfalls.htm (last visited Mar. 29, 2009) ("Among older adults, falls are the leading cause of injury deaths and the most common cause of nonfatal injuries and hospital admissions for trauma.").

162. *See* Stevens et al., *supra* note 161, at 1221 ("Unintentional falls are a common occurrence among older adults, affecting approximately 30% of persons aged ≥65 years each year.").

163. *See id.* at 1221-23 (providing statistics on elder falls and related injuries).

164. J.A. Stevens, K.A. Mack, L.J. Paulozzi & M.F. Ballesteros, *Self-Reported Falls and Fall-Related Injuries Among Persons Aged ≥65 Years—United States, 2006*, 57 (9) MORBIDITY & MORTALITY WKLY. REP. 225, 225, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5709a1.htm.

165. *Id.* at 225-29 (detailing frequency of elder falls and emphasizing seriousness of problem, especially with increasing age of elderly).

166. *See id.* at 228 (citing J.S. Stevens, P.S. Corso, E.A. Finkelstein & T.R. Miller, *The Costs of Fatal and Non-Fatal Falls Among Older Adults*, 12 INJURY PREVENTION 290, 290-95 (2006), http://injuryprevention.bmj.com/cgi/reprint/12/5/290) ("A recent study determined that 31.8% of older adults who sustained a fall-related injury required help with activities of daily living as a result, and among them, 58.5% were expected to require help for at least 6 months.").

167. *Id.*

As the elder population increases in size, the number of low-income persons in need of long-term care increases correspondingly,[168] potentially reducing profit margins for skilled nursing facilities as a function of the number of Medicare- and Medicaid-dependent patients the facility houses. This trend, coupled with increasing litigation and the naturally high risk of injury for the elder population, has increased nursing home insurer risk, leading to increased insurance premiums for both general and malpractice insurance.[169] At higher premiums, some nursing homes forego insurance or self-insure, which, in turn, results in the market flight of insurers in certain high-risk geographic areas.[170]

C. Corporate Restructuring

Because of increased litigation and high insurance premiums, some nursing homes have turned to business organization laws as a shield from legal liability. Small nursing home facilities are typically set up as limited liability corporations (LLCs).[171] Larger chains typically incorporate so that shareholder owners are separated from the business. Using this approach, any liability flowing from the operation of the business is imputed to the corporate form itself, so the most a shareholder can lose is his or her initial investment in the corporation.[172] Taking liability avoidance further, some nursing home entities "have converted each of their facilities into an independent

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168. *See* Bedell, *supra* note 130, at 372-74 ("As the elderly population in this country increases, there will be a corresponding 'increase in demand for long term care services.'" (quoting J. A. Frank, *The Necessity of Medicaid Planning*, 30 U. BALT. L. F. 29, 29 (1999))). Additionally, as life-expectancy increases, coupled with the increasing elder population, the impoverished elderly could cause a financial crisis. *See id.* at 372-74. "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. This number will double again by 2040, with a population of 14 million . . . ." *Id.* at 374.

169. *See id.* at 368-69 (explaining cause of increasing insurance rates). The per-bed prices for nursing home insurance in Florida, California, and Texas have all increased drastically over the last ten years. *See id.*

170. *See id.* at 368 (describing Florida's insurance market). "In Florida, increasing insurance costs have caused at least ten insurance carriers to leave the Florida market or to stop underwriting new business."); *see also* Texas Research Center, *supra* note 57, at 2 (detailing flight of nursing home insurance companies from Texas's market).

171. Jurand, *supra* note 80, at 14 (describing corporate structuring trends of nursing homes). "Limited liability company statues generally are flexible and allow the business owners, or members, substantial freedom to operate their business pursuant to the limited liability company operating agreement." Casson & McMillen, *supra* note 82, at 586. "The company is managed either by the members directly or by a board of managers, thereby allowing the separation of ownership and control in a manner similar to a corporation." *Id.* at 586-87. Also, LLC members are taxed like partners in a partnership, but provided with "limited liability akin to a corporation." *Id.* at 587.

172. *See* Jurand, *supra* note 80. ("In larger chains, nursing homes are often structured as independent corporations to protect the assets of the parent company.").

limited liability corporation."[173] Incorporated nursing home businesses may also have a series of corporations, each of which owns or controls different assets of the business.[174]

When considering the strategy of reducing their asset exposure, some attorneys counsel nursing home owners to perform a cost-benefit analysis that considers the costs of implementing and operating complex business structures against the associated risk levels of operating nursing home facilities and having a large liability judgment executed against the business.[175] Some nursing home companies have formed a series of single-purpose entities, each of which performs one role in the complex chain of the nursing home company: owning one piece of real estate, holding the requisite licensing for a single nursing home facility, or managing and operating a single facility.[176]

Beyond liability avoidance, partitioning a company into a number of single purpose entities can have additional economic benefits, such as an increased willingness by lenders to loan money to those entities not engaged in nursing home operations, and an increased ease in acquiring or divesting a single facility.[177]

V. PIERCING THE CORPORATE VEIL

Corporate structures that reduce liability, coupled with the inability of successful plaintiffs to collect fully because of minimally funded liability insurance, have resulted in plaintiffs increasingly attempting to pierce the corporate veil in order to recover damages against nursing home defendants.[178] Corporate structures that limit liability can be abused, leading courts to occasionally "ignore the separate existence of a valid corporation and hold the stockholders

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173. DeMoor, *supra* note 78.

174. *See* Jurand, *supra* note 80, at 14 (describing notion of "pass-through" corporations as tactic used by nursing homes to mitigate liability).

175. *See* Casson & McMillen, *supra* note 82, at 579 ("Ultimately, any decision to restructure must be made based on an assessment of the nursing home company's business goals. That assessment involves a balancing of acceptable risk with acceptable costs.").

176. *See id.* (detailing concept of "single-purpose entity (SPE)"). "For example, a company could decide to restructure down to the individual facility level by forming real property SPEs to own each piece of real estate that is used as a nursing home, and by forming a corresponding number of operating SPEs to lease and operate the nursing homes." *See id.*

177. *See id.* at 579-80 (listing benefits other than liability avoidance to single-purpose entity structuring).

178. Jurand, *supra* note 80, at 14 (quoting Minneapolis plaintiff attorney regarding difficulty of recovering judgments from nursing home defendants). In fact, "the key to getting clients recovery in [nursing home] cases is to pierce the corporate veil." *Id.*

personally liable for the obligations of the corporation."[179]

Piercing of the corporate veil, as a practical matter, is principally applied to closely held business entities.[180] When the corporate veil is pierced, courts have imposed "personal liability on otherwise immune corporate officers, directors, and shareholder for the corporation's wrongful acts."[181]

Different jurisdictions have developed different tests for piercing of the corporate veil, but the equitable doctrine is generally used only where there is some excessive unity of interests and where invoking the doctrine avoids a social unfairness.[182] "Although the tests announced by the courts for piercing the corporate veil are often similar from state to state, the manner in which those tests are applied, and therefore the incidence of piercing, may vary considerably across jurisdictions."[183] In a 1991 study of over 2,000 cases involving piercing of a corporate veil, the veil was successfully pierced in 31% of tort-based cases.[184]

A. Town Hall Estates-Whitney, Inc. v. Winters *(Texas Law)*

In *Town Hall Estates-Whitney, Inc. v. Winters*, a 2007 case from the Court of Appeals of Texas, a former employee attempted to pierce the corporate veil of a nursing home to collect damages on a

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179. ROBERT W. HAMILTON & RICHARD A. BOOTH, BUSINESS BASICS FOR LAW STUDENTS 280-81 (4th ed. 2006).

180. *See id.* at 281 (discussing practical aspects of piercing doctrine).

181. BLACK'S LAW DICTIONARY 1184 (8th ed. 2004).

182. *See* Fletcher v. Atex, Inc., 68 F.3d 1451, 1456-61 (2d Cir. 1995) (applying Delaware law in alter ego theory of piercing corporate veil to determine test for piercing is whether parent and subsidiary economically operated as one and overall element of unfairness, but no requirement of fraud); Sea-Land Servs., Inc. v. Pepper Source, 993 F.2d 1309, 1311 (7th Cir. 1993) (upholding *Vand Dorn* test for piercing corporate veil, requiring unity of interest and fraud or injustice); Slottow Fidelity Fed. Bank v. Am. Casualty Co., 10 F.3d 1355, 1360 (9th Cir. 1993) ("Under California law, inadequate capitalization of a subsidiary may alone be a basis for holding the parent corporation liable for acts of the subsidiary."); Radaszewski v. Telecom Corp., 981 F.2d 305, 311 (8th Cir. 1992) (requiring element of fraud in claim to pierce corporate veil and stating that insurance is adequate capitalization to avoid charge of undercapitalization); Minton v. Cavaney, 364 P.2d 473, 475 (Cal. 1961) ("The equitable owners of a corporation, for example, are personally liable when they treat the assets of the corporation as their own and add or withdraw capital from the corporation at will; when they hold themselves out as being personally liable for the debts of the corporation; or when they provide inadequate capitalization and actively participate in the conduct of corporate affairs."); Walkovsky v. Carlton, 223 N.E.2d 6, 9 (N.Y. 1966) (refusing to pierce corporate veil because of absence of fraud and stating that "[t]he corporate form may not be disregarded merely because the assets of the corporation . . . are insufficient to assure him the recovery sought.") .

183. MELVIN ARON EISENBERG, CORPORATIONS AND OTHER BUSINESS ORGANIZATIONS: CASES & MATERIALS 190 (Concise 9th ed. 2005).

184. *See id.* at 190 (citing study by Professor Robert Thompson).

retaliatory discharge complaint.[185] In a footnote of the opinion, the court summarized the existing theories for piercing the corporate veil:

> Those [various theories that exist for piercing the corporate veil or disregarding the corporate form] are:
>
> - [W]hen the fiction is used as a means of perpetrating fraud;
> - [W]here a corporation is organized and operated as a mere tool or business conduit of another corporation ("alter ego");
> - [W]here the corporate fiction is resorted to as a means of evading an existing legal obligation;
> - [W]here the corporate fiction is employed to achieve or perpetrate monopoly;
> - [W]here the corporate fiction is used to circumvent a statute;
> - [W]here the corporate fiction is relied upon as a protection of crime or to justify wrong;
> - [I]nadequate capitalizations as to work an injustice; and
> - [T]wo or more businesses were operated as a single business enterprise.[186]

The plaintiff in *Town Hall*, Cathy Winters, was an experienced nurse who worked for "Town Hall Estates-Whitney, Inc. (Town Hall), a nursing home owned by American Religious Town Hall Meeting, Inc. (ARTH)."[187] A husband and wife served as the administrator and assistant administrator of Town Hall and served on the boards of both Town Hall and ARTH.[188] The *Town Hall* court construed Winters's complaint as pleading an alter-ego theory of corporate veil piercing.[189] Winters sought to hold ARTH liable for a retaliatory discharge verdict entered in her favor by the district court.[190] Winters relied on three pieces of evidence in arguing that the corporate veil insulated ARTH from liability resulting from Town Hall's actions: (1) that the administrator and assistant administrator of Town Hall were members of both boards of directors, (2) that a single sentence in a Town Hall personnel manual was worded "'employees of Town Hall and ARTH,'" and (3) that ARTH's president "had the authority to discipline and terminate" Town Hall's

185. *See* Town Hall Estates-Whitney, Inc. v. Winters, 220 S.W.3d 71, 76-78 (Tex. Ct. App. 2007) (describing facts of case).

186. *Id.* at 86 n.11 (citations omitted).

187. *Id.* at 76.

188. *Id.* (describing corporate structure and management).

189. *Id.* at 86 (reviewing pleadings to construe complaint).

190. *See id.* at 77 ("A jury unanimously found that [Winters] was terminated for reporting sexual abuse of a resident to her supervisor and awarded her [$57,300 in various damages].").

administrator.[191]

The court ruled that such "evidence is legally insufficient to support a finding that ARTH is vicariously liable for Town Hall's retaliation liability under an alter ego theory."[192] The court also stated as dicta that the evidence presented by Winters would "be legally insufficient under a single business enterprise theory, which some courts consider to be a separate and distinct theory from alter ego."[193]

Prior to ruling against the plaintiff on the piercing of ARTH's corporate veil, the *Town Hall* court emphasized the judiciary's hesitancy to exercise the equitable doctrine of veil piercing: "[d]isregard of the 'legal fiction of corporate entity' is 'an exception to the general rule which forbids disregarding corporate existence.'"[194] Only if "it appears the corporate entity of the subsidiary is being used as a sham to perpetrate a fraud, to avoid liability, to avoid the effect of a statute, or in other exceptional circumstances" will a court hold a parent corporation liable for the actions of its subsidiaries.[195]

Piercing the corporate veil requires "something more than mere unity of financial interest, ownership and control."[196] In order to hold the parent liable, the subsidiary must have been used to "'bring about results which are condemned by the general statements of public policy.'"[197] In the case of nursing homes, caring for the elderly is a substantial public policy rationale, thus increasing the likelihood for corporate veil piercing. In *Town Hall*, the plaintiff was a discharged employee, not a nursing home resident; however, if any resident brought a claim against Town Hall, he would be unable to pierce the corporate veil of Town Hall based on this precedent, without providing additional evidence. Thus, this case represents a chilling effect on Texas nursing home litigation in general, and acts

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191. *Id.* at 87.

192. *Id.*

193. *Id.* at 87 n.12. The *Town Hall* court went on to review the factors considered under a single business entity theory for piercing the corporate veil: "common employees; common offices; centralized accounting; payment of wages by one corporation to another corporation's employees; common business name; services rendered by the employees of one corporation on behalf of another corporation; undocumented transfers of funds between corporations; and unclear allocation of profits and losses between corporations." *Id.* (citing Paramount Petroleum Corp. v. Taylor Rental Ctr., 712 S.W.2d 534, 536 (Tex. Ct. App. 1986)).

194. *Id.* at 86 (quoting Lucas v. Tex. Indust., Inc. 696 S.W.2d 372, 374 (Tex. 1984) (citing First Nat'l Bank in Canyon v. Gamble, 132 S.W.2d 100 (Tex. 1939))).

195. *Id.* (citing *Lucas*, 696 S.W.2d at 374-75).

196. *Id.* (citations omitted).

197. *Id.* at 87 (citing *Lucas*, 696 S.W.2d at 374-75; Roylex, Inc. v. Langson Bros. Constr. Co., 585 S.W.2d 768, 772 (Tex. Ct. App. 1979); Sutton v. Reagan & Gee, 405 S.W.2d 828, 836 (Tex. Ct. App. 1966)).

as a virtual bar on litigation against Town Hall in particular because of the disincentive of being unable to pierce its corporate veil.

B. Attorney General v. M.C.K., Inc. *(Massachusetts Law)*

In 2000, the Supreme Judicial Court of Massachusetts ruled in *Attorney General v. M.C.K., Inc.* that separate corporate entities that owned nursing homes and the sole shareholder of those entities could be combined for purposes of executing a judgment of liability; that is, the court pierced the corporate veil of the separate nursing home entities.[198]

As with any case involving the disregard of corporate structure, the facts of *M.C.K.* were particularly relevant to the outcome. In 1993, Michael Konig, one of the defendants in *M.C.K.*, "purchased five nursing homes in Massachusetts."[199] For all five nursing homes, Konig created a separate "corporation to hold title to the real estate on which each home was located" and an additional separate corporation to hold each nursing home operating license.[200] One of Konig's five nursing homes was Union Square Nursing Center, for which Konig created Reifer, Inc. "to hold title to the real estate and tangible assets used in the operation of the home, and M.C.K., Inc." to control the home's licensing.[201] "Konig was the sole shareholder of both M.C.K. and Reifer."[202]

Another of Konig's nursing homes was Valley View Nursing Home, which eventually had its certification terminated by the Massachusetts Department of Public Health after a 1995 inspection revealed harmful and unhealthy conditions.[203] Konig also owned and operated Crescent Hill Nursing Center, which was determined to be in similarly poor condition just two months later.[204] At this point, the Massachusetts Department of Public Health warned Konig that, pursuant to Massachusetts state law, it might revoke all five of Konig's operating licenses.[205]

Pursuant to an agreement reached by Konig, the various nursing home corporations involved, and the Massachusetts Department of Health, the Union Square Nursing Center facility would either be

198. *See* Attorney General v. M.C.K., Inc., 736 N.E.2d 373, 382 (Mass. 2000).

199. *Id.* at 375.

200. *Id.*

201. *Id.*

202. *Id.*

203. *Id.* (detailing conditions of Valley View Nursing Home).

204. *Id.* (noting Massachusetts Department of Public Health findings at Crescent Hill Nursing Center).

205. *Id.* at 375-76; *see also id.* at 376 n.5 (providing statutory background that allows revocation of licensure).

sold or closed.[206] In June of 1997, Konig informed the Department of Health that he, Reifer, Inc., and M.C.K., Inc. intended "to abandon Union Square [Nursing Center]," thus placing its "residents in imminent danger."[207] Responding to a complaint filed by the Massachusetts Attorney General, a Massachusetts Superior Court judge appointed a receiver to oversee the nursing home and imposed a lien on the property for the costs of the receivership.[208]

In 1999, the Commonwealth of Massachusetts moved to end the receivership of Union Square Nursing Center by means of "a court-ordered sale of the nursing home, including its equipment, and the building and the real estate upon which the nursing home [was] located."[209] A Massachusetts Superior Court judge determined that such a sale was not statutorily authorized unless Konig, M.C.K., Inc., and Reifer, Inc. were "essentially one and the same."[210] After an expedited and narrow trial on that issue, the judge determined that "'MCK and Reifer are in fact the alter egos of Konig and disregard of their separate corporate forms is warranted.'"[211]

On appeal, the Supreme Judicial Court of Massachusetts discussed "the doctrine of corporate disregard" (synonymous with piercing the corporate veil).[212] The court defined the doctrine as "an equitable tool that authorizes courts, in rare situations, to ignore corporate formalities, where such disregard is necessary to provide a meaningful remedy for injuries and to avoid injustice."[213] Additionally, the court stated that "[i]n certain situations, the doctrine may also properly be used to carry out legislative intent and to avoid evasion of statutes."[214] The court then outlined the twelve factors considered by Massachusetts courts when deciding whether to pierce the corporate veil:

> The relevant factors are (1) common ownership; (2) pervasive control; (3) confused intermingling of business assets; (4) thin capitalization; (5) nonobservance of corporate formalities; (6) absence of corporate records; (7) no payment of dividends; (8) insolvency at the time of the litigated transaction; (9) siphoning

206. *Id.* at 376 (providing details of settlement agreement).

207. *Id.* (detailing letter from Konig to Department of Health).

208. *Id.* (describing actions of Attorney General in response to Konig's attempted abandonment).

209. *Id.*

210. *Id.* at 376-77.

211. *Id.* at 377.

212. *Id.* at 380.

213. *Id.* (citing My Bread Baking Co. v. Cumberland Farms, Inc., 233 N.E.2d 748 (Mass. 1968)).

214. *Id.* (citing Packard Clothes, Inc. v. Dir. of the Div. of Employment Sec., 61 N.E.2d 528 (Mass. 1945)).

> away of corporation's funds by dominant shareholder; (10) nonfunctioning of officers and directors; (11) use of the corporation for transactions of the dominant shareholders; and (12) use of the corporation in promoting fraud.[215]

In upholding the superior court judge's conclusion to pierce the corporate veil, the *M.C.K.* court emphasized that Konig had "pervasive control of MCK and Reifer," that Konig siphoned corporate funds, and that Konig acted as "sole director, officer and shareholder of MCK and Reifer."[216] The court also found that both MCK and Reifer were thinly capitalized, that the address for all ten of the license holding and real estate owning corporations was the same—Konig's business address—and that the corporations did not follow formalities.[217] "Konig [made] agreements on behalf of both MCK and Reifer" and "was the primary signatory on [Union Square Nursing Center's bank account]."[218] Konig also hired a single management company for all five of his nursing homes and authorized that company to transfer "loans" between those accounts and his personal accounts.[219] Additionally, "Konig purported to 'gift' all his stock in Reifer to the Moshe Isaac Foundation for no consideration. The trustees of the Moshe Isaac Foundation are Konig and his wife, and its address is Konig's home address."[220]

On appeal from the ordered sale of the nursing home, Konig argued that in the absence of fraud, the court could not disregard the corporate structure of a corporation. The court responded: "when one of the corporations (Reifer) later seeks to disassociate itself from the other (MCK), in a way that leads to complete frustration of a statutory purpose, the court may be warranted in carefully scrutinizing the corporate form, regardless whether actual fraud has been shown."[221] The court characterized the corporate structuring as "a situation where two corporations (MCK and Reifer) were formed to carry out the objectives and purposes of the person controlling them (Konig)."[222] This result potentially opens the door for further corporate veil piercing within the nursing home industry because it negates the need for fraud and emphasizes the use of the doctrine in cases where corporate structuring purposefully avoids binding

215. *Id.* at 380 n.19 (citing Pepsi-Cola Metro. Bottling Co. v. Checkers, Inc., 754 F.2d 10, 14-16 (1st Cir. 1985); Evans v. Multicon Constr. Corp., 574 N.E.2d 395 (Mass. App. Ct. 1991)).

216. *Id.* at 381 & n.20.

217. *Id.*

218. *Id.* at 381 n.20 (describing blended nature of Konig's businesses).

219. *See id.* (describing financial singularity of accounts).

220. *Id.*

221. *Id.* at 381-82 (citation omitted).

222. *Id.* at 381.

legislation. If Massachusetts enacted statutory protection of nursing home residents and required minimal capitalization and assets for nursing home entities, then, based upon the *M.C.K.* precedent, the doctrine of piercing the corporate veil could be increasingly used against Massachusetts nursing homes. This would create an increased incentive for nursing home fiscal responsibility.

The facts of *M.C.K.* are somewhat limiting however—there was an extreme unity of interests among the parties involved and an immediate need to protect susceptible elderly residents from grossly negligent care, typified by deplorable conditions. Although *M.C.K.* represents positive precedent for the strategy of piercing the veil of nursing home corporations, future nursing home defendants will likely be able to differentiate the factual circumstances.

C. Autrey v. 22 Texas Services, Inc. *(Pennsylvania Law)*

In the 2000 case *Autrey v. 22 Texas Services, Inc.*, the United States District Court for the Southern District of Texas extensively discussed the application of Pennsylvania law of piercing the corporate veil in the context of a nursing home defendant.[223] "J.D. Autrey was a resident at the Caldwell Health & Rehabilitation Center,"[224] which is "one of forty-nine nursing homes and assisted living facilities in Texas owned by . . . 22 Texas Services, L.P."[225] While a resident at Caldwell, Autrey developed a bacterial infection—which ultimately developed into pneumonia—leading to hospitalization and, eventually, death.[226] Because of Autrey's death, Autrey's estate and family filed suit against 22 Texas Services in a wrongful death action.[227]

The corporate structure involved in the *Autrey* case is extremely complex, as suggested by the twelve corporate and individual co-defendants in the case.[228] The corporate structure is also determinative of both the applicable law and the plaintiff's ability to

223. *See* 79 F. Supp. 2d 735, 740-46 (S.D. Tex. 2000) (denying defendant's motion for summary judgment and finding reasonable basis for jury to pierce corporate veil of defendant).

224. *Id.* at 737.

225. *Id.* at 738.

226. *See id.* at 737 (detailing timeline of Autrey's increasing sickness).

227. *Id.* (detailing procedural background of case).

228. The co-defendants in the *Autrey* case are: (1) 22 Texas Services, Inc. (a Pennsylvania corporation), (2) 22 Texas Partners Management, Inc., (3) Complete Care Services, L.P. (a Pennsylvania limited partnership), (4) Arizona Partners, Inc. (a Pennsylvania corporation), (5) John H. Durham, (6) Peter J. Licari, (7) Michael D. D'Arcangelo, (8) John P. Durham, (9) Wallace Cannon, (10) Bob Sorenson, (11) Christine Bogrette, and (12) Carol Durham. *Id.* at 735. Other entities involved in the case but not named as defendants are 22 Texas Services, L.P. (a Texas limited partnership) and Venture 22 Corporation. *See id.* at 738.

pierce the corporate veil. In 1997, Complete Care Services, L.P. (CCS), purchased forty-nine nursing homes from Beverly Enterprises at a total cost of approximately $152 million.[229] CCS then assigned its ownership interest to 22 Texas Services, L.P.[230]

22 Texas Services, L.P. is "a limited partnership formed under the laws of Texas."[231] "22 Texas Services, L.P. has one general partner, 22 Texas Services, Inc., a Pennsylvania corporation."[232] In consideration for the assignment of interest, 22 Texas Services, L.P. gave CCS a "'development fee' and an exclusive twenty-year management contract to manage the homes."[233] Thus, both CCS and 22 Texas Services, L.P. employ personnel at the homes.[234]

CCS "is a limited partnership formed under the laws of Pennsylvania" that has "one general partner, Arizona Partners, Inc.," which is also a Pennsylvania corporation.[235] CCS has six limited partners: five individuals and one corporation.[236]

John P. Durham and Christine Bogrette are the sole shareholders of Arizona Partners, Inc.[237] "John H. Durham and Carol Durham are the sole shareholder of 22 Texas Services, Inc."[238] Furthermore, 22 Texas Services, Inc., and Arizona Partners, Inc. have the same business address.[239] By way of a simplified summary, all of the business entities at issue in *Autrey* were owned, operated, and controlled by the same handful of individuals and all of the business entities owned pieces of one another in various forms and magnitudes, creating a complex, web-like corporate structure. At issue in *Autrey* was whether the plaintiffs could pierce the complex mixture of corporations and limited partnerships and hold the individuals liable for the wrongful death damages related to Mr. Autrey's passing.[240]

Applying Pennsylvania law, the district court initially noted:

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229. *See id.* (detailing corporate structure).

230. *See id.* (noting agreement between businesses).

231. *Id.*

232. *Id.* 22 Texas Services, L.P.'s limited partners are John P. Durham, John H. Durham, Peter Licari, and Michael D'Arcangelo. *Id.*

233. *Id.*

234. *See id.* (noting overlap in employee oversight at facilities).

235. *Id.*

236. *See id.* (describing corporate makeup of CCS). The five individuals are John H. Durham, John P. Durham, Christine Bogrette, Peter Licari, and Michael D'Arcangelo. *Id.* The corporate limited partner of CCS is Venture 22 Corporation, "of which John H. Durham is the sole shareholder." *Id.*

237. *See id.* (detailing shareholder structure).

238. *Id.* at 739.

239. *See id.* at 739 (illustrating similarities across business entity defendants).

240. *See id.* at 738, 740.

"there is a strong presumption against piercing the corporate veil."[241] The court then recited a non-exhaustive list of factors considered when piercing the corporate veil under Pennsylvania law: "undercapitalization, failure to adhere to corporate formalities, substantial intermingling of corporate and personal affairs, and use of the corporate form to commit a fraud."[242] Finally, before ruling on the cross motions for summary judgment, the court noted: "Pennsylvania law has long provided that the corporate veil may be pierced if justice and public policy would be served."[243] Because of the substantial public interest in caring for society's elderly, courts may be more willing to find necessary elements in fact patterns before the court in order to pierce the corporate veils of nursing homes.

Arizona Partners had "a net worth of approximately $42,000" at the time of the incident that gave rise to the case of action in *Autrey*.[244] It also "operated with virtually no liquid assets" despite assuming "one hundred percent liability for the operation of not only forty-nine nursing homes in Texas but of numerous other facilities across the United States."[245] Because the plaintiffs failed to provide evidence regarding the capitalization of Arizona Partners at the time of its incorporation, the court could not conclusively rule that its corporate veil should be pierced on undercapitalization grounds.[246] The court then noted that "[a]t the time of incorporation, Arizona Partners had no employees, office space, or expenses; consequently, the company paid no rent and spent no money on advertising."[247]

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241. *Id.* at 740 (citing Lumax Indus., Inc. v. Aultman, 669 A.2d 893, 894 (1995)); *see also* Sch. Dist. of Scranton v. Fowler, 45 Pa. D. & C.4th 332, 334 (2000) ("Pennsylvania law does not favor the remedy of piercing the corporate veil.").

242. *Autrey*, 79 F. Supp. 2d at 740 (citing *Lumax*, 669 A.2d at 895). "The 'alter ego' theory is applicably only where an individual or corporate owner controls the corporation to be pierced and the controlling owner is to be held liable." *Fowler*, 45 Pa. D. & C.4th at 336 n.1 (citing Miners, Inc. v. Alpine Equipment Corp., 722 A.2d 691, 695 (Pa. Super. 1998)). "A court will pierce the corporate veil on an alter ego theory where there is a showing of injustice after the establishment that corporate owner wholly ignored the separate status of a corporation and so dominated and controlled its affair that its separate existence was a mere sham." *Id.* (citing Lycoming County Nursing Home Ass'n Inc. v. Commonwealth, Dep't of Labor and Indus., Prevailing Wage Appeal Board, 627 A.2d 238, 243 (Pa. Commw. Ct. 1993)); *see also* Pearson v. Component Tech. Corp., 247 F.3d 471, 484-85 (3d Cir. 2001) (outlining basis for piercing corporate veil and noting agent, instrumentality and alter-ego theories of piercing corporate veil).

243. *Autrey*, 79 F. Supp. 2d at 740 (citing Revere Press, Inc. v. Blumberg, 246 A.2d 407, 411 (Pa. 1968)).

244. *Id.*

245. *Id.*

246. *See id.* at 741 (discussing lack of evidence to support summary judgment motion in favor of plaintiffs with regard to Arizona Partners, Inc.).

247. *Id.*

Furthermore, the court noted that Arizona Partner's' corporate officers appeared "nonfunctioning."[248] The plaintiffs in *Autrey*, however, failed to pierce Arizona Partners' corporate veil on a motion for summary judgment. However, the court counseled plaintiffs that if they "can prove at trial that Defendants asserted control over the management and ownership of the Texas nursing homes owned by Arizona Partners," they would likely be able to show that Arizona Partners is "nothing more than a corporate sham . . . ."[249]

The *Autrey* court next looked to 22 Texas Services, Inc., the owner of "forty-nine nursing homes and assisted living facilities in Texas" and "the sole general partner in 22 Texas Services, L.P."[250] The partnership agreement between 22 Texas Services, Inc. and 22 Texas Services, L.P. entitles 22 Texas Services, Inc. to one percent of the partnership's profits, but one hundred percent of the liability.[251] Just six months after formation, 22 Texas Services, Inc. had a negative net worth.[252] 22 Texas Services, Inc. was initially capitalized with just $25,000, and it "pa[id] no rent, ha[d] no employees or expenses."[253] Nonetheless, the court left the issue of piercing the corporate veil up to the jury and refused to resolve the issue upon cross motions for summary judgment.[254]

In response to the arguments set forth by the plaintiffs, the defendants argued that a fair market value assessment, compared to the depreciated values used by the plaintiff's financial expert witness, would display the defendant companies' financial situations in a more accurate and favorable light.[255] The defendants also argued that the businesses were initially capitalized sufficiently, that the businesses in question were entirely solvent, and that the various businesses had combined liability insurance surmounting $21 million.[256] Nonetheless, the court failed to view the defendants' arguments as persuasive and denied the cross motions for summary judgment, ruling that plaintiffs "set forth evidence that provides a basis for a reasonable jury to pierce the corporate veils of 22 Texas Services, Inc. and Arizona Partners, Inc.," enough to let the issues go to trial.[257]

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248. *Id.*

249. *Id.*

250. *Id.*

251. *Id.* (describing partnership agreement).

252. *Id.* (noting suspicious financial positioning of 22 Texas Services, Inc.).

253. *Id.* at 741-42.

254. *See id.* at 742 (noting inability of court to definitively rule on veil piercing).

255. *Id.* at 742-43 (summarizing defendants' arguments for shortcomings of plaintiffs' expert evidence).

256. *Id.* at 743-45 (summarizing defendants' arguments).

257. *Id.* at 746.

In *Autrey*, without definitively advancing the common law regarding corporate piercing beyond those standards required to survive a motion for summary judgment, the court chastised the corporate structuring of the defendants, hinting throughout the opinion that should the plaintiffs go to trial, they would likely win.[258] Thus, denying the defendants' motions for summary judgment provides the plaintiffs with a huge bargaining chip for settlement negotiations, without significantly entangling the court's future flexibility with precedent.

This result is demonstrative of the court's difficulty in choosing between recognizing corporate structures and ensuring equitable results for wronged elder plaintiffs. The court's "hands-off" result in *Autrey*, which disallowed for dismissal on legal grounds at the pleading stage, serves as substantial warning to nursing home operators and entities because of the unpredictability of jury verdicts that are often perceived as plaintiff-friendly. At the same time, the court denied the plaintiff's motion for summary judgment—despite the evidence of initial undercapitalization, and complex corporate structuring that veiled a small group of individuals. Although somewhat discouraging to plaintiffs seeking to pierce the corporate veils of nursing home defendants, the *Autrey* precedent serves as a blueprint for how to get the case to a jury, which represents a substantial bargaining chip for settlement negotiations with nursing home defendants.

D. Fanning v. Brown *(Oklahoma Law)*

In the 2004 case, *Fanning v. Brown*,[259] the Supreme Court of Oklahoma delineated the necessary requirements to state a claim for disregarding the corporate veil.[260] In *Fanning*, the guardian of an elderly resident at Oak Dale Manor sued the nursing home and its shareholders, asserting several causes of action.[261] Oak Dale Manor was owned and operated by Sand Springs Care Center, Inc.[262] Fanning—the plaintiff in the matter and guardian of the injured Oak Dale Manor resident—sought to hold Sand Springs Care Center's "shareholders individually liable for the obligations and conduct of [the corporation]."[263] "Fanning alleged the shareholders used the corporate entity to defeat the public policy of protecting a resident

258. *See, e.g., supra* note 249 and accompanying text.

259. 85 P.3d 841 (Okla. 2004) (reviewing pleading standard for piercing corporate veil).

260. *Id.* at 846-48.

261. *See id.* at 843-44 (listing causes of action as negligence, statutory violations, and breach of contract).

262. *See id.* at 844 (summarizing plaintiff's petition).

263. *Id.* at 847.

from neglect and abuse, that they failed to secure and maintain liability insurance, and that they allowed [Sand Spring Care Center] to become suspended from doing business within the state."[264]

In reviewing the defendant's' motion to dismiss, the Supreme Court of Oklahoma first noted that "[g]enerally, a corporation is regarded as a legal entity, separate and distinct from the individuals comprising it."[265] The court then noted that "[c]ourts may disregard the corporate entity and hold stockholders personally liable for corporate obligations or corporate conduct under legal doctrines of fraud, alter ego and when necessary to protect the rights of third persons and accomplish justice."[266]

The court determined that under the notice pleading requirements statutorily enacted in 1984, a complaint does not have to be precise and fact-specific, but instead must provide "a short and plain statement of the claim showing . . . entitle[ment] to relief; and . . . [a] demand for judgment."[267] Thus, despite the relative absence of fact in Fanning's pleading—which did not provide a detailed listing of (1) the corporate structure, (2) the ownership or control exerted by the shareholders or the corporation over the nursing home staff when the event occurred, or (3) the financing or capitalization of the entities—the court allowed the claim to proceed to discovery.[268] The court asserted that "the defendants [were given] fair notice of her claims and the grounds upon which they rest."[269]

Similar to *Autrey*, the *Fanning* court provides the plaintiff with a significant bargaining chip for settlement negotiations. With the Supreme Court's order for discovery to proceed on a rather factually bald complaint, the plaintiff has court-approved access to the business and financial records of not only Oak Dale Manor and Sand Spring Care Center, but also the individual shareholder owners of Sand Spring Care Center.

This case, therefore, set the precedent of a low factual threshold at the pleading stage in order to advance to discovery. That is, as long as a plaintiff can plead enough facts to evoke suspicion of the circumstances required to pierce the corporate veil, an Oklahoma court will allow discovery into the business records of the nursing home and its owners. If this precedent were to be legislatively recognized, or were to gain wide acceptance in the common law as an

264. *Id.* at 847.

265. *Id.* at 846 (citing Buckner v. Dillard, 89 P.2d 326, 328 (Okla. 1939)).

266. *Id.* (citing Frazier v. Bryan Memorial Hosp. Authority, 775 P.2d 281, 288 (Okla. 1989); Mid-Continent Life Ins. Co. v. Goforth, 132 P.2d 154, 156 (Okla. 1942)).

267. *Id.* at 847 (quoting OKLA STAT. tit. 12, § 2008(A)(1)-(2) (2001)) (reviewing pleading standards).

268. *Id.* at 848.

269. *Id.*

appropriate response to nursing home veil piercing cases, it could serve as a significant incentive for fiscal responsibility and corporate transparency by nursing home entities.

E. Corporate Liability for Specific Acts

A parent corporation may be held directly liable for the actions of its subsidiaries if it has forced the subsidiaries to act in a certain and specific way.[270] "A parent corporation is accountable where it 'manages, directs or conducts operations specifically related to the violation.'"[271] If a plaintiff can direct discovery toward upper-level management and decision making and the resultant negligent care, a parent company may be attached to the lawsuit.[272] "When corporate actors make management decisions . . . they may be personally liable."[273]

F. Summary of Corporate Veil Piercing Laws

Among cases where the issue of piercing the corporate veil is deeply discussed, common trends are evident. Generally, only where corporate owners have engaged in a particularly predatory act or a series of deceptive acts that result in financial damage to a particularly vulnerable class of plaintiffs, with a particular social policy implicated, will courts pierce corporate structures and award corporate funds to injured plaintiffs.

The intrinsic fragility of the elderly, coupled with the forecasted increase in the elder population, could leave nursing home corporate structures increasingly susceptible to veil piercing. However, if state or federal legislation mandates minimum liability insurance or asset set-asides, the frequency of veil piercing by the courts could be reduced in favor of such preemptive legislative measures.

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270. *See* Pearson v. Component Tech. Corp., 247 F.3d 471, 486-87 (3d Cir. 2001) (outlining rarely used theory of parent's direct liability for subsidiary actions). The *Pearson* court stated:

> Although not often employed to hold parent corporations liable for the acts of subsidiaries in the absence of other hallmarks of overall integration of the two operations, it has long been acknowledged that parents may be "directly" liable for their subsidiaries' actions when the "alleged wrong can seemingly be traced to the parent through the conduit of its own personnel and management," and the parent has interfered with the subsidiary's operations in a way that surpasses the control exercised by a parent as an incident of ownership.

Id.

271. Martin S. Kardon, *Legal Issues in Pursuing Parent Corporation Liability*, *in* NURSING HOME NEGLIGENCE LITIGATION 79, 79 (2006) (quoting United States v. Days Inn of Am., Inc., 151 F.3d 822, 826 (8th Cir. 1998)).

272. Jurand, *supra* note 80, at 16 (quoting Minneapolis plaintiff attorney).

273. *Id.* (quoting Minneapolis plaintiff attorney).

VI. ELEMENTS OF A SOLUTION

Caring for the elderly is a growing, evolving, complex social responsibility fraught with design and implementation issues that impede legislative solutions. "There are no 'quick fixes' to improve the availability and cost of [general liability or professional liability] insurance for nursing homes."[274] However, certain legislative actions—verdict guidelines, mandated minimum coverage, corporate structuring constraints, conditional licensure, and increasing Medicare and Medicaid funding—could be useful.

A. Verdict Guidelines

Legislatures could impose the equivalent of "sentencing guidelines" as a mechanism for judges to limit jury awards to elder plaintiffs. Tort reforms that impose statutory caps on non-economic damages in malpractice suits have been widely advocated as one means of bringing down the costs of long-term care.[275] However, such legislative solutions would likely have an unfairly heightened effect on the elderly due to their general inability to collect for lost wages.[276] Verdict guidelines could balance the need for general tort reform and non-economic damage caps with the frequent inability for elderly plaintiffs to collect economic damages.[277] Federal courts already abide by sentencing guidelines in criminal matters, and because constitutional protections of due process are significantly lower in civil matters than in criminal matters, a parallel system for civil matters would likely be upheld against constitutional challenge.[278] According to Professor Albert Alschuler of the University of Chicago Law School:

> Constructing damages guidelines would in fact be easier than constructing sentencing guidelines. Tort damages serve one clear, primary purpose, while criminal punishment serves many conflicting purposes and may depend upon an assessment of

274. *See* CAL. DEP'T OF HEALTH, *supra* note 121, at 75.

275. *See generally* Rustad, *supra* note 17, at 331 (describing effect of proposed tort reforms, such as noneconomic damages, on elderly plaintiffs with valid claims of injury).

276. *See generally id.* at 390-91 (describing effect of noneconomic damages on elderly plaintiffs unable to collect lost wage damages due to retirement or inability to earn living).

277. *See generally* Jeffrey Spitzer-Resnick, *Protecting the Rights of Nursing Home Residents: How Tort Liability Interacts with Statutory Protections*, 19 NOVA L. REV. 629 (1995) (discussing economic damages in Nursing Home suits).

278. An example of this civil-criminal differentiation is the ability of a federal judge to grant a new trial upon a motion after a jury returns a verdict in civil matters compared to the constitutional preclusion of double jeopardy in criminal matters. *See* FED. R. CIV. P. 59(a)(1)(A).

> innumerable circumstances including the offender's character. Damages, moreover, consist simply of money. Unlike a sentencing commission, a "damages commission" would not be required to draw lines among various types of sanctions—fines, probation, community service, home detention, boot camp, and prison.[279]

Thus, creating a series of verdict guidelines, based on what legislators deem "reasonable" in light of the broad scope of historically rendered verdicts, would be significantly less difficult than drafting sentencing guidelines; it would also involve fewer constitutional implications of due process. As a result, this solution could be legislated relatively quickly, without being subject to strict constitutional scrutiny.

B. Mandated Minimum Coverage

Nursing homes could have mandated minimum coverage against liability, based on a combination of assets and insurance, and varying by the size and scope of a given nursing home's operations. State legislatures could impose a minimum coverage scale with an adjustable rate based on the number of residents in a facility and the facility's performance history—such as the number and scope of claims brought on behalf of its residents in past years.

Alternatively, a flat percentage of gross revenues could be charged. This option could incorporate incentives for improved quality of care over time, such as requiring less coverage for an improved or a claim-free record. Such a flexible structure would incentivize nursing home companies to employ greater numbers of better-trained staff, and to improve the safety features of facilities.

Furthermore, this system could require all facilities to pay into a performance contingency account at the beginning of each fiscal year with the incentive of a return check at the end of the year based on performance.[280] The interest earned on the aggregate state-held account could be directed toward increasing the scope and availability of care for the elderly indigent or as payment of bonuses

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279. Albert W. Alschuler, *Explaining the Public Wariness of Juries*, 48 DEPAUL L. REV. 407, 412 (1998).

280. This would act similar to Pay-for-Performance systems that have made significant inroads in the health care industry as a means of incentivizing quality health care providers. *See generally* Stacy L. Cook, *Will Pay for Performance Be Worth the Price to Medical Providers? A Look at Pay for Performance and Its Legal Implications for Providers*, 16 ANNALS HEALTH L. 163, 163 (2007) (describing Pay-for-Performance reimbursement). The American Medical Association (AMA) has even proffered standards for Pay-for-Performance reimbursement plans. *See* AMA, PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS, June 21, 2005, http://www.ama-assn.org/ama1/pub/upload/mm/368/principles4pay62705.pdf; AMA, GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS, June 21, 2005, http://www.ama-assn.org/ama1/pub/upload/mm/368/guidelines4pay62705.pdf.

for the best performing facilities.[281] Because of the neutral fiduciary duties imposed upon the trustee of the account, nursing home companies, as both the settlors and the beneficiaries of the account, would have limited access to the funds in the account, thereby ensuring the availability of funds in the event of a judgment or settlement.[282]

C. *Corporate Structuring*

Regulation on the strategic use of corporate structuring could balance the corporate goal of immunity from liability with the social goals of facilitating the creation of adequate elder housing and care regardless of a resident's ability to pay.

Corporate law is largely within the purview of the individual states.[283] Because it would be difficult for states to withstand constitutional challenges of ownership and corporate structuring restrictions of nursing home facilities, states could alternatively statutorily enact new, incentive-laden corporate structures, specifically tailored to skilled nursing and long-term care facilities. For a parallel example, "[b]y 1971, all states had enacted statutes allowing physicians to practice through professional corporations, although such laws generally restrict share ownership to licensed professionals."[284] With significant tax, liability, and loss-utilization incentives, a new corporate entity could have the effect of attracting nursing home facilities. Thus, all such organized facilities would be subject to a single, known body of statutory and, over time, common law. States that enacted such corporate structures could improve their tax bases by attracting nursing home businesses, not unlike

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281. This aspect would function similar to IOLTA accounts in the legal profession (Interest on Lawyers' Trust Accounts), which are pooled accounts of lawyers' nominal amounts owed to clients. The interest accrued on these accounts supports public interest law programs. *See* Mark A. Armitage, *Professional Responsibility*, 53 WAYNE L. REV. 541, 548 (2007) (discussing IOLTA accounts). Although the amounts deposited in the proposed nursing home accounts would be larger, the use of the interest for public benefit would be similar.

282. *See* ROGER W. ANDERSON & IRA MARK BLOOM, FUNDAMENTALS OF TRUSTS AND ESTATES 327-31 (2d ed. 2005) (describing fiduciary duties of trusts). "The hallmark of the modern trust device is the fiduciary relationship between the trustee and trust beneficiary that results from the separation of the legal and equitable interests in the property." *Id.* at 328. "In operation, the trustee has active duties to perform for the trust beneficiary, even though the trustee holds legal title to the trust property as far as the outside world is concerned." *Id.*

283. *See* Thomas W. Joo, *The Modern Corporation and Campaign Finance: Incorporating Corporate Governance Analysis into First Amendment Jurisprudence*, 79 WASH. U. L.Q. 1, 4 (2001) (detailing separation of federal and state corporate law).

284. Andrew Fichter, *Owning a Piece of the Doc: State Law Restraints on Lay Ownership of Healthcare Enterprises*, 39 J. HEALTH L. 1, 6 (2006).

Delaware with its corporate laws.[285] The legislation could also set entry-level corporate restrictions, such as financial minimums and proof of ability to meet unforeseen expenses, of thereby reducing the risk of business insolvency.

D. Conditional Licensure

Another facet of the complex solution could be for regulatory bodies to stipulate licensure or local approval, such as township or county zoning boards, for proposed nursing homes upon an adequate showing of forecasted financial stability. Licensing determinations partially founded on sufficiency of financial forecasts have been upheld in several cases.[286] Additionally, state health departments or insurance regulators could require annual financial reports from all nursing home facilities.[287] These requirements could be included in the new corporate structures specifically tailored to nursing homes, and could be tied to the minimum coverage state trust funds described above.

E. Increase of Medicare and Medicaid Funding

Insufficient Medicare and Medicaid payments to long-term care facilities are one of the principal causes of eroding nursing home profit margins. One solution is to increase Medicare and Medicaid payments; but, in order to invoke such increased payments, government funding of Medicare and Medicaid must be increased in parallel. Increasing federal income taxes to provide the funding would be a politically unpopular solution. Increasing nursing home corporate taxes would further increase costs of nursing homes—the government would be giving to the right hands of nursing homes only to take from their left. Increasing fines levied against delinquent

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285. *See* Lucian Arye Bebchuk & Assaf Hamdani, *Vigorous Race or Leisurely Walk: Reconsidering the Competition Over Corporate Charters*, 112 YALE L.J. 553, 591-92 (2002) ("In particular, it would be quite difficult for a challenge to succeed unless the challenger offered not only a corporate law system more favorable to shareholders than Delaware's but also one that would be as (or more) favorable to managers as Delaware's.").

286. *See* Crown Nursing Home, Inc. v. Axelrod, 155 A.D. 2d 455, 456 (N.Y. App. Div. 1989) ("[The] total amount of funding available to the petitioner fell far short of the facility's initial operating expenses."); Fahey v. Pub. Health Council, Dep't of Health, 89 A.D. 2d 702, 704 (N.Y. App. Div. 1982) (upholding initial inquiry into financials and noting "report prepared by respondent indicated . . . the likelihood of a substantial operating deficit."); Schultz v. Pub. Health Council, Dep't of Health, 46 A.D. 2d 580, 582 (N.Y. App. Div. 1975) (finding financial considerations to be "pertinent" part of application consideration).

287. *See* Katz v. Blum, 460 F. Supp. 1222, 1223 (S.D.N.Y. 1978) (finding requirement that Annual Financial Reports be submitted to Department of Social Services by operators of private, for-profit proprietary homes for adults was constitutional).

nursing homes—those that do not meet federal standards for facility conditions and quality of care—would likely be unsuccessful because such fines would be hard to collect from already indebted facilities.[288] Nonetheless, increasing fines would incentivize compliance, which, theoretically, would increase facility conditions and patient care.

VII. CONCLUSION

The dynamism and complexity of the eldercare problem makes the implementation of a solution difficult. The growing demand for eldercare adds pressure to the need for a solution. Multiple stakeholders—the elderly, legislators, regulators, health care providers, health care insurers, health care employees, the investing public, taxpayers—share the common goal of providing adequate housing and health care for society's elderly. Where stakeholders differ, however, is the implementation and cost sharing of that common goal.

Nursing home care in the United States is approaching the eleventh-hour crisis, necessitating that proactive legislation be implemented to avoid an eldercare crisis. Although litigation on behalf of nursing home residents has significantly increased in the last two decades, such lawsuits are largely meritorious. Rising insurance premiums and insurer flight from high-risk jurisdictions are also major contributors to the troubled state of the nursing home industry. Corporate restructuring can be an effective method for avoiding liability, but frequent abuse of corporate structuring schemes by nursing home owners and operators has increasingly led to corporate veil piercing and "hands-off" approaches from various courts.

To meet the imminent eldercare crisis, legislatures should consider developing verdict guidelines that prevent exorbitant jury awards to nursing home plaintiffs, and yet do not deny wronged or injured elders the right to recover damages suffered. State legislatures should simultaneously consider mandating that nursing homes maintain minimum liability coverage through a combination of assets or insurance, in the event of judgments against the corporation. Local legislatures should investigate the option of granting building permits and facility licenses to nursing home owners and operators on condition of proof of financial solvency for

288. Increasing fines against facilities that fail inspections is, however, one of the principal aspects of newly proposed federal legislation. *See* Robert Pear, *Serious Deficiencies in Nursing Homes Are Often Missed, Report Says*, N.Y. TIMES, May 15, 2008, at A23 ("Mr. Grassley and Mr. Kohl have introduced a bill to upgrade nursing home care and increase the penalties for violations of federal standards. The maximum fine, now generally $10,000, would be increased to $25,000 for a serious deficiency and $100,000 for one that resulted in a patient's death.").

every location. Finally, federal and state legislatures should adjust Medicare and Medicaid funding and regulations to cover actual nursing home costs. In combination, these elements may refine the operation of a safe, growing, and economically viable nursing home industry that provides the quality of eldercare that the society intends for its members.

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