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Health Care REITs: Increased Revenue, Increased Risk

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Special to the Legal

Health care real estate investment trusts, or REITs, have been aggressive investors in the senior housing market, with acquisition volume reaching peak levels in the past few years. Historically, their investments have been limited to real estate, with the REITs functioning as passive landlords, leaving management to the senior housing operators (independent living, assisted living and skilled nursing, in particular). However, this insulated level of participation changed with the passage of the REIT Investment Diversification and Empowerment Act, or RIDEA, which allowed the REITs to share in profits from operations through the ownership of the operators. While this has so far served as a reward to REIT investors, it has also created additional risk, including exposure to new and dangerous theories of liability, many of which are untested against this relatively new structure. This article will explore the litigation risks posed to health care REITs.

REITS AND RIDEA

Health care REITs have long viewed the senior housing industry as a source of low-risk, steady income in an ever-expanding market. Historically, REITs purchased senior housing properties and then leased them back to operators through a triple-net structure in which the independent operators exercise control and responsibility over health care and facility operations. Essentially, the REIT acted as a passive, out-of-possession landlord, collecting rent from the operator. Fueled by billions of dollars of capital



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and demand for investment yield, the publicly traded health care REITs have transformed the landscape of property ownership in the industry. From a litigation perspective, the triple net also provided a liability shield against claims associated with building-based operations.

This structural boundary line was not self-imposed. By law, health care REITs were prevented from participating in the operations. This limitation set them apart from REITs that invest in other types of commercial properties, such as hotels and shopping malls, which historically have been allowed to indirectly participate in the operations of their properties. So, while health care REITs benefited from a fixed, stable level of revenue with predetermined escalation, they were prevented from capitalizing on substantial growth in profitable operations.

That all changed in 2008, when Congress passed RIDEA. The act allowed health care REITs to establish taxable subsidiaries to oversee operations of their facilities. The recession took hold shortly thereafter, dampening mergers and acquisitions, especially for the assisted-living sector. However, by 2010, the market had rebounded with a corresponding rapid adoption of RIDEA structured deals. The "big three" health

care REITs—Ventas, HCP Inc. and Health Care REIT—have all capitalized on RIDEA arrangements by entering the sphere of operating company ownership. While the RIDEA structure typically employs a management company to handle the daily affairs of the operating company's business, the management company is often closely affiliated with the operating company and also subject to the operating company's direction, governance and control.

The REITs have enjoyed robust growth through operating company ownership, creating significant returns on investment that outpaced the inflationary escalators under the traditional triple-net lease. They have, however, also absorbed additional risk in the form of variability in revenue, additional operation expenses, and exposure to negative publicity that may be occasioned by the operating company. But the greatest (and least appreciated) risk may lie in the exposure to aggressive personal injury litigation that has gripped the long-term care industry. Indeed, the very nature of the REIT may make it especially vulnerable in a litigation arena that has become more about vilifying health care operators than compensating for traditional injuries.

CORPORATE LIABILITY

The rise of corporate liability in health care litigation has been an evolution decades in the making. The basis stems from the notion that the patient looks to the health care provider for care, not just the professionals who work within its walls. This establishes a direct relationship between the entity and the patient, giving rise to a duty. The nature of that duty may vary, depending on the entity, but it is generally predicated on

the corporation's responsibility to monitor the quality of care and supervise its implementation.

The first such entities to be exposed to liability were hospitals. Historically, hospitals were formed as charitable institutions and were afforded immunity. As the hospital system evolved, the immunity slowly eroded and hospitals were held responsible for the conduct of their employees under vicarious liability principles. Then, in 1982, California formally adopted the doctrine of corporate (direct) liability, which has since expanded to other states in both application and scope.

Pennsylvania is a prime example. In 1991, its Supreme Court formally recognized the doctrine in *Thompson v. Nason Hospital*, 527 Pa. 330, 591 A.2d 703 (1991), articulating four types of duties a hospital owes directly to its patients. The holding was premised upon the concept that a hospital plays a central role in the health care of its patients. Over the next two decades, Pennsylvania courts struggled with the scope of the duty and its application to nonhospital entities, such as HMOs, physician practices and long-term care providers. That all changed in 2012 when the state Supreme Court issued its opinion in *Scampono v. Highland Park*, 57 A.3d 582 (Pa. 2012).

The focus of *Scampono* was a skilled nursing facility and its management company, but the decision potentially impacts any entity involved in health care operations. The court held that the "central role" inquiry did not capture the appropriate standard in deciding whether a corporate duty exists. Rather, the court must apply either of two tests.

The first test is Section 323 of the Restatement (Second) of Torts, which states: "One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if (a) his failure to exercise such care increases the risk of such harm, or (b) the harm is suffered because of the other's reliance upon the undertaking."

The second test was a weighing test using the following factors: (1) the relationship between the parties; (2) the social utility of the actor's conduct; (3) the nature of the risk imposed and foresee-

ability of the harm incurred; (4) the consequences of imposing a duty upon the actor; and (5) the overall public interest in the proposed solution.

The Second Restatement has been adopted in multiple jurisdictions. Arguably, application would impose a duty upon the operator of a health care property. In contrast, the second test involves a number of broad ideas that can be applied in an arbitrary manner, creating potential liability for any entity with a role in operations.

LONG-TERM CARE LITIGATION

There has been a relative explosion of litigation surrounding the long-term care industry, driven by claims of "abuse and neglect" directed at corporations accused of seeking to increase profits without regard to the quality of care. Originally, these theories were employed against operators of skilled nursing facilities. However, that has changed over the last few years, with an increasing emphasis on assisted-living operators. Profitability for those operators is typically tied to census, especially where debt service is high. This segment has also seen an uptick in the acuity level of their residents, as the demand for residential-based aging in place increases. This, in turn, has led to claims of operators keeping residents in the facility even though they require a higher level of care. Putting aside whether there is any truth to such allegations in any given case, which is a hotly contested issue, the aim of trial lawyers is to anger juries, sometimes by suggestion, and thereby drive compensatory and punitive damages verdicts beyond what would be anticipated under traditional measures.

This is not a fanciful rumination, as one only needs to look to a 2013 verdict against Emeritus for validation. At the time, Emeritus was one of the largest providers of assisted-living housing. The plaintiff claimed that systemic understaffing and a lack of training, combined with Emeritus' retention policies, designed to keep "heads in the beds," resulted in the pressure-sore-related death of a resident. The overarching theme was that a corporate drive for profits put the bottom line above the resident's care. Those claims were vehemently denied by Emeritus. Nevertheless, the jury returned a verdict of nearly \$4 million com-

pensatory and \$23 million in punitive damages.

The fallout was significant, resulting in negative press and a devastating Frontline exposé that tarnished the Emeritus brand. The following year, Emeritus merged into Brookdale Senior Living, creating the largest senior-living provider in the nation. Coincidentally, Brookdale operates many of its properties under a RIDEA structure with health care REIT partners.

RIDEA'S BENEFITS COME WITH RISK

RIDEA has been a boon to the senior-housing industry. Investors have seen an increase in economic returns and the potential for further growth, especially as the industry benefits from significant demographic tailwinds. The structure has also afforded operators substantial access to capital markets, which, in turn, can allow for improved quality of care to meet the community demands. But it is not without risks, especially under theories of "corporate profit over care." Given the deep-pockets perception of RIDEA partnerships, the REIT could easily serve as the new corporate bogeyman in long-term care litigation.

Indemnity agreements alone do not solve the issue, as discovery in litigation can often be as destructive as an adverse verdict. There are a number of steps that must be taken at all levels of the organizational structure to assess risk and limit exposure, ranging from facility-based practices to corporate governance strategies.

For now, the liability of REITs under RIDEA-structured deals remains uncharted waters. The failure to adequately plan a course through those waters is at the REITs' own peril. •

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