The boomers are coming! The boomers are coming!

But let's not jump the gun.

While a great deal of attention has been devoted to the aging of the baby boom generation and how it may overtax the nation's long term care capabilities, providers would be wise to study current senior demographics as highlighted by the 2000 U.S. census. Unlike the 1990 census, which recorded increasing growth rates in the 65 and above age groups, the latest population count reveals a near-term lull.

The cause of the decline is aptly named the "silent generation," and it's comprised of people born during the Depression years—a time of low birth rates and strict immigration laws. The decline in birth rates actually started in 1925 and continued through 1945, says Donald Redfoot, a public policy analyst with AARP's Public Policy Institute. He notes that the "birth dearth's" lowest period was from 1933 to 1936, which is confirmed by the decrease in the 65 to 69 group demographic in the 2000 census.

This "trough," as one expert calls it, may already be affecting assisted living, but other experts anticipate that the low number of seniors will affect other long term care markets as well. As this group ages, says Redfoot, long term care can expect a slower rate of growth—at least until the next census in 2010.

The current dip in the seniors population, say Redfoot and others, will create stiffer competition among facilities that will not abate until after 2010, when providers can expect to see a small resurgence in market growth. But the surge of baby boomers will not begin

LISA GELHAUS

DRILLING DOWN FOR MARKET VIABILITY

Providers prepare for the arrival of the 'silent generation.'

arriving in assisted living and skilled nursing facilities (SNFs) until around 2020, when business growth should skyrocket.

During the 1990s, the most rapid rate of growth occurred among the oldest age groups. Those seniors 85 years and older increased from 3.1 million in 1990 to 4.2 million in 2000, a 38 percent increase. In contrast, the number of seniors 65 to 69 years old decreased by 6 percent.

Unlike the 1990s, however, the next two decades will see growth in the youngest seniors.

"Between 2000 and 2020, the bulk of the growth will be among the young old," says Redfoot. "It's important for providers to look at the size and the economic characteristics of this age cohort in order to understand what's driving the market."

Identifying Customers

For the near term, however, market feasibility experts and providers must examine the 2000 population numbers. And a good place to begin is by looking at the demographics of the 65 years and older segment, which is broken down in the 2000 U.S. census into people 65 to 74 years old, 75 to 84 years old, and 85 and older (*see chart,page 24*).

The current profile of the average assisted living resident at the time of admission is an 80-year-old female, according to the American Health Care Association's "Facts and Trends," which posits that the average female SNF patient is also 80 years of age, while men typically enter SNFs at around age 75.

Thus, census numbers that pinpoint the demographics of the 75- to 84-year-old age group and those 85 years and older constitute the largest group of potential clients for today's facilities. Most providers are looking at five- and 10-year projections, so the 75 to 84 and the 65 to 75 age groups become more important.

"Most of the focus is on the 75 to 84" group, says Susan Brecht,president of Brecht Associates, a market consulting firm in Philadelphia. Facilities are busy targeting this demographic for potential admissions because this tends to be the age at which people move in—particularly the 80 to 84 age group, she says.

On a national level, according to 2000 census figures, the 75- to 84-year-old group is still growing. The number of seniors between the ages of 75 and 84 increased by 2.3 million, to 12.3 million, as counted in the 2000 census. This constitutes a 23 percent increase over 1990 census figures. The 65 to 74 age group—the so-called silent generation—showed a minimal growth rate of about 2 percent, from 18.1 million in 1990 to about 18.4 million in 2000.

Bureau Ups Its Estimates

The Census Bureau also projects from birth and death rates that the growth in the elder sectors is expected to increase. The last projection of birth and death rates was completed using 1990 census data. With a fresher set of data from the 2000 census, the bureau increased its projected estimat-

ed number of seniors for the next 30 years.

The Annapolis,Md.-based National Investment Center for Seniors Housing and Care (NIC) analyzed the Census Bureau projections and found that the 2000 census projects 97,240 more people in the 65- to 74-year-old category for 2010 than it had in1990. This would bring the total estimated number of seniors in this age group to 21.2 million.

The increase, according to NIC senior researcher Harvey Singer, is due to an increasing number of immigrants in the United States and more seniors living longer.

National Population Trends: 1990 Census Vs. 2000 Census

	1990	% Of Population	2000	% Of Population
U.S. Pop.	248,709,873	100	281,421,906	100
Total 65+	31,241,831	12.6	34,991,753	12.4
85+	3,080,165	1.2	4,239,587	1.5
	1990	**% Of 65+**	**2000**	**% Of 65+**
65 to 74	18,106,558	58	18,390,986	52.6
65-69	10,111,735	32.4	9,533,545	27.2
70-74	7,994,823	25.6	8,857,441	25.3
75 to 84	10,055,108	32.2	12,361,180	35.3
75-79	6,121,369	19.6	7,415,813	21.2
80-84	3,933,739	12.6	4,945,367	14.1
85 to 94	2,829,728	9.1	3,902,349	11.2
85-89	2,060,247	6.6	2,789,818	8.0
90-94	769,481	2.5	1,112,531	3.2
95+	250,437	.8	337,238	1.0

Source: U.S. Census Bureau, The 65 Years and Over Population: 2000, Census 2000 Brief; Table 9. States and Puerto Rico Ranked by Percent 85 and Over: 1990 and 2000

Top States Show Seniors Tr ends

But pure numbers cannot tell the whole story. Providers are already aware of seniors moving to warm-weather climates or following their adult children. The 2000 census reaffirmed that these trends continued through the 1990s. The states that experienced a growth in overall population as well as seniors populations were California,Florida, and Texas.

A review of the 1990 and 2000 census shows that California remained the state with the largest total population and the state with the largest number of seniors aged 65 and older. The state had 3.5 million seniors in 2000, compared with 3.1 million in 1990, an increase of about 12.9 percent.

Florida, among the most popular states for retirees, continues to be the second hot spot for seniors. The state had 2.8 million seniors in 2000, compared with 2.3 million in 1990, an increase of about 21.7 percent.

The growth in Texas' total population pushed the Lone Star State into second place in overall population among U.S. states. Texas seniors'population rose by 355,956, from about 1.7 million in 1990 to slightly more than 2 million in 2000.

While state population demographics can indicate where seniors are living, market consultants say that seniors population numbers alone do not determine potential business for long term care facilities. Individual market nuances will affect how many of those seniors could become potential long term care clients,they say.

New Population Characteristics

One of the key factors to study when determining an area's market potential, consultants say, is statistics on seniors'health, gauged by level of need for assistance with activities of daily living (ADLs). Other considerations include seniors' yearly incomes and whether or not they own their own homes. By categorizing seniors according to need for assistance with ADLs, marketers can determine the potential market for seniors housing by category: independent living, assisted living, or skilled nursing.

However, providers must also contend with the downward trend of people needing assistance with ADLs. New drugs and medical treatments have helped increase longevity while decreasing the level of assistance that people need, says Christine Bishop, a researcher and professor at Brandeis University's Schneider Institute for Health Policy, Waltham, Mass. Bishop spoke about the chronic and long term care needs of elders and people with disabilities at a recent National Academy of Social Insurance conference held in Washington, D.C. Her presentation included statistics from a variety of federal studies that explain health and longevity trends.

In 1982, the "National Long-Term Care Survey" found that 26.2 percent of people 65 and older needed assistance with ADLs or instrumental ADLs such as telephone use or money management. Many in this group were already residing in long term care facilities. By 1999, according to a follow-up study, the number of seniors needing assistance had fallen to 19.7 percent.

Surveys also show a drop in the rate of cognitive impairment. In 1982, 5.7 percent of people 65 and older exhibited signs of cognitive impairments. But by 1994 that number had decreased to 3.2 percent, according to a 1998 article in *The Journals of Gerontology: Series A, Biological and Medical Sciences*.

At least part of this decrease is attributable to higher levels of education, which has been shown to be a factor in preservation of cognitive function, Bishop said. She explained that diseases like cancer, once considered terminal, are now being categorized as chronic, meaning people are living with the condition because of the advancement in medical treatments and drugs.

The effect of these medical advances is, in itself, skewing the demographic picture. According to "The 2001 Board of Trustees of Social Security Annual Report," people's life expectancy is steadily increasing. Women who were 65 in 2000 have a life expectancy of 84.6 years, the report said, while women who will be 65 in 2040 should have a life expectancy of 86.7.

Men who were 65 in 2000 have an average life expectancy of 81.2; those 65 in 2040 will have a life expectancy of 83.6, the report said.

All these factors must be incorporated into the demand formula to determine a potential customer base, experts say.

Short-Term Projections

"The demographic effect for skilled nursing and assisted living facilities is just slightly under 2 percent growth per year," says Tony Mullen, managing director of Philadelphia-based KMF Senior Housing Investors and chair of NIC's research group. "And the growth rate doesn't change meaningfully until the baby boomers arrive in 2020."

Mullen says the equation for determining the overall rate of growth for assisted living and skilled nursing can be broken into two parts: demographics and consumer usage. If people continue to use assisted living and skilled nursing at the current rate, then the only place for business growth is in the demographics, he says. Mullen says his projection of business growth is based on the assumption that seniors will continue to choose assisted living and skilled nursing at approximately the same rate that they have in the past.

"More people will not be choosing skilled nursing unless the government expands the Medicare program. And that doesn't seem likely. We already know that the Medicaid budgets are shrinking," Mullen says. He adds, however, "the wild card will be assisted living. It has shown growth in the past, but the evidence is mixed for the future."

Mullen does expect some slight increase in the use of assisted living by the general public, but not enough to significantly impact business growth.

Because of the current availability of skilled nursing beds and assisted living units, the increasing seniors population will absorb those vacancies, says Gilbert Till,principal of URBEK, a Seattle-based company that analyzes markets for long term care companies and lenders.

"Since the 85-plus [group] is growing at a tremendous rate, this typically strengthens occupancy in skilled nursing facilities," he says. But providers are going up against stiffer competition and caring for frailer seniors as well, experts say.

"A flat census makes for a more competitive marketplace," says Crista Stark, vice president of marketing for Integrated Health Services (IHS). IHS' five-year strategic business plan, completed last year, was based on 2000 census data. "We believe we will see frailer, older, and sicker patients coming to us for care," she says.

Top 10 States Ranked By Population 65 And Over

	2000		1990	
	Number	% Of Total	Number	% Of Total
Total U.S.	**34,991,753**	**12.4**	**31,241,831**	**12.6**
1.Calif.	3,595,658	10.6	3,135,552	10.5
2. Fla.	2,807,597	17.6	2,369,431	18.3
3. N.Y.	2,448,352	12.9	2,363,722	13.1
4. Texas	2,072,532	9.9	1,716,576	10.1
5. Pa.	1,919,165	15.6	1,829,106	15.4
6. Ohio	1,507,757	13.3	1,406,961	13.0
7. Ill.	1,500,025	12.1	1,436,545	12.6
8. Mich.	1,219,018	12.3	1,108,461	11.9
9. N.J.	1,113,136	13.2	1,032,025	13.4
10. N.C.	969,048	12.0	804,341	12.1

Source: 2000 U.S. Census

Unlike the upswing in skilled nursing occupancy, the dip in the seniors population may force some assisted living operators to reconsider how to deliver services until the rate of growth picks up, says Till.

Silent Generation Characteristics

Providers need to understand the characteristics and preferences of the silent generation, who range in age from 58 to 77 years old, says Brecht of Brecht Associates.

"They are silent, but they know what they want, and they have the money," she says. During their working years, this generation was loyal to companies, and companies took care of them with good pension plans, Brecht says. They are conservative about spending money, and their savings have grown, she says. Many of them have bought and own homes.

The silent generation benefited from the declining disability rates and the increased longevity of men, experts say. Fewer women of the silent generation will be widowed because the silent generation's men are living longer.

"Since demand for long term care will be relatively weak, this gives consumers more power," says Redfoot of AARP. "They'll have more economic resources. They'll have more spousal support or more kids to help support them. [The silent generation] is less likely to find themselves in institutional care."

In addition, this generation has a higher level of education, meaning they'll also be more savvy and knowledgeable about their choices, he says. "They'll be looking for alternatives. We're already seeing the effects of the birth dearth during the Depression," he says.

After completing a feasibility study for a client in the Detroit market, Till discovered that providers are already feeling the pinch of a declining seniors population. He suggests that providers be careful and examine local census data.

"The trough will affect assisted living facilities that won't be able to refill their empty units," Till says. "Those providers may need to provide heavier care to maintain their occupancy. We can no longer assume that every market is going to increase demographically."

"You'll see the traditional skilled nursing facilities with double-occupancy rooms decline. People will demand private rooms," says Redfoot. "It is going to be the providers who are innovative and can really provide the quality of care and the quality of life that this sophisticated group of consumers is going to demand that will succeed."

Till has been studying markets and their demographics for long term care clients

and banks for the past 20 years. He says the decrease in seniors is causing concern. "Housing and Urban Development market analysts are asking how providers are going to keep up their occupancy rates when the silent generation begins moving in," he says.

Market-By-Market Analysis

A closer analysis of county populations supports Till's concern. The 2000 census shows that Florida has the highest proportion of seniors 65 and older, at 17.6 percent (2.8 million) of the more than 15.9 million people living in the state. The older population represented 30 percent or more of the total population in five counties in Florida (*see chart, right*).

In Charlotte County, seniors constituted 34.7 percent of the population, the highest in the nation. The 2000 census also found that of cities with 100,000 or more people, Clearwater, Fla., had the highest proportion of people 65 and older.

But that's only part of the story. The Clearwater-St. Petersburg area is located in Pinellas County. A comparison of the total population of Pinellas County in 1990 and 2000 revealed that while the county is growing overall, the population of those 65 and older is declining. The population of the 75 to 84 group is essentially flat, and the 85-plus age group increased by slightly more than 4,000.

"Each local market must be evaluated carefully," says Till. "As the silent generation age group works its way through the various age classes, we can no longer simply assume every seniors age group is growing."

Till provides another example of market fluctuations. The total population of Douglas County, Ore., in 2000 was 100,399, and in 1990 it was 94,649. Bucking the national decline in 65- to 74-year-olds, Douglas County showed an increase in both 65- to 74-year-olds and 75- to 84-year-olds. The total 65-plus population grew from 14,563 in 1990 to 17,888 in 2000, an increase of nearly 23 percent.

Till believes a regional medical center serving the local area is drawing seniors into Douglas County and possibly the Billings,Mont., area as well. In Billings, located in Yellowstone County, the 85-plus community grew by more than 64 percent, from 1,365 in 1990 to 2,241 in 2000. The census also shows a large increase in the 75- to 84-year-old age group. "It's a good bet that many of these seniors have moved to the Billings-Yellowstone County area for its medical services," Till says.

Top 10 U.S. Counties Ranked By Percent Of Population 65 And Over: 2000

	Total Population	Number 65+	% 65+
1.Charlotte Co., Fla.	141,627	49,167	34.7
2.McIntosh Co., N.D.	3,390	1,160	34.2
3.Highlands Co., Fla.	87,366	28,833	33.0
4.Citrus Co., Fla.	118,085	38,010	32.2
5.Kalawao Co., Hawaii	147	47	32.0
6.Sarasota Co., Fla.	325,957	102,583	31.5
7.Hernando Co., Fla.	130,802	40,353	30.9
8.Llano Co., Texas	17,044	5,225	30.7
9.McPherson Co., S.D.	2,904	859	29.6
10.Divide Co., N.D.	2,283	674	29.5

Source: 2000 U.S. Census

Case Studies

Again, high concentrations of seniors do not necessarily indicate business success. Senior Resource Group (SRG), a San Diego-based operator of independent,assisted living, and Alzheimer's facilities, found that while high concentrations of seniors are living in both Los Angeles and Phoenix,Ariz., other factors could be barriers to filling units.

In Los Angeles, SRG built a 244-apartment independent and assisted living facility that opened in mid-December 2001. By early February, the facility was almost 50 percent occupied. SRG's business plan estimated it would take 24 months to fill the facility. "Los Angeles is an area that is reaping the bounty of the census," says Donna Thomas, a spokeswoman for SRG. "There are so many people that need these facilities and so few facilities to accommodate those needs." Thomas says the high barrier to market entry in Los Angeles is finding land to build on. Land is scarce, and what is available is expensive, she says.

By contrast, Phoenix has its own market barriers. Arizona experienced an increase of 189,065 seniors into the state during the 1990s. But the Phoenix assisted living market is overbuilt and overserved, Thomas says. The result is a market filled with assisted living facilities willing to negotiate their rates. In addition, some of those seniors are not year-round residents, spending only the warm winter months in Arizona, Thomas says.

"Few communities enjoy year-round, full occupancy," she says. "Most assisted living markets are within five to 10 miles of the facility, but it is so competitive in the Mesa area [a Phoenix suburb] that the adult children of assisted living residents will drive 45 minutes to an hour, from Phoenix to Mesa, to save $500 a month on assisted living care. The market is so cost-conscious that many assisted living communities operate at less than full."

In response to this market complexity, Thomas says, the company plans to develop congregate campus living on a rental basis, offering a continuum of care without the high entrance fees of a continuing care retirement community.

"It is the most beneficial business model from our perspective, as well as from the residents' viewpoint because as their needs change, residents can access all levels of care without moving," Thomas says.

"Globally, the combination of the census trends and the professional trends has helped us become more sharply focused," says Stark of IHS. She says IHS will stay competitive by conducting further research into a facility's market and then determining if services are meeting that market's demand. ■

NATHAN CHILDS

THE LINGERING FPO INSURANCE QUESTION

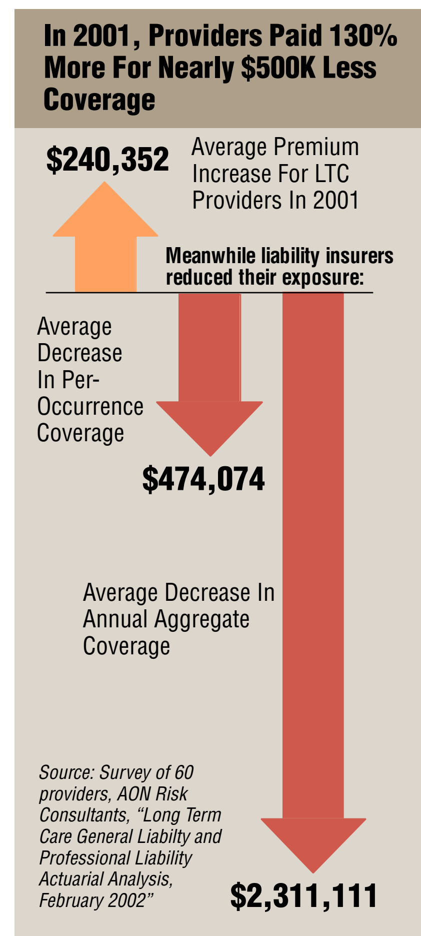
The cost and availability of liability coverage can sometime trump even the best demographic profiles.

They rank as the No. 4 and No. 2 largest states in total population size and No. 2 and No. 4 in the key long term care demographic of inhabitants over age 65. At first glance, Florida's and Texas' mirror-image numbers couldn't be more encouraging for long term care providers seeking ideal markets for growth. So why have a handful of the nation's largest long term care companies abandoned these states?

Just this past January, the country's largest nursing facility chain, Ft. Smith, Ark.-based Beverly Enterprises, completed the sale of all 49 of its Florida nursing facilities and its four assisted living centers. Beverly's high-profile move was prefaced by the January 2001 Florida pull-outs of Milwaukee-based Extendicare and Murfreesboro, Tenn.-based National Healthcare Corp.—the ninth and 11th largest nursing facility chains in the United States. The flight from Texas started even earlier, when Beverly withdrew in 1997. Many of the other major for-profit players followed suit.

The answer, at least the one universally cited by the providers in haste to leave Florida and Texas, is the exploding cost of general and professional liability (GL/PL) insurance for nursing facilities, assisted living centers, and intermediate care facilities for the mentally retarded and developmentally disabled. The bad news for providers operating in the other 48 states is that Florida's and Texas' liability insurance headaches appear to be headed their way.

"Our survey found that in 2001 the average nursing facility paid premiums 130 percent higher than what they did in 2000," says Theresa Bourdon, managing director and actuary at Chicago-based AON Risk Consultants. Bourdon was the primary researcher behind a February 2002 report detailing that liability costs directly related to long term care quadrupled between 1995 and 2001. The study found that the average long term care claim has tripled from $67,000 in 1990 to $219,000 in 2001.



On average, providers' GL/PL premiums went up by nearly $250,000 last year, while insurance coverage limits simultaneously dropped by almost $500,000 (*see box,left*). Annual aggregate limits were reduced by $2.3 million per insured. Premium increases of this size are unlike anything else the insurance industry is seeing, says Bourdon.

"Typically, liability premium increases trend slightly ahead of inflation, with 3 to 7 percent annual increases," says Bourdon. "Nothing is trending the way long term care premiums have escalated."

Of course, for providers focused on caring for their patients with limited resources, a quarter-million-dollar insurance hike may translate into bankruptcy, says Charles Roadman II, M.D.,president and chief executive officer of the American Health Care Association (AHCA). "And it can also mean the difference between hiring or laying off more nurse assistants."

Not surprisingly, insurers have backed away from the long term care GL/PL business in droves, seeking to escape the volatility and ever-growing number of negligence lawsuits being filed against providers. In February 2001, only 17 insurers out of 515 authorized to write commercial liability were offering coverage to Florida providers, according to a status report from Florida Deputy Insurance Commissioner Susanne Murphy. Even the insurers-of-last-resort, the so-called reinsurers like Lloyd's of London that charge towering premiums for "surplus" lines, have withdrawn from the markets of some states. Of the 17 left in Florida, 10 are reinsurers. In Mississippi, only three insurers of any type are actively writing liability coverage, according to a January report from Mississippi State University.

"Uniformly across the nation,there are very few carriers willing to write this coverage," says Bourdon.

The lack of competition has made insurance so expensive in Florida and Texas that the majority of facilities in both states are operating without liability coverage—or to use insurance lingo—"going bare," according to recent surveys. According to the Texas Department of Human Services, 55 percent of Texas nursing facilities were operating without general and professional liability insurance in 2001. A December report from the University of South Florida's Policy Exchange Center on Aging estimated that as much as 83 percent of the Florida long term care sector is likely to go bare this year.

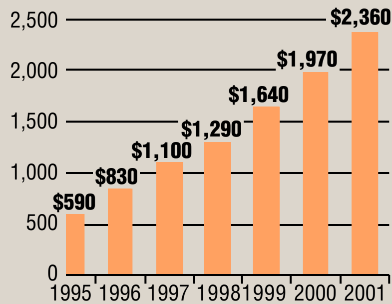
Insurance Affordable, Available?

With the national average annual premium hovering around $236,000 for a typical 100-bed facility, the operative question for most providers is quickly becoming where is liability insurance relatively affordable—and, perhaps even more important—available?

The GL/PL insurance market as a whole, including coverage for manufacturers and other nonhealth businesses, has hardened across the board since Sept. 11, as property and casualty insurance companies have attempted to reduce their risk

Long Term Care Liability Costs Have Quadrupled Since 1995

Nationwide Loss Cost Per Occupied Bed



Source: AON Risk Consultants, "Long Term Care General Liability and Professional Liability Actuarial Analysis, February 2002"

exposure, according to John Andre, vice president of the Oldwick, N.J.-based insurance intelligence firm A.M. Best. As a result, even providers operating in the states where long term care GL/PL coverage remains relatively inexpensive are likely to take a serious premium hit this year, Andre says.

Kentucky providers are "fretting that their liability premiums went up 300 to 400 percent this year," says Rich Miller, executive director of the Kentucky Association of Health Care Facilities. "That's bad, but I remind them that they could be seeing 1,700 percent increases like providers in Florida."

AON's Bourdon contends that the best information on where GL/PL coverage remains relatively affordable can be found in her February 2002 nationwide survey of the liability costs of approximately 440,000 licensed nursing facility beds and 32,000 assisted or independent living units. According to the survey, insurance costs remain relatively low in 42 states, mostly clustered in the Midwest and Northeast. Excluded from her list of lower-cost states are six Southern states (Alabama,Arkansas, Florida, Georgia, Mississippi, and Texas) plus California in the West and the Mid-Atlantic's West Virginia. Bourdon stresses that in this case "relatively low" does not mean "inexpensive" or even "not too bad." In the 42 "relatively low" states, liability loss costs—the key statistic insurers use to set rates—have nearly tripled, from $220 per long term care bed in 1995 to $620 per bed in 2001, increasing at a rate of 20 percent per year.

That increase far outpaces typical liability claims costs for every other industry that buys GL/PL insurance, Bourdon says. Typical cost increases for claims tend to be in the 5 to 10 percent range, roughly half of what long term care providers in the 42 "relatively low" states are experiencing. And even then, Bourdon says, it is likely that there are significant variations in the cost of GL/PL coverage just among the "low-cost" states. There's no guarantee, she says, that smaller, independent providers dependent on Medicaid and Medicare will be able to afford coverage in these states either.

Those $620 per bed loss costs directly translate into premium increases, explains Janet Kulhanek,partner with the Houston-based liability insurance broker Colley & Associates. Although insurers used to build a 5 to 10 percent profit margin into their premiums, most now rely on the earnings garnered by investing premium dollars for their bottom-line profit. While reinsurers still figure in such a bonus fee, most commercial insurers set rates using loss costs alone, she says.

A.M. Best, which rates the financial stability of insurance firms, has recently downgraded many carriers in the patient care liability segment—with Bermuda-based Legion Indemnity Group the latest victim. The segment, made up of a small number of medical malpractice insurers for physicians and an even smaller number of companies who sell GL/PL coverage to nursing facilities, hospitals,and surgical centers, "remains in flux," says Best's Andre.

The downgrades are just the latest hit for the segment. In 1999, St. Paul Insurance Cos.—at that time the largest health care GL/PL insurer in the nation—decided not to renew most liability policies for its skilled nursing facility clients throughout the country. In February 2000, Employers Reinsurance Corp., Reliance Na-

tional Insurance Co., The Doctors Co., USF Insurance Co., Agricultural Excess and Surplus Insurance Co., and Admiral Insurance Co. all either withdrew entirely from markets or stopped writing new policies, according to William Warfel, professor of insurance and risk management at Indiana State University in Terre Haute.

A move just two months ago highlighted the vulnerability of providers in all states—even those without a robust history of long term care lawsuits. Princeton, N.J.-based Princeton Insurance Co. announced in late February that it would stop renewing liability policies for Pennsylvania providers beginning May 1. The decision will affect a wide range of health care providers in Pennsylvania, from nursing facilities to podiatrists, according to Princeton's Web site.

Liability Rates Skyrocket

Florida and Texas have historically been the leaders in driving the increase in long term care GL/PL costs, but the February AON study found that six other states are showing similar trends.

While liability-loss costs are growing by an average of 20 percent annually in the rest of the nation, the cost of settling or trying long term care negligence lawsuits is mushrooming in Georgia, up 50 percent; West Virginia, up 50 percent; Arkansas, up 45 percent; Mississippi, up 40 percent; Alabama, up 31 percent; and California, up 29 percent, according to AON's Bourdon.

The nation's highest liability-cost state remains Florida, with the average per-bed loss topping out at $10,800 last year—more than $5,000 per bed more than Texas, the next most expensive state. Florida's providers and the insurance industry are hopeful that tort reform legislation passed last year, including a cap on noneconomic damages for some cases, may help stem the growth of those costs.

Florida's liability troubles can be traced back to a cluster of unusual statutes in the state's civil justice system, says Doug Mannheimer, a partner with the Tallahassee-based firm Broad & Cassel. Prior to the passage of the 2001 tort reform package, a 1993 Florida state law singled out long term care facilities by removing the requirement that civil suits be brought under the state medical malpractice statute. Instead, personal-injury attorneys were permitted to bring action against facilities under "strict liability" law.

The change in burden-of-proof was earth-shattering for Florida providers and a boon for the plaintiffs' bar, Mannheimer says. Instead of requiring plaintiffs' counsel to prove that a facility and its staff failed to exercise the "skill and care of other similarly trained caregivers," now the state only asked that they prove their client had, indeed, suffered a decline in health. Usually reserved solely for defective product suits, "strict liability" meant that the court didn't care what caregivers had done to try to prevent the health problem—only whether or not it happened.

"Not only did [the strict liability standard] stack the deck against providers, it virtually rendered every nursing facility guilty until proven innocent," says Mannheimer. "It was the first time strict liability had been applied in any health care setting."

The Florida "strict liability" change was inserted deep within a more sweeping and generally positive patients' bill of rights for nursing facility patients, a tactic that the plaintiffs' bar reused to get similar bills passed in several other states. Along

States With Laws That Might Encourage LTC Provider Litigation

State	Statutory Patients' Rights	Civil Cause Of Action Based On Patients' Rights	Add-On Attorneys' Fees	Actions Brought Under Medical Mal-Practice
Arizona	X (vulnerable adult)	X	X (vulnerable adult)	no
Arkansas	X	X	unknown	yes
California	X	X	X	yes
Connecticut	X	X	X (if punitive damages found)	yes/no
Delaware	X	X		yes
Florida (recently amended)	X	X		no
Illinois	X	X	X	yes
Kentucky	X	X	X	no
Massachusetts	X	X	X	yes
Minnesota	X	X		yes
Missouri	X	X	X	yes
Nevada	X	X	X	no
New Jersey	X	X	X	no
New York	X	X	X	yes/no
Ohio	X	X	X	no
Oklahoma	X	X	X	no
Tennessee	X	X (for elder abuse)	X (for elder abuse)	no
Wyoming	X	X		yes

Source: Broad and Cassel: Draft Report to the American Health Care Association Tort Reform Task Force

with the burden-of-proof modification,the 1993 Florida law also required that nursing facilities pay "add-on attorneys' fees" if they lost a case in court.

While Florida personal injury lawyers could only collect the add-on fees if they won in court, the threat of the fees was frequently used "as a cudgel to force providers and their insurers to consider larger settlements," says Florida Health Care Association spokesman Ed Towey.

"Their attitude was 'you can either pay me now or you can pay me more later,'" says Towey. While attorneys are typically paid a contingency fee, usually a percentage of the overall payment, the old Florida law required defeated providers to pay them by the hour at a rate of the lawyer's choosing. "There were some suits, especially those that took a few years to get to trial, where the add-on attorneys' fees were even larger than the patient's compensatory damages," Towey says.

Those attorney fees continue to add up, the AON report found. Almost half (47 percent) of total long term care GL/PL claim costs go to plaintiff and defense attorneys' fees and related litigation costs, according to the report. Plaintiffs' attorneys claim approximately three out of every four of those dollars.

Spotting Emerging 'Floridas'

Given that the GL/PL industry is expected to spend $1 billion adjudicating long term care liability claims in 2001 alone, it's no wonder that carriers get queasy if they run across laws with even a whiff of a semblance to Florida's now-repealed "strict liability" statute, says Bourdon.

And like the small army of aggressive personal injury lawyers attempting to restore their "strict liability" cash cow, insurers are sparing no expense to make sure they know which states have similar laws so they can pull out, hike providers' premiums, or cancel renewals.

Providers are keeping a wary eye out as well. In a bid to keep tabs on what the plaintiffs' bar and its politically connected trade group, the Association of Trial Lawyers of America, are up to, AHCA asked Broad & Cassel's Mannheimer to poll knowledgeable defense attorneys across the country to determine how widespread the key problematic features of Florida's old law had become.

The resulting fall 2001 survey found 18 states with laws that had at least some similarities to Florida's (*see table, page 32*). Unlike the mostly deep South states noted by AON, Mannheimer's survey determined that states as seemingly safe as Ohio and Nevada had statutes that looked, at least on paper, to grant add-on attorneys' fees and establish a civil cause of action outside the medical malpractice statute.

Community attitudes about going to

court play a big role in determining liability loss costs in some of the states with onerous statues.

Such community factors help explain the glaring absence of Texas on the Mannheimer watch list. Although the Texas legislature did pass a patients' bill of rights for nursing facility patients, the law didn't serve as a Trojan Horse for add-on attorneys' fees or a strict liability standard adjustment.

"Texas proves the point that liability costs are hard to predict," says Bourdon. "It's a function of more than whether they have a law or not—the general populace has to want to sue and juries have to give enormous awards."

In February 2002, the *National Law Journal* listed the 100 largest "mega-verdicts" of 2001. A total of four nursing facility negligence cases made the *Journal's* top 100, with three out of the four coming out of Texas courtrooms. The axiom that Southern juries give larger awards tends to be true, Bourdon says.

Instead of tracking state laws, Bourdon says insurance carriers are paying a lot of attention to where key Florida law firms that made a killing off of strict liability are opening satellite offices. They have noticed a pattern that the opening of a new office often coincides with an effort to pass Florida-like liability statutes and an increase in claims, Bourdon notes.

For example, Wilkes & McHugh, a Tampa-based firm that reaped millions on nursing facility litigation and pushed strict liability statutes in other states, has opened offices in Arkansas, California, Tennessee, and Texas. The firm is currently attempting to expand into Mississippi.

Taking On Tort

The stars may be aligning this year to create an environment favoring meaningful tort reform, says Tom Plowman, director of financial and rate analysis at the Texas Health Care Association.

The withdrawal of the St. Paul Cos. from the medical malpractice market in December has precipitated a severe shortage of affordable and available liability coverage for physicians and hospitals, he says.

With long term care, hospitals, and physicians all in the same liability boat, Plowman and Florida's Towey are optimistic that a powerful coalition could drive caps on noncompensatory damages; increase peer review protection for quality improvement activities; and initiate newer, better risk-pooling arrangements through state legislatures next year.

A.M. Best's Andre says that public pressure for some kind of reform could increase even more because many commercial GL/PL and malpractice carriers need to rebuild reserves—driving coverage prices even higher and shrinking the overall market's capacity. That could keep the missing-in-action GL/PL carriers out of the long term care market for even longer, he says.

"It's going to be quite a while before the insurers that left this market come back home again," Andre says. ■