# ARKANSAS SENATE

84th General Assembly - Regular Session, 2003

**Amendment Form**

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**Subtitle of House Bill No. 1213**

"AN ACT TO ADDRESS INSURANCE COVERAGE FOR NURSING HOME PATIENTS AND PERSONAL INJURY CLAIMS AGAINST NURSING HOMES."

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**Amendment No. 3 to House Bill No. 1213.**

Amend House Bill No. 1213 as engrossed, 2/17/03:

Delete everything after the enacting clause and substitute:

"SECTION 1. Title 20, Subtitle 2, Chapter 10 of the Arkansas Code is amended by adding the following new subchapter 19 to read as follows:

20-10-1901. Title.

This subchapter shall be referred to as the "Fair Care and Treatment Act of 2003".

20-10-1902. Purpose and intent.

(a) The purpose and intent of this act is to provide for the fair care and treatment of persons receiving long-term care in skilled nursing facilities licensed to operate in this state.

(b) This act authorizes the creation of a liability insurance pool known as the Patient's Recovery Fund to provide a secure and sustainable source of funds to satisfy personal injury claims by or on behalf of patients of participating facilities.

(c) This act provides fair court procedures for the resolution of disputes between facilities and their patients.

20-10-1903. Definitions.

As used in this subchapter:

(a) "Action for injury" means any civil action, whether based in tort, contract or otherwise, to recover damages on account of an injury to a patient of any skilled nursing facility.

(b) "Affiliate" of a skilled nursing facility means any person or entity controlling, controlled by, or under common control with the facility.

(c) "Board" means the Patient's Recovery Fund Board created by this subchapter.

(d)(1) "Claim" means a demand for recovery of damages from the Patient's Recovery Fund, whether based in tort, contract or otherwise, on account of an injury to a patient of a participating facility.

(2) A claim may be brought by the patient, or by the guardian, representative, executor, administrator, or person acting on behalf of the

patient, including a third party whose right to recover damages is derivative of the legal rights of the patient.

(e) "Claimant" means the person or persons alleging a claim or action for injury against a skilled nursing facility.

(f) "Injury" means the personal injury or death of a patient of a skilled nursing facility arising out of or sustained in the course of the services rendered to the patient by the facility, its owners, principals, officers, employees, agents and affiliates, or any person or entity providing management services to the facility, or arising out of or sustained in the course of the relationship between the patient and the facility, its owners, principals, officers, employees, agents and affiliates, or any person or entity providing management services to the facility.

(g) "Occupied beds" means:

(1) Beds occupied by patients at midnight;

(2) Those beds placed on hold during a period of time not to exceed five (5) consecutive calendar days during which a patient is in a hospital bed; and

(3) Those beds placed on hold during a period of time not to exceed fourteen (14) consecutive calendar days during which a patient is on therapeutic home leave.

(h)(1) "Participating facility" means a skilled nursing facility which participates in and contributes to the Patient's Recovery Fund, including the owners, principals, officers, employees, agents, and affiliates of the skilled nursing facility.

(2) "Participating facility" does not include any unaffiliated person or entity providing management services to the facility.

(i) "Patient" means a person receiving care or treatment from a skilled nursing facility.

(j) "Skilled nursing facility" means a "long-term care facility" as defined by § 20-10-213(4).

(k) "Wrongful act" means any act or conduct, whether by commission or omission, which is a proximate cause of an injury.

20-10-1904. Patient's Recovery Fund – Participation.

(a)(1) The Patient's Recovery Fund is created for the payment of valid claims or judgments against participating facilities.

(2) Each participating facility shall remit monthly assessments to the fund, or make payments to the fund in lieu of assessments, based upon the number of occupied beds as of the first business day of each month.

(3) Assessments may be prepaid upon terms approved by the board.

(4) Assessments and other payments, together with earned income, surplus and all other moneys accruing to the fund, shall be held in trust by the board for the purposes stated herein.

(b)(1) The fund shall not be deposited or maintained in the state treasury, but shall be a cash fund under the direction and control of the board, as stated herein.

(2) The fund shall not be subject to regulation by the State Insurance Department.

(c)(1) Only claims, judgments or awards arising from a wrongful act or acts which occur during a period of participation in the fund shall be covered by the fund.

(2) The fund shall offer tail coverage to participating

facilities upon terms approved by the board.

(d)(1)(A) A skilled nursing facility which is certified to provide services under Title XVIII or Title XIX of the Social Security Act, as they existed on March 1, 2003, shall participate in and contribute to the fund as a condition of maintaining its license to provide long-term care in this state.

(B) A skilled nursing facility which is not certified to provide services under Title XVIII or Title XIX of the Social Security Act, as they existed on March 1, 2003, or which receives no reimbursement or other payment under Title XVIII or Title XIX of the Social Security Act, as they existed on March 1, 2003, for services provided to any of its patients, may elect to participate in the fund, but shall not be required to participate in the fund as a condition of maintaining its license to provide long-term care in this state.

(2)(A) Subject to the rules and regulations of the fund and upon terms approved by the board, a skilled nursing facility which is required to participate in the fund as a condition of maintaining its license to provide long-term care in this state may opt out of participation in the fund by giving notice to the administrator that the facility is owned and operated by a nonprofit, government or church affiliated organization as defined by the board.

(B) Wrongful acts occurring during the facility's prior period or periods of participation shall be covered.

(3)(A) A participating facility shall be dismissed as a participant in the fund for nonpayment of assessments or payments in lieu of assessments, as determined by the rules and regulations of the fund.

(B) The board shall provide by regulation for a grace period for curing a default in the payment of assessments or other payments before formal dismissal and may impose a late fee not to exceed five dollars ($5.00) per occupied bed per event of default.

(C) Upon dismissal of a facility from the fund, wrongful acts occurring during the facility's prior period or periods of participation shall be covered.

20-10-1905. Election by participating facility – Initial assessments and payments.

(a) A participating facility may elect:

(1) To carry a higher deducible, or to retain a higher limit of its risks, by providing evidence satisfactory to the board that it is qualified to fund its risks of loss and that the facility or its affiliate maintains segregated accounts to fund the deductible and self insured retention losses;

(2) To purchase commercial insurance coverage by providing proof of coverage to the board; or

(3) To accept the insurance coverage provided by the fund and to pay monthly assessments as provided herein.

(b) A participating facility which elects to self insure or to purchase commercial insurance:

(1) Shall maintain coverage of not less than two hundred fifty thousand dollars ($250,000) per claim and an annual aggregate limit of coverage of not less than five hundred thousand dollars ($500,000);

(2) Shall pay an administrative fee to the fund in lieu of

monthly assessments, as provided in § 20-10-1904(c); and

(3) Shall participate in the fund upon equal terms with other participating facilities; provided, that the fund shall not pay claims or judgments on behalf of the facility, unless, and only to the extent that, the facility acquires coverage from the fund.

(c)(1) Assessments and payments in lieu of assessments shall be paid from and after January, 2004, based upon the number of occupied beds as of the first business day of the month.

(2) The initial amount of the aggregate annual assessment, payable monthly, shall be one thousand dollars ($1,000) per occupied bed and the initial amount of the annual administrative fee in lieu of assessments shall be two hundred dollars ($200) per occupied bed.

20-10-1906. Initial limits of coverage and deductible.

With respect to participating facilities which elect to accept the insurance coverage provided by the fund, the initial amount of the per claim limit of coverage shall be two hundred fifty thousand dollars ($250,000), the initial amount of the annual aggregate limit of coverage per participating facility shall be five hundred thousand dollars ($500,000), and the initial amount of the deductible shall be ten thousand dollars ($10,000) per claim.

20-10-1907. Patient's Recovery Fund Board — Powers and duties.

(a)(1) The Patient's Recovery Fund Board shall have four (4) directors and shall consist of:

(A) One (1) physician licensed in this state;

(B) One (1) registered nurse licensed in this state;

(C) One (1) pharmacist licensed in this state; and

(D) One (1) private citizen, who shall be a non-voting director, and shall have training and experience in risk management or in general business management.

(2) The Governor shall appoint the private citizen director, who shall be the chair of the board.

(3) The Attorney General shall appoint the physician director, who shall be the vice chair of the board, from a list of two (2) nominees submitted by the Arkansas Medical Society, or its successor.

(4) The President Pro Tempore of the Arkansas Senate shall appoint the nurse director, who shall be the secretary of the board, from a list of two (2) nominees submitted by the Arkansas Nurses Association, or its successor.

(5) The Speaker of the Arkansas House of Representatives shall appoint the pharmacist director from a list of two (2) nominees submitted by the officials responsible for the appointment of the voting directors on or before July 1, 2003.

(6)(A) The initial board shall be appointed on or before August 1, 2003.

(B) The initial terms shall be staggered so that the private citizen director and the physician director shall serve for three (3) years, the nurse director shall serve for two (2) years, and the pharmacist director shall serve for one (1) year.

(C) Subsequent terms shall be three (3) years.

(D) Directors shall be eligible for reappointment.

(b)(1) A director may be removed for cause by the Governor upon ten

(10) days' written notice to the director.

(2) A director whose term expires, or who resigns, is removed, or becomes incapacitated, shall be replaced within forty-five (45) days after the vacancy or expiration of the term by a successor of the same profession or standing.

(3) If a successor is not appointed within the forty-five (45) day period, the remaining directors shall select an interim director of the same profession or standing who shall serve for the new term or the unexpired portion of the term, as the case may be.

(4) Directors whose terms expire shall continue to serve until their successors are appointed.

(c)(1) The board shall supervise the management and activities of the fund.

(2) Each director shall be compensated from the fund at the rate of one hundred fifty dollars ($150) per hour devoted to official board activities, not to exceed one thousand five hundred dollars ($1,500) each month, plus out-of-pocket expenses incurred within the state, documented by appropriate receipts.

(d) Directors shall be immune from suit while acting in their official capacities, except for intentional wrongful acts or violation of fiduciary duty.

(e)(1) The board shall have the power and discretion, after notice to the affected participating facilities and a hearing, and based upon accepted risk management practices, to determine the amount of the aggregate annual assessment per occupied bed, the amount of the annual administrative fee in lieu of monthly assessments, the amount of the per claim limit of coverage, the amount of the annual aggregate limit of coverage per participating facility, and the amount of the per claim deductible.

(2) Notice of a change in the foregoing amounts, or any of them, shall be given to the affected participating facilities not less than sixty (60) days before the effective date of the change.

(f) The board shall determine terms, conditions and charges for providing tail coverage to participating facilities and shall have the power and discretion to offer supplemental coverage to participating facilities upon terms approved by the boards; provided, that supplemental coverage shall be not less than one hundred thousand dollars ($100,000) per claim.

(g) The board shall have the power to enter into contracts, and to sue and be sued, in its own name, to borrow public or private funds in the amounts and upon the terms as may be negotiated with a creditor or creditors, subject to otherwise applicable laws, and to assess an annual surcharge upon the assessments of a participating facility, after notice and a hearing, which demonstrates a disproportionately high history of payable claims or judgments, the surcharge not to exceed two hundred dollars ($200) per occupied bed.

(h) The board shall promulgate rules and regulations to govern the terms and conditions of participation in the fund, the administration of the fund, including the collection, management and disposition of fund assets, and the procedures for the timely resolution of claims before the administrator.

20-10-1908. Administrator – Powers and duties.

(a)(1) The board shall employ an administrator of the fund who is a

graduate of an accredited four-year college or university with at least ten (10) years experience in the field of risk management or business administration.

(2) All qualifications, terms and conditions of employment, including compensation, which shall be paid from the fund, shall be at the sole discretion of the board.

(3) The board shall employ the administrator in sufficient time for the administrator to assume the duties of office on or before January 1, 2004.

(b)(1) The administrator shall conduct and supervise the business affairs of the fund, under a written business plan approved by the board, which may include a plan for voluntary mediation of claims.

(2) The administrator shall employ appropriate professional personnel to assist with the business affairs of the fund, which shall include a nationally recognized risk management consultant.

(3) With board approval, the administrator may purchase or lease appropriate office space, equipment and other necessary assets for the use of the fund, and may expend fund moneys for all other necessary and appropriate purposes, subject to the rules and regulations of the fund.

(c) The administrator shall exercise best efforts to locate and approve a list of commercial insurance carriers to offer supplemental insurance coverage in aggregate amounts of up to two million five hundred thousand dollars ($2,500,000) at negotiable rates.

20-10-1909. Patient's Recovery Fund Advisory Board.

(a)(1) The Patient's Recovery Fund Advisory Board shall have five (5) members and shall consist of:

(A) The State Insurance Commissioner;

(B) The Attorney General;

(C) The Director of the Department of Human Services;

(D) One (1) director appointed by the President Pro Tempore of the Arkansas Senate; and

(E) One (1) director appointed by the Speaker of the Arkansas House of Representatives.

(2) The directors appointed by the President Pro Tempore of the Arkansas Senate and the Speaker of the Arkansas House of Representatives shall serve for terms of two (2) years and shall be eligible for reappointment.

(b)(1) The advisory board shall advise the board and the administrator on the proper execution of the fund and the business plan approved by the board.

(2) The advisory board shall meet not less often than semiannually to review and examine financial statements and progress reports, prepared by the administrator and previously reviewed by the board, and to advise the administrator and the board of the sufficiency of the reports.

(3) The financial statements shall include a balance sheet and income statement, prepared according to generally accepted accounting principles.

(4) The board shall issue an annual financial report prepared and certified by a certified public accountant on the first business day of July of each year, which shall be subject to inspection.

20-10-1910. Accumulation of fund assets – Disposition.

(a)(1) All moneys held by the fund shall be deposited in banks located within the state or shall be invested in obligations which are permitted investments for the board of trustees of any public employee retirement system of any political subdivision of the state.

(2) An accurate inventory of all personal property of the fund shall be maintained at all times.

(b) The fund shall be used and expended for the payment and satisfaction of claims and judgments under this subchapter, for the payment of reasonable fees and expenses incurred by counsel employed by the fund, for the payment of the costs of operation of the fund, including but not limited to compensation, fees and ordinary business expenses, and for no other purposes.

20-10-1911. Venue.

Notwithstanding any other provision of law:

(a) This subchapter provides a remedy for any action for injury, as defined herein, brought against any skilled nursing facility, its owners, principals, officers, employees, agents and affiliates, or any person or entity providing management services to the facility.

(b)(1) Any action for injury, as defined herein, shall be commenced in the circuit court of the county in which the injury occurred, and not otherwise.

(2) Any claim filed against a participating facility before the filing of an action for injury shall be dismissed by the administrator without prejudice.

20-10-1912. Participating facilities – Employment of counsel.

(a) Upon request by a participating facility, other than a participating facility which maintained commercial insurance coverage for the relevant period, the fund shall employ counsel to defend any action for injury against the facility.

(b) Fees and expenses incurred by counsel employed by the fund shall be paid by the fund; provided, that the administrator has the authority to determine the reasonableness of the fees and expenses, subject to the rules and regulations of the fund.

20-10-1913. Claims – Authority of administrator.

(a)(1) A claim against a participating facility which maintained coverage from the fund for the relevant period shall be filed with the administrator by the claimant on a form created by the administrator.

(2) The claimant shall serve copies of the claim upon the parties.

(3) Claims shall be for compensatory damages only and shall not include punitive damages, costs or attorneys' fees.

(4) Within twenty (20) days from the filing of the claim, the participating facility shall file its response to the claim on a form created by the administrator.

(5) When service of the claim is effected by mail or by electronic means, three (3) days shall be added to the time for filing a response.

(b)(1) The administrator has the sole authority to approve, modify or settle any claim against a participating facility to the extent of the applicable limit of coverage provided by the fund, including the deductible.

(2) The administrator is without authority to approve, modify or settle any claim, or to consent to any award, in an amount greater than the applicable limit of coverage provided by the fund, including the deductible.

(c) The administrator may make an investigation of the claim as the administrator considers necessary.

20-10-1914. Payment of claims.

(a) With respect to a participating facility which maintained coverage from the fund for the relevant period, a claim that has been approved or settled by the administrator, or a claim that has been adjudicated to a final judgment of a circuit court, shall be paid as follows:

(1) The participating facility shall pay the deductible and the self-insured portion of the award, if any, that were in effect when the claim or action for injury accrued; and

(2)(A) Provided that commercial insurance coverage is inapplicable, the fund shall pay the balance of the award to the claimant, subject to the per claim limit of coverage and the annual aggregate limit of coverage per participating facility in effect when the claim or action for injury accrued, exclusive of fees and expenses.

(B) The fund shall not pay punitive damages or costs and attorneys' fees incurred by the claimant.

(b)(1)(A) Claims or judgments which become final and unappealable during the first six (6) months of the calendar year shall be paid by the fund on the following August 15.

(B) Claims or judgments which become final and unappealable during the last six (6) months of the calendar year shall be paid by the fund on the following February 15.

(2)(A) If the balance in the fund is insufficient to pay in full all claims and judgments which have become final and unappealable during a six-month period, the award paid to each claimant shall be prorated.

(B) Any amount left unpaid as a result of the proration shall be paid before the payment of claims or judgments which become final and unappealable during any subsequent six-month period.

(c)(1) Prejudgment interest shall not be payable on any claim or judgment.

(2)(A) Simple interest at the rate of six percent (6%) per annum shall be paid on the unpaid balance of a claim or judgment from and after August 15 or February 15, as the case may be.

(B) In any action for injury that is tried before a jury, postjudgment interest shall be payable as provided by law.

20-10-1915. Liability of medical director.

With respect to any action for injury, the medical director of a skilled nursing facility shall be liable severally only for a wrongful act or acts performed when acting in the capacity of a medical director of a skilled nursing facility, and shall not be jointly liable.

20-10-1916. Statute of limitations.

(a) All actions for injury shall be commenced within two (2) years

after the action for injury shall have accrued.

(b) An action for injury accrues on the date of the wrongful act complained of, and no other time.

20-10-1917. Evidence — Burden of proof.

(a) Reports of investigations or surveys conducted by any governmental or regulatory agency, quality assurance surveys, satisfaction surveys, evidence of the care and treatment of other patients of the skilled nursing facility, quality indicator reports, quality assurance committee records or reports, peer review committee records or reports, or any other evidence of the general pattern and practice of the operation of a skilled nursing facility shall not be admissible unless the evidence is relevant to the plaintiff's injury. Before admitting any the evidence the court must hold:

(1) The evidence sought to be admitted has any tendency to make the existence of any fact that is of consequence to the determination of the action, such as the plaintiff's injury or the defendant's culpability for that injury, more probable or less probable than it would be without the evidence;

(2) The evidence is not used to prove the character of a person or entity and that the person or entity acted in conformity with that character, but instead is used for some other relevant purpose such as proof of motive, opportunity, intent, preparation, plan, knowledge, identity, notice, or absence of mistake or accident; and

(3) Either of the two conditions set forth in subdivisions (a)(1) and (a)(2) of this section is not substantially outweighed by the danger of unfair prejudice, confusion of the issues, misleading the jury, undue delay, waste of time or presentation of cumulative evidence.

(4) In no event shall any such evidence be admitted if it was created more than two (2) years before the accrual of the plaintiff's cause of action.

(b) The claimant shall have the burden of proving:

(1) The degree of skill and learning ordinarily possessed and practiced by a skilled nursing facility in good standing in the same or a similar locality;

(2) That the skilled nursing facility failed to act in accordance with that standard; and

(3) That as a proximate result thereof, the patient suffered injury which otherwise would not have occurred.

(c) In any action for injury which is tried before a jury:

(1) Applicable standard of care and a violation thereof shall be established by expert testimony as determined by the trial court to be admissible under the Arkansas Rules of Evidence; and

(2) Expert opinion testimony by owners, principals, officers, employees or agents of the skilled nursing facility during the relevant period shall not be admissible without the consent of the facility.

20-10-1918. Punitive damages.

(a) In order to recover punitive damages from the defendant, the plaintiff has the burden of proving that the defendant is liable for compensatory damages and that either or both of the following aggravating factors were present and related to the injury for which compensatory damages

were awarded:

(1) That the defendant knew or ought to have known, in light of the surrounding circumstances, that his or her conduct would naturally and probably result in injury or damage and that he or she continued the conduct with malice or in reckless disregard of the consequences from which malice may be inferred; or

(2) That the defendant intentionally pursued a course of conduct for the purpose of causing injury or damage.

(b) Except as provided in subsection (c) of this section, a punitive damages award shall not be more than the greater of the following:

(1) Two hundred fifty thousand dollars ($250,000); or

(2) Three (3) time the amount of compensatory damages awarded in the action not to exceed one million dollars ($1,000,000).

(c) As to the punitive damages limitations established in subsection (b) of this section, the fixed sums of two hundred fifty thousand dollars ($250,000) set forth in subsection (b)(1), and one million dollars ($1,000,000) set forth in subsection (b)(2), shall be adjusted as of January 1, 2006, and at three-year intervals thereafter, in accordance with the Consumer Price Index rate for the previous year as determined by the Administrative Office of the Courts.

(d) When the fact finder determines by clear and convincing evidence that, at the time of the injury, the defendant intentionally pursued a course of conduct with the knowledge that it could cause injury or damage and determines that the defendant's conduct did, in fact, cause harm, then subsection (c) of this section shall not apply.

20-10-1919. Limitation on supersedeas.

In any appeal of a judgment of a circuit court against a skilled nursing facility, the amount of a supersedeas bond or other security approved by the court shall not exceed:

(1) One million dollars ($1,000,000) in the case of a skilled nursing facility which, together with its affiliates, had one hundred fifty (150) or fewer occupied beds on the date of the judgment;

(2) Two million dollars ($2,000,000) in the case of a skilled nursing facility which, together with its affiliates, had more than one hundred fifty (150), but four hundred (400) or fewer occupied beds on the date of the judgment; or

(3) Five million dollars ($5,000,000) in the case of a skilled nursing facility which, together with its affiliates, had more than four hundred (400) occupied beds on the date of the judgment.

SECTION 2. No provision of this act:

(a) Shall apply to, or alter existing law with respect to, any claim, charge, action, or suit brought or prosecuted by the Attorney General; or

(b) Shall be construed to diminish or enlarge the powers or duties of a coroner or medical examiner.

SECTION 3. Applicability.

(a) This act applies to all causes of action accruing on or after the effective date of this act.

(b) This act shall not apply to any action filed or cause of action

accruing before the effective date of this act.

SECTION 4. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that adequate commercial insurance coverage at affordable rates is not available for nursing homes in this state; that lawsuits and claims which may become lawsuits threaten the financial stability of nursing homes; that patients of nursing homes do not have recourse to adequate sources of funds to redress legitimate claims for personal injury; and that existing procedures are inadequate to protect the interests of nursing homes and of those persons, primarily the elderly, who are in need of long-term care. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

**The Amendment was read the first time, rules suspended and read the second time and** _____

**By: Senator Salmon**

**PBB/RCK - 032420031353**

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**RCK793** **Secretary**