How the Nursing Home Transparency and Improvement Act Will Impact Nursing Homes

Summary. With new Health Care Reform changes set to go into effect over the next 12-24 months, many remember the impact that the previous reform changes had on the Nursing Home insurance marketplace. This paper will look at the history of Nursing Home reform as well as the major changes taking place today with the passage of Nursing Home Transparency and Improvement Act. Finally, it will focus on how this will affect underwriting, claims and the marketplace as a whole.

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Nursing home reform history. On July 30, 1965, Lyndon Johnson signed the Social Security Act Amendments, which we know today as Medicare and Medicaid. This was the first time that health care reform impacted nursing homes. Medicare provided persons aged 65 and older a program which gave broad coverage of inpatient expenses which included inpatient care in skilled nursing facilities. This was the first time that health care reform was aimed at providing aging Americans with reliable health care and this “pay for service” type approach allowed them to receive the treatment they needed in a skilled nursing setting.

In 1987, the Omnibus Budget Reconciliation Act (OBRA) was passed which included the Federal Nursing Home Reform Act. The passage of this bill marked the most sweeping change for nursing home care that the county had ever seen. OBRA states that nursing homes must provide services so that “each resident can attain and maintain her highest practicable physical, mental, and psycho-social well-being.”

The impact that OBRA had on the nursing home industry was colossal because it introduced “Resident’s Rights.” More emphasis was placed on residents’ quality of life and the quality of care they were receiving, as well as expectations that residents’ ability to perform the basic activities of daily living should improve absent any medical conditions. It stated that residents must be free of unnecessary chemical and physical restraints and have access to their own personal physician. It protected residents by requiring that they be able to return to the nursing home after hospital stays and strengthened rules about when a nursing home could evict a resident. These changes also impacted the way state surveyors conducted their annual inspections. Surveyors no longer focused solely on staff and patient records, but now talked to residents and their families about their experiences in the nursing home. Surveyors observed meal service and medication administration to ensure that residents’ dignity and safety were being maintained.
While these changes overhauled the substandard care that was being provided in so many nursing homes across the country, a small fire was starting to burn that would have significant unforeseen consequences for the entire industry.

**History of nursing home litigation.** In 1985, Jim Wilkes and Tim McHugh joined forces to create the law firm Wilkes & McHugh, but it wasn’t until 1989 that they took on their first nursing home abuse case. Historically, plaintiff lawyers would not take on nursing home cases as they knew that aged clients do not have significant economic or income loss and therefore obtain smaller jury awards. But Wilkes & McHugh approached this case in a way that had never been done before. By using the then obscure nursing-care Resident’s Rights law, they were able to cite the broad statutes set forth in the law which had “demanding standards for nursing homes and allowed the plaintiff to sue to recover legal fees.” In the early 1990’s, Wilkes & McHugh was able to obtain multi-million dollar settlements in several cases against large nursing home operators. They used the term “profits over people” to show juries that these large operators were raking in millions a year while chronically understaffing their facilities and cutting care to further pad their own pockets. The reform that was supposed to be put in place to protect residents had now become the single most powerful weapon that plaintiffs firms had in their arsenal. Supporters of Wilkes & McHugh argue that they have single-handedly improved resident care and filled “a void left by Florida’s traditionally lax oversight of nursing homes.” Critics argue that these cases do not improve care but only drive up the already high costs of care through higher insurance rates. Most critics agree that the law put in place to protect residents’ rights only serves to encourage litigation.
Nursing home litigation grew very quickly in the 1990’s with multi-million dollar verdicts becoming more of the norm rather than the exception. This caused many carriers to pull out of the marketplace completely leaving very few insurance options for nursing homes, especially those with claim activity. Many facilities were forced to consider alternative risk transfer mechanisms including captive arrangements and risk retention groups and some stopped buying insurance altogether opting for the “throw them the keys” approach where operators would simply hand over the nursing home rather than pay a large claim. Carriers tightened up on coverages and the Occurrence policy form became nearly extinct because some of these forms contained weak language which allowed liability limits to be stacked over multiple policy years. The marketplace that carriers had once viewed as lucrative and low risk had now become a target of aggressive lawsuits with huge payouts. The Health Care Reform that had been passed to protect residents’ well being had caused an unprecedented hardening of the nursing home insurance marketplace almost overnight.

Health Care Reform today. Today we are seeing the most sweeping Health Care Reform changes in more than 20 years. Passed in March 2010, the Patient Protection and Affordable Care Act includes several provisions specific to nursing homes with the most significant being The Nursing Home Transparency and Improvement Act. Historically information on the ownership structure and financial “chain of command” was confidential and mostly unavailable to the public through complicated, multi-level structures. Essentially the only way to get at this information was to go to court and make your case to the judge for why you should be allowed access to this level of detail.
These structures make it difficult for not only consumers to identify the true owners of a facility, but it is almost impossible for government regulators to figure out as well. These structures may act as a shield for substandard care investigations because:

• the operating entity usually contracts with a management company to perform day-to-day operations;
• these complex structures and associated lack of transparency in ownership and management create challenges for ensuring accountability and greatly complicate law enforcement investigations;
• profit-seeking investors compete against residents for resources.³

The Act now requires nursing homes to clearly identify owners, managers, and the organizational structure of the facility. This will allow for better oversight of both corporations and individual facilities by the government and will allow consumers to make better informed decisions when researching nursing homes. The transparency requirements focus on three areas:

• Title – Requires the disclosure of any officers, directors, members, partners, and managing employees including individuals who manage, advise, and/or supervise any element of the practices, finances, or operations.
• Function – Operational, managerial, financial, policies and procedures, cash management, and financial services.
• Ownership – who owns, leases, subleases, or partly owns.⁴

Ultimately this information will be available to everyone via the internet once the provision is fully implemented.

The transparency requirements also extend to the financials of facilities as they will have to disclose specifically how the money is being distributed. Operators will have to be transparent about where the money is going and how much is being spent on direct and indirect care, capital assets, and administrative services costs. This will give
consumers a better understanding of how the facilities are using their resources and if they truly are investing back into the facility and the care that is being given, or if they are pocketing the profits.

The Nursing Home Transparency and Improvement Act also includes a provision that will update the Centers for Medicare and Medicaid (CMS) website with real time and up to date information that consumers are able to access. The data will be collected from verifiable sources such as payroll data. This includes:

- **Staffing data** – will include hours per resident per day which can be compared to the state average, turnover, and retention rates.
- **Survey information** – will provide links to copies of actual state surveys along with the plan of correction for each violation.
- **Facility Complaints** – Will include specific data on the number, type, severity and outcome. They have also added a standardized complaint form that can be used to report violations.

In addition to the above changes, there will be more oversight of the information on the CMS website to ensure the data is timely, accurate, and comprehensive.

Administrators now face the daunting prospect of being personally liable if they do not comply with certain provisions within the Act. For example, the Act requires that administrators provide written notice at least 60 days prior to the closure of a facility to the residents and their legal representatives. The notification must include “a plan for the transfer and adequate relocation of residents, including assurances that the residents will be transferred to the most appropriate facility, and it must take into consideration the best interest of each resident.” Administrators who do not comply with these requirements face fines up to $100,000.
Impact on underwriting and insurance. Although many of the nursing homes today already have complicated, multi-level ownership structures, consumers don’t generally see this and probably assume that the ownership is much shallower than it actually is. There is a perception in the nursing home industry that when there are deep pockets, people are more likely to sue and there is a greater potential for larger jury awards. From an underwriting perspective, the best risks tend to be small, family owned facilities because the residents build relationships with the other residents, staff, management and even the owners. People often are less likely to sue in this type of environment because the perception is that the claim would directly impact the “mom and pop” owners or other residents. More money would be spent on higher deductibles and insurance premiums instead of investing in facility improvement and betterment for the residents. However, if the residents or their families learn that the facility is actually owned by a Real Estate Investment Trust (REIT) they may be more likely to sue because of the perception of deep pockets at the top. With the added financial disclosure requirements, it makes it easier to see where the money is going and the “profits over people” argument is hard to defend if you are able to see that most of the money is going right into the pockets of the people at the top. Underwriters will have to understand the ownership structure to determine if it presents additional risk and can no longer assume that a small rural facility is owned by a single operator. There will have to be increased focus on how the facility is spending its money and underwriters will have to review financials more thoroughly to understand how the resources are being used.

One of the biggest issues that the industry may face is the confusion that these disclosures will create around who needs insurance, what type of insurance, and what their exposure is. Owners and investors may start drafting contracts requiring Named or Additional Insured status on the facility’s GL/PL policy and brokers will start seeing
change requests come in on current policies to have these newly disclosed owners added. Underwriters will have to be more proactive in determining who these people and entities are and what their relationship is to the First Named Insured. The biggest issue is the general misunderstanding of who should be a Named Insured on the policy, who should receive Additional Insured status and most importantly those entities that should not be given coverage on the policy at all. For instance, most of the people and entities involved at the top level should only be given Additional Insured status but may request Named Insured status. The issue with granting Named Insured status is that these entities generally have interests in other properties, facilities, and business ventures that are unrelated to the operations of the Long Term Care facility holding the policy. By granting Named Insured status, the nursing home’s insurance policy may respond even if the claim results from something they did that was completely outside of their ownership and responsibilities at that facility. While it is unlikely that two separate policies would respond to the claim, the confusion caused by adding as a Named Insured may result in costly and unnecessary coverage litigation. Because of this a facility who was not actually involved in the allegations of the claim, could end up paying a higher premium because of the claim activity of the owner. Nevertheless, carriers will face pressure to grant broader coverage to entities that should be considered Additional Insureds as opposed to Named Insureds.

We may start to see a new wave of insurance products or endorsements coming to market aimed at protecting these newly disclosed parties. For example, an administrator who can be fined directly for not following the notice requirements of a facility closure may wish to carry some additional protection. As a result, administrators need to be intimately involved in the purchasing of insurance for their facilities to ensure they have the protection they need. However, Administrators have to understand what the insurance coverage will provide them. The
insurance policy is not going to pay the fines on their behalf as this would go against public policy, but it may provide them with a defense to certain claims that involve a potential violation and fine. Administrators also need to understand the requirements and ensure they comply, as some facilities may agree to pay the fines on their behalf if there are any violations. However, the ultimate responsibility to pay falls on the administrator.

The real question when discussing Health Care Reform is who is going to pay for these changes? Nursing Homes have faced the same economic crisis that the rest of the country is enduring and many of these changes will further impact the bottom line. Some of the other measures in this bill look to cut Medicare and Medicaid reimbursements which are the facilities main source of income. In addition, there is a push for states to create incentive plans to move residents into home based care programs rather than remaining in nursing homes long term. Occupancy levels are already at historical lows as people stay at home longer or are choosing to move in with family because they cannot afford skilled care. This will result in more facilities facing financial distress or going bankrupt and more consolidation within the industry. Underwriters will have to focus on the financial picture to ensure that the facility is making enough money to avoid cutting staff or impacting care.

Conclusion. Overall many of the changes will have a positive impact on the industry as consumers will have better access to information to help them decide what is most important to them when placing loved ones in a nursing home. But it remains to be seen if the overall quality improvements outweigh the financial impact that facilities may be forced to endure for both implementation of the new requirements as well as claim activity and stricter underwriting pricing guidelines.
Will Health Care Reform cause a hardening of the nursing home insurance market? The short answer is no, as Health Care Reform on its own may not be enough to change the market. There is simply too much capacity in the marketplace with new carriers jumping in to take advantage of the historically low loss ratios. But when you take into consideration increasing claim activity, the declining pricing over the last several years, and the confusion in the marketplace with some carriers pulling out and others tightening their underwriting guidelines, we may be on the cusp of a market shift. It remains to be seen how these new Health Care Reform changes will impact claims and losses and until they go into effect it is hard to predict what the outcome will be. The new disclosures may result in claims being filed to take advantage of the new requirements as we saw with the Resident’s Rights claims. Plaintiff attorneys may try to file class action lawsuits based on a chronic misreporting of facility data or the failure to identify the resident population of a facility closure. While the marketplace has a different make up today than it did in the late 1990’s when most of the policies were written on an Occurrence form with bed rates significantly below where they needed to be, pricing today is once again threatening to hit bottom and Health Care Reform may be the final trigger needed to shift the market.

1 http://www.allhealth.org/briefingmaterials/obra87summary-984.pdf
3 http://www.thecustomervoice.org/advocate/issueindex/nursinghometransparency
4 http://plusweb.org/files/Events/Healthcare%20Reform%20Change%20LT%20Care%203-24-111.ppt