CHAPTER 31 • LIABILITY, LIABILITY SHIELDS, AND WAIVERS

Liability, Liability Shields, and Waivers

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SUMMARY. COVID-19 lawsuits are not easy to win. Viral transmission of COVID-19 remains possible even where reasonable care is taken and litigation against cohorts such as employers, health care providers, and nursing homes is already difficult. Notwithstanding, both health care providers and re-opening businesses (as well as essential businesses and nursing homes) have lobbied hard for liability shields. About half the states have listened to their entreaties, passing various narrow to broad immunities that may deter litigation at least until courts grapple with their constitutionality and interpretation. In addition, some businesses have deployed exculpatory clauses in their contracts or signage refuting any liability for injury or damages. Courts have various doctrines in place for analyzing these clauses including voiding them if they impact necessary services.

Introduction

The Volume I assessment examined the potential liability of businesses and medical professionals for acts and omissions involving COVID-19, and provided an analysis of long-established, new and contemplated federal and state liability shields. At the time of publication, that Chapter noted a number of state liability waivers, typically applicable to health care providers and usually promulgated as part of gubernatorial emergency orders. Also noted were some early “re-opening” shields designed to protect other businesses such as restaurants (Terry, 2020).

Since then, state legislatures have been far more active, turning their attention to re-opening waivers of varying scope. This Chapter will identify the trends in the waivers now passed or proposed. Additionally, it will expand on a topic only briefly discussed in the earlier Chapter: the use of waivers or exculpatory clauses that seek to create an affirmative defense that would excuse the negligent conduct of businesses in their mitigation of COVID-19.

Updates

COVID-19 Lawsuits

There has been a large but not overwhelming number of COVID-19 lawsuits filed against cruise lines, nursing homes, health care facilities, and general businesses (Hunton Andrews Kurth, 2021). From the earliest days of the pandemic the health care businesses at the highest risk of virus outbreaks and, subsequently, legal risks have been long-term care facilities. A generally for-profit industry with a woeful quality and safety record, the long-term care industry swiftly became the largest incubator of COVID-19 and the locus for the largest cohort of cases (more than one million by early 2021) and deaths (more than 130,000) (KFF, 2021). Plaintiffs have brought lawsuits, including class actions, for injuries or death that residents, their visiting relatives, and staff members have suffered. Frequent allegations include substandard infection control, failure to isolate residents with symptoms, insufficient staffing, and a lack of personal protective equipment (PPE).

During the first peak in spring 2020, hospital emergency departments were overrun, and shortages of staff, PPE, ICU beds, and ventilators threatened patient care. In successive surges, PPE supply chains proved more resilient and, with the undersupply of personnel being country-wide, professionals became less likely to travel to assist in other states. Further, information had improved about which drugs, antibodies, and treatment protocols were effective and, as important, which were not. However, the magnitude of the winter 2020/2021 surge again overwhelmed hospital bed and ICU availability. The knock-on effects included delayed elective surgery and, where delay was not possible, hospital-acquired infection — the potential exposure of non-COVID patients to the virus. These scenarios all involve some legal risk for providers.

In mid-2020 the number and range of businesses that re-opened expanded considerably. States or counties controlled the cadence of the closing, restricting occupancy, or re-opening of these businesses. Over time, however, high-risk endeavors including bars, restaurants, gyms, personal care services, places of worship, schools, and colleges re-opened. Many of these activities endangered people other than the businesses and their customers. For example, there is a strong correlation between the re-opening of universities and increased cases and deaths in their communities. Throughout the pandemic, and often in violation of state or county occupancy limits, we have witnessed infections and deaths associated with obviously dangerous super-spreader events including weddings and political rallies. These, too, invited legal risk.
Exactly what type of risk depends in large part on the identity of the defendant. The standard of care in most cases will be ordinary negligence, posing to the jury the question of whether the defendant acted as a reasonable person in all the circumstances. In contrast, some but not all cases brought against health care providers may be categorized as medical malpractice and turn on expert testimony as to whether there was compliance with the professional standard of care. However, non-medical negligence allegations such as an absence of supplies or lack of infection control only require a showing of ordinary negligence. A small number of cases may attract intentional tort liability. For example, there have been reports of people objecting to mask rules or other restrictions — deliberately coughing on others or boarding an aircraft when knowingly symptomatic, for example. As with actions brought by individuals against those they believe transmitted the HIV virus to them, these will be pursed on intentional and reckless causes of action (Doe v. Johnson, 1993). Some defendant cohorts will be subject to specific statutory claims that may be more amenable to action such as elder abuse or qui tam Medicaid fraud suits against nursing homes.

### Liability Shields

#### Federal shields.

The PREP Act applies to “covered countermeasures,” principally drugs, devices, and vaccines used to fight a national emergency that cause death or serious physical injury, and shields manufacturers and others in the supply chain. In addition to immunity, the PREP Act includes the Countermeasures Injury Compensation Program (CICP) that provides benefits to individuals who sustain a serious physical injury or die. The immunity does not extend to willful misconduct.

The PREP Act itself, or the Secretary’s Declaration made thereunder, have been amended several times during the pandemic. In March 2020, the PREP Act was amended by the Families First Coronavirus Response Act to include “personal respiratory protective devices.” Subsequently, the Secretary extended the Declaration to include respiratory protective devices (April 2020), pharmacists providing immunization (August 2020), and those using telehealth to administer countermeasures (December 2020) (Department of Health & Human Services, 2021). In the first COVID-19 case to argue PREP, a federal district court held that the argument that the Act protected a nursing home from state law liability was insufficient to justify removal of the case to the federal courts (Estate of Maglioli v. Andover Subacute Rehabilitation Center I, 2020). In a January 2021 advisory opinion, the U.S. Department of Health and Human Services took the position that the PREP immunity would apply to non-use or non-administration of countermeasures — common allegations against long-term care facilities (HHS Office of General Counsel, 2021). The opinion’s broad reading of the immunity is contrary to at least one district court ruling (Lutz v. Big Blue Healthcare, Inc. 2020).
Beginning in July 2020, then-Senate Majority Leader McConnell announced that any post-CARES pandemic economic relief or stimulus legislation would have to include a five-year lawsuit shield for businesses. Drafters included the primary components of this shield in the Safe to Work Act, creating a safe harbor for businesses accused of exposing people to the coronavirus absent clear and convincing evidence of gross negligence or willful misconduct or a failure to make reasonable efforts to comply with government standards and guidance (2020). Other provisions would have tightened up causation rules (actual exposure to COVID-19 caused the injury), limitation periods, and recoverable damages. In the end, as negotiations continued in December 2020, legislators traded off the federal shield against the relief for state governments and the shield was absent from the COVID-19 Economic Relief Bill that President Trump signed. With the loss of control of the Senate by the GOP, a federal shield becomes less likely going forward. However, without a filibuster-proof majority, the new administration of President Biden may still encounter it in negotiations for further relief packages.

State shields. As noted in Volume I, mainstream liability shields such as those that gubernatorial emergency declarations triggered in workers’ compensation laws and pre-COVID-19 immunities, may be applicable to some defendants. In the first months of the pandemic these were supplemented by a series of COVID-specific shields aimed at immunizing health care providers (Terry, 2020). The obvious intent behind these shields was to protect front-line health care workers and health care facilities from negligence liability. Their likely imperative was the large number of health care workers working beyond their jurisdiction of licensure and malpractice insurance or outside their scope of practice. This interpretation is consistent with the large number of northeastern states that introduced such liability shields at a time when the outbreak was concentrated there. As with most “Good Samaritan” type statutes, the immunity is lost in cases of willful, criminal, or reckless conduct.

The earliest shields were promulgated as part of gubernatorial emergency declarations. However, subsequent waivers tended to be statutory. As of the end of January 2021, 24 states have some type of liability shield applying to health care providers, split equally between executive orders and legislation (Figure 31.1).

The broadest health care liability shield in that first batch of legal protections in spring 2020 was New York’s Emergency or Disaster Treatment Protection Act of 2020. Reportedly, health care provider and nursing home lobbyists drafted the legislation themselves. It explicitly immunized health care professionals and facilities, including nursing homes, home care services, and even health care facility administrators and executives. The immunity extended to “the diagnosis, prevention, or treatment of COVID-19” and “the care of any other individual who presents at a health care facility or to a health care professional during the period of the COVID-19 emergency declaration.” In an apparent display of buyer’s remorse, in July 2020, New York restricted the immunity to “the diagnosis or treatment of COVID-19” or “the assessment or care of an individual as it relates to COVID-19, when such individual has a confirmed or suspected case of COVID-19” (Emergency or Disaster Treatment
Protection Act, 2020). That reduced immunity is more consistent with that in other states that tend to tie the shield more directly to COVID-19 activities or patients.

Following the spring 2020 re-opening, there has been reduced activity with regard to health care immunity, although recently Michigan (COVID-19 Response and Reopening Liability Assurance Act, 2020) and Ohio (Ohio HB 606, 2020) enacted limited civil immunities for the health care community, and the proposed federal shield would have included health care providers.

In contrast to the slowing of immunizing activity with regard to health care providers, state legislatures continue to be active in providing immunity for businesses, ostensibly to encourage them to re-open or stay open. As of January 2021, 15 states have enacted shields by statute and two by executive order, and legislation is proceeding rapidly in two additional states (Figure 2). The northeastern states that were quick to enact provider liability shields so far have not favored this broader business immunity.

There are, of course, both narrow and broad differences between the approaches in these 19 states. For example, they vary as to their applicable dates (both as to accrual and the length of the immunity) and the definitions of the protected businesses. While it is common to include exceptions for reckless or willful conduct, there is little consistency as to the reach of the immunity. For example, the Michigan statute immunizes those who act “in compliance with all federal, state, and local statutes, rules, regulations, executive orders, and agency orders related to COVID-19” and also excuses an “isolated, de minimis deviation from strict compliance” (COVID-19 Response and Reopening Liability Assurance Act, 2020). The Tennessee statute is more direct, denying liability “unless the claimant proves by clear and convincing evidence that the person caused the loss, damage, injury, or death by an act or omission constituting gross negligence or willful misconduct. A plaintiff filing such a claim must also file a certificate that a physician has provided a signed written statement that the physician is competent to express an opinion on exposure to or contraction of COVID-19 and, upon information and belief, believes that the alleged loss, damage, injury, or death was caused by an alleged act or omission of the defendant or defendants” (Tennessee COVID-19 Recovery Act, 2020). The Ohio statute provides that, in the absence of the statutory immunity applying, class actions are still not permitted. (Ohio HB 606 §2(B), 2020).

Exculpatory clauses. In addition to lobbying for legislative relief, some businesses have begun to incorporate exculpatory clauses or waivers in their contracts or signage. News reports have noted such waivers at theme parks, political rallies, and even a bar examination.

With rare exception (for example, New York’s General Obligations Law § 5-326, which provides a catalog of businesses that may or may not waive their liability) the controlling law in the states is to be found in case law. Only a very small number of states outright prohibit exculpatory clauses. What distinguishes the state jurisprudence is the doctrine courts primarily use to limit the applicability of such clauses (some may use multiple doctrines). (Figure 31.3).
A large number of jurisdictions view the primary validity issue as whether the activity involved was discretionary or recreational, as opposed to being a public or necessary one. Because this “public policy” exception is applied on a case-by-case basis and only the extremes are easy to predict (for example, hang-gliding can be waived, health care cannot), arguably, events such as political rallies or bar exams seem to fall on the side of the latter. Another approach courts take is to allow the waiving of negligence liability but not willful or reckless conduct. Debatably, a political rally that ordered the removal of social distancing signs would be acting recklessly. Finally, some courts use a procedural screen, requiring that for an exculpatory clause to be valid it has to be explicit as to the conduct it seeks to waive – negligence, for example.

At least one state has narrowed the line between liability shields and waivers. Thus, the Georgia statute creates a rebuttable presumption of the affirmative defense of assumption of risk for a health care provider or business that posts at a point of entry a sign, in at least one-inch Arial font, stating the following:

**Warning**

*Under Georgia law, there is no liability for an injury or death of an individual entering these premises if such injury or death results from the inherent risks of contracting COVID-19. You are assuming this risk by entering these premises.*

**Assessment**

Little has changed since the publication of Volume I that alters the assessment therein of COVID-19 liability or liability waivers. It remains understandable that, with all the safety and economic uncertainties, businesses would seek the certainty of legal immunity. Less admirable are opportunistic stakeholders with imperfect safety records seeking broad immunity for the types of acts or omissions that caused harm prior to COVID-19 (Terry, 2020). It should also be noted that liability shields are not apolitical but give state legislatures the opportunity to pass “easy” pro-business legislation while failing to address much harder questions such as supporting or calibrating mitigation policies.

**Liability**

It remains the case that COVID-19 lawsuits are not going to be easy to win. Viral transmission of COVID-19 remains possible even where reasonable care is taken. Further, before the pandemic some of the defendant cohorts had succeeded in blocking or reducing liability by persuading legislatures to cap damages (health care providers) or allow cases to be moved out of courts into binding arbitration (nursing homes).

**Shields**

Reliance on the large number of shields now in force will slow but not eliminate COVID-19 litigation. Courts may be sympathetic to constitutional complaints about statutes that differentiate between plaintiff cohorts (those injured by coronavirus infection rather than some other premises defect) and access to the courts. Consider, for example, a recent opinion of the Oregon Supreme Court overturning a legislative noneconomic damage cap as violative of the state constitution’s remedy clause (Busch v. McInnis Waste Systems, Inc., 2020). Also, the recklessness of some businesses and their refusal to obey occupancy limits and other mitigation efforts will pierce many shields. Then, there are the interpretative questions such as the extent to which the defendant’s conduct must arise from COVID-19 emergency treatment or state ordered mitigation for a shield to apply.

**Equity**

Liability and liability shields raise concerns about equity and disparate impact that are difficult to calibrate. Health care providers and retail businesses face extreme economic difficulties during COVID-19. However, they are usually successful in externalizing their liability risks with liability insurance. Injured patients, nursing home residents, and business invitees have no equivalent mechanisms beyond the uncertainties surrounding their own health insurance. Equally, those businesses have proven adept at lobbying against regulation, the alternative to liability or markets to deter irresponsible conduct. In general, therefore, liability and the minimalization of shields or waivers appear to be on the side of equity. Long-term, therefore, adding “private Attorneys General” to the fight should break down disparities. Short-term, however, the question is more difficult. Large businesses such as supermarkets often close their locations in less affluent areas because of liability concerns fueling further decline. Further, while large businesses can weather the pandemic’s economic impact, the same is not true of small businesses in less affluent areas that are often owned by persons of color. Unfortunately, liability laws are insufficiently nuanced to deal with these issues not least because tort law does not take into account financial resources in setting the reasonable care standard. However, liability shields could incorporate more progressive approaches, for example by limiting liability to businesses with lower turnovers.

**Lessons Learned and Recommendations**

Over time some states will likely begin to roll back over-protective liability shields or remove certain less-deserving cohorts such as nursing homes from their protection. In other state capitols business interests having successfully lobbied for COVID shields may be emboldened to extend or expand the shields beyond their current role. One continuing truism should govern how states should respond: responsible actors likely will operate conscientiously whatever the liability model, only bad actors need liability shields or waivers. 😞
Recommendations for Action

Federal government:

- There is no evidence that a broad federal liability shield is necessary. Demands for such not only are unwarranted but also typify unconscionable, opportunistic behavior by industries with poor safety records.

State governments:

- Calls for broader immunity shields should be resisted, particularly where the conduct for which the shield is sought was not in mitigation of the pandemic but actually increased the transmission.
- State policymakers would better serve businesses and other stakeholders not by providing immunity from unreasonable care but by reducing uncertainty with transparent, data-driven guidance on re-opening and allowing that to inform the existing and appropriate reasonable care standard.
- States considering liability shields should exclude well-financed business that are less in need by, for example, referencing annual turnover.

Courts:

- The federal courts should narrowly interpret the PREP immunity and not extend it to failure to obtain or implement adequate countermeasures.
- State courts should carefully scrutinize the constitutionality of liability shields and not show the same deference to legislative action given to malpractice reform and interpret liability shields narrowly.
- State courts should void the exculpatory clauses being inserted into theme park and other contracts where they impact services of general public interest and emphasize that such waivers do not apply to reckless conduct.
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References


Emergency or Disaster Treatment Protection Act, 30-D § 3080 et seq. (N.Y. 2020).


