Testimony of
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On
Medical Liability in Long Term Care
Before the
House Judiciary Committee
140 Main Capitol
State Capitol Building
10 a.m., April 22, 2010

Chairman Caltagirone, Chairman Marsico, and members of the Committee: I appreciate the opportunity to appear before you today to discuss a variety of issues relating to medical liability in Pennsylvania's nursing homes. While the data is clear that the quality of care in Pennsylvania's nursing homes has steadily improved because of the ongoing commitment to quality improvement, the cost of frivolous litigation continues to increase. I will discuss this paradox in considerable detail shortly.

My name is Dr. Stuart Shapiro, and I am President and CEO of the Pennsylvania Health Care Association (PHCA). PHCA is a statewide advocacy organization for the commonwealth's elderly and disabled residents. Our sole mission is to ensure that those who need long-term care services receive quality care in the most appropriate setting as they age.

Our membership --- comprising for-profit and nonprofit providers --- offers services that range from integrated retirement communities and multi-level care campuses to freestanding nursing homes, assisted living/personal care homes, and ancillary care/home-care enterprises. Overall, PHCA represents more than 337 long-term care and senior service providers that care for over 33,000 elderly and disabled individuals across the state.

My testimony will consist of three main parts. First, I would like to briefly provide the members of the committee a snapshot of Pennsylvania's demographics with respect to our elderly. Secondly, I will briefly discuss the financial condition of the providers of long term care in Pennsylvania and how the costs of defending frivolous law suits negatively impacts an already precarious financial condition; and, finally, I will discuss some solutions, and will specifically address a key legislative initiative that is before the House: Apology legislation, which we support, and which we believe will enhance the communication between patients and their providers. Lastly, I will discuss one particular piece of legislation (HB 2123) that proposes to eliminate voluntary arbitration agreements, which we strongly oppose.

Demographics: If we look at the population of Pennsylvania today, twenty percent, or one out of every five people in the Commonwealth of Pennsylvania, is age 60 or older. Pennsylvania has the third highest

percentage of people over age 65. Only Florida and West Virginia rank higher. Four states have a higher number of older residents than Pennsylvania: California, Florida, New York and Texas.

By the year 2020, Pennsylvania's 60 and older population is expected to be 26 percent of the total population -- more than 3.2 million people. Most of the baby boomers will be over age 60 by that time. The 65 and older population is projected to increase to 2.4 million and the 85 and older population is projected to increase to about 362,000.

There has been a dramatic shifting of Pennsylvania's population since 1960. In 1960 almost 30 percent of our population was under age 15 and only 10 percent of our population was age 65 and older. By the year 2020, it is projected that those under age 15 will make up only 12% of the total population and those ages 65 and older will constitute about 19 percent of the total population.

Current baby boomers will have increased assets and will not want to be considered as seniors until they are "really" old. According to the 2000 U.S. Census, there are approximately 3.6 million baby boomers in Pennsylvania, individuals between the ages of 46 and 64 or those born between 1946 and 1964. They are beginning to think about and plan for their older years.

Costs of Care and Cost of Unnecessary Litigation: Pennsylvania currently has 725 nursing homes with 89,201 beds, and demand for nursing home services remains steady. Our facilities, on average, are 91 percent occupied, compared to 88 percent nationally.

While Pennsylvania demographics are certainly driving both financial and policy decisions, both for providers and government, it is important for the committee to understand that no other health-care provider is as dependent on state and federal governments as nursing homes. Together, almost 80 percent of our residents are on Medicaid and Medicare. On average, sixty-five percent of residents are on Medicaid, and approximately fifteen percent are on Medicare. Private resources and long-term care insurance make up the remaining balance. Historically about one-third of those entering nursing homes as private pay individuals spend down their own assets to eventually qualify for Medicaid.

Virtually every nursing home in Pennsylvania, whether for-profit or not-for-profit, loses money caring for Medicaid patients. A 2009 study by Eljay, LLC found that Pennsylvania's nursing homes were projected to lose $13.88 per Medicaid patient per day. That is a slight increase over the previous year. The actual shortfall in 2009 will likely be somewhat higher due to greater than projected inflationary pressures on nursing home costs.

Nationally, un-reimbursed nursing home care under Medicaid is estimated to be over $4.6 billion. In 2009, Pennsylvania's nursing homes will deliver approximately $254 million in un-reimbursed care. The Medicaid reimbursement outlook for 2010 and 2011 is just as bleak according to the same national study. In other words, nursing homes are experiencing a financial loss on virtually every resident they care for under Medicaid.

In spite of these financial pressures, our members, along with long-term care providers all over this Commonwealth, are providing some of the highest possible quality care to some of the frailest and sickest Pennsylvanians – all while their costs continue to rise. The Department of Health data backs up this claim. Their recent study of the care being delivered to Pennsylvanians in nursing homes indicates

marked improvement in service and quality. For example, from 2005 to 2007, the number of provisional licenses has decreased by more than 50 percent, and the total number of incident reports from 2006 to 2007 has gone down by more than 25%. Of the total amount of complaints received, less than one-third were substantiated.

In addition to State reimbursement challenges, the high costs of defending inappropriate and unnecessary liability claims adds to the economic burden on nursing homes. Based on a detailed analysis prepared by AON, a global provider of insurance coverage, the number of claims filed has quadrupled from 4 claims per 1000 occupied beds in 1997 to 16 claims per 1000 occupied beds in 2007. While the rate of claims was somewhat volatile from 1997 to 2001, since 2001, there has been a steady annual growth of claims per bed and severity of about 11%. Pennsylvania loss costs per occupied bed have increased since 1997 at an annual trend rate of approximately 17% from a low of $210 to a high in 2007 of $1340.

This dramatic increase is also apparent when assessing the per diem loss cost per occupied bed as a percentage of Medicaid reimbursement. The per diem loss cost per bed has risen from $.58 in 1997 to $3.57 in 2007 which means that the loss cost as a percentage of Medicaid Reimbursement has risen from 0.5% in 1997 to 1.9% in 2007. Clearly these costs widen the gap of underfunding even further.

Although, as I indicated a moment ago, the data clearly indicates **improved** service and quality of care, the loss costs have continued to rise. Unfortunately, this is, in part, due to the fact that Pennsylvania nursing homes have become the focus of a national plaintiff's firm and are thus burdened with voluminous document requests and depositions, which increase the day to day cost of doing business, both in human capital and dollars.

Liability costs have dropped significantly in states that have passed some form of tort reform in the past several years. As a group, the average loss cost of Florida, Georgia, Louisiana, Mississippi, Ohio, Texas, and West Virginia dropped from $7,190 in 1998 to an estimated loss cost of $1,230 in 2005.

Both frequency and severity are down in states that have passed tort reform. The number of claims per 1,000 occupied beds for this group peaked at 20.9 in 2002 and has since dropped to 12.2 in 2007.

A Potential Solution: Our industry, along with the support of others in the healthcare sector, have put forth a proposal that we believe is in the best interest of both patients and providers as it will both enhance communications and reduce costs. This is called apology legislation (HB 1804) and has been introduced in the House by Representative Dan Frankel.

Apology legislation is a common sense approach to an adverse health care outcome that benefits both consumers and providers, and has no impact on the commonwealth's budget. However, it does result in cost savings for healthcare providers, as has been proven in other states. In addition to House Bill 1804, introduced by Representative Dan Frankel, Senate Bill 208 has been introduced by Senator Pat Vance. Both have received substantial bi-partisan support.

Apology legislation permits a doctor, or a hospital or nursing home employee, to acknowledge and take ownership of an unforeseen outcome without the risk of retaliatory litigation *based solely* on the statements made at the time of the apology. Apology legislation **does not** relieve the doctor or hospital

of liability; it simply allows the doctor or employee to communicate openly and honestly with patients and their families without fear that their statements will be used against them.

It has long been known and understood that anger – not greed – drives most consumers to file medical malpractice lawsuits. Under the umbrella of apology legislation, a healthcare provider can, without fear of reprisal, achieve a policy objective that includes elements of responsibly acknowledging, via apology as well as communication with the patient/resident, regret for an outcome.

This deviation from the traditional "deny and defend" strategy has not only resulted in fewer claims, but it also has improved customer service ratings for facilities that offer this approach. Although apology legislation has yet to be passed in Pennsylvania, the Central Pennsylvania Physicians Risk Retention Group, representing 1,200 health-care professionals, has seen their premiums drop to 35% below market rates due to the adoption of this type of innovative policy. Thirty-five states, including the surrounding states of Ohio, Delaware and Maryland, have passed apology legislation enabling a disclosure program to be a viable option for doctors, hospitals and nursing homes to reduce liability claims. Not only have claims gone down, but customer service ratings have skyrocketed.

At the University of Michigan Health System, one of the first to experiment with disclosure policies, existing claims and lawsuits dropped from 262 in 2001 to 83 in 2007. During this period their legal defense costs and the money they set aside to pay claims have each been cut by two-thirds, and the time taken to resolve cases has been halved.

The Michigan's health system's chief risk officer, Richard C. Boothman, told the *New York Times* last May, "Improving patient safety and patient communication is more likely to cure the malpractice crisis than defensiveness and denial."

Similarly, the number of malpractice filings against the University of Illinois has dropped by half since it started its disclosure program just over two years ago. And in the 37 cases where the hospital acknowledged a preventable error and apologized, only one patient has filed suit.

In states with apology legislation, medical mistakes have become teaching opportunities, not potential cover-ups.

We hope that the best of Pennsylvania's trial lawyers will join their colleagues in other states who have stood behind the passage of apology legislation, noting that as advocates for those who have been harmed, their core responsibility is to seek redress for their patients and families in four ways: get answers, ensure accountability, find fixes and achieve swift justice.

Apology legislation accomplishes all four. It allows medical professionals to talk with patients about what went wrong and why. In those cases where a lawsuit was still filed, settlements are often agreed upon in months, rather than years. Families and health care professionals say they are able to heal sooner and move forward with their lives.

The bi-partisan sponsorship of Representative Frankel's legislation is an example of how our legislature can work on behalf of the people of Pennsylvania. In a year when you as lawmakers are confronted with

tremendous fiscal challenges, you should move swiftly to pass this common-sense cost-saving measure that would reduce costs to the State's Medicaid program from unnecessary litigation.

Expensive and Unnecessary Legislation: While apology legislation is common sense, that is not the case with HB 2123 which is strongly opposed by the Pennsylvania Chamber, The Pennsylvania Medical Society, the Pennsylvania Association of County Affiliated Homes, the Hospital and Healthsystem Association, the Insurance Federation of Pennsylvania, the National Federation of Independent Business, and the Pennsylvania Association of Non Profit Homes for the Aging.

This legislation and a companion bill in the Senate (907) would eliminate the use of voluntary arbitration agreements that were signed prior to the date of a medical claim.

These bills, represent a real departure from more than 75 years of national and state policy direction favoring the use of arbitration and other alternative dispute resolution (ADR) programs across America.

The so called policy reasons offered to justify such changes are based on common misconceptions about the content, fairness and use of arbitration agreements. The General Assembly should carefully gather objective facts about ADR, including arbitration, in all health care settings and evaluate how such agreements actually are regulated and used. Then the benefits of ADR to both consumers and government will become obvious.

Let me try and dispel some of the myths associated with arbitration in long term care. First, many believe that arbitration agreements are required as a condition of admission to nursing homes. That could not be further from the truth. Arbitration agreements are not required as a condition of admission or continued stay in a nursing home. Further, the Centers for Medicare and Medicaid Services ("CMS"), which regulates nursing homes that participate in the Medicare and Medicaid programs has the authority to impose regulatory penalties if nursing homes require or enforce arbitration agreements in a way that is abusive of resident rights or as a condition of continued stay. Recent history has shown us that if a nursing home fails to clearly delineate the arbitration clause from the admissions agreement, courts are likely to invalidate the agreement as unfair.

Second, many will say that arbitration agreements, in effect, are "involuntary" and nursing homes "coerce" residents with questionable capacity into signing agreements. Again, this is simply not true. Arbitration agreements by their terms are voluntary and are often signed by family members or other legally authorized representatives, not by residents. Nursing home ADR programs typically highlight the fact that arbitration agreements are voluntary and contain provisions that give consumers up to 30 days to rescind their agreement to arbitrate after signing the agreement.

Typically, arbitration agreements are signed only after full disclosure and discussion with staff members who have been trained to ensure that family members or legally authorized patient representatives are properly informed and, where patients are involved, to assure that patients have requisite mental capacity. Courts have upheld and validated nursing home arbitration agreements as voluntary and not

the result of undue coercion.[1] In rare cases where arbitration agreements have been involuntary or coercive, however, courts have protected consumer interests by invalidating such agreements.[2]

Nursing home arbitration agreements typically DO NOT impose artificial caps on awards, rather they defer to the same state laws that apply in the judicial system. Most nursing home arbitration agreements explicitly do not impose artificial limits on damages. History shows us that arbitrators have awarded large damages where circumstances warrant. In fact, courts have invalidated arbitration agreements that sought to place artificial limits on damages not existing under state law.[3]

Arbitration agreements provide each party with equal rights, including discovery and other procedural protections, such as representation by counsel and selection of an independent arbitrator. Consumers in nursing home ADR programs have the right to be represented by counsel and typically choose to do so. Most arbitration agreements require a process where both parties must agree to the selection of an independent arbitrator from a national roster of carefully scrutinized arbitrators. It is not uncommon for nursing home ADR programs to impose the administrative costs of arbitration proceedings on the nursing home.[4] In rare instances where arbitration agreements are unfair, one-sided or coercive, courts have invalidated them.[5]

Nursing home arbitration agreements provide swifter resolution to disputes, provide compensation to consumers without undue litigation expense for either party and reduce the funding burden on the Medicare and Medicaid programs. That last statement is important. With the funding problems mentioned previously, both to states and providers, these agreements can help. Arbitration agreements generally result in much swifter resolution of disputes between consumers and nursing homes than the court system. As a result, consumers who are entitled to compensation receive payment much sooner. A substantial majority of cases in arbitration result in awards to consumers, but the average expense amount for claims is 20% lower than for claims that are not subject to arbitration.

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[1] *See Holifield v. Beverly Health & Rehab. Svs.,* No. 3:08CV-147-H at *5 (W.D. Ky. June 20, 2008) (court specifically found arbitration agreement in question expressly not a condition of admission, was not "deceptive" or "misleading," and was not binding on either party upon execution since either party could rescind agreement within 30 days).

[2] *See, e.g*., *Howell,* 109 S.W.3d at 734-35 (court invalidated arbitration agreement in part because nursing home employee presented arbitration agreement on "take-it-or-leave-it" basis, patient was admitted to nursing home in emergency, and patient's agent could not read and nursing home representative did not adequately explain that the agent was waiving a right to a jury trial if a claim were brought against the nursing home); *Prieto v. Healthcare and Retirement Corp. of America,* 919 So.2d 531, 533 (Fla .App. 2005) (court invalidated nursing home arbitration agreement because the resident's agent was asked to sign an arbitration agreement in order to complete the admission process while resident was in route to nursing home, arbitration agreement was included in a package of numerous documents, and arbitration agreement was not explained by nursing home employees).

[3] *See, e.g., Romano ex rel Romano v. Manor Care,* 861 So.2d 59 (Fla. App. 4 Dist. 2004) (Florida appellate court invalidated nursing home arbitration agreement because, among other issues, agreement prevented award of punitive damages and improperly limited compensatory damages).

[4] In its arbitration agreements, for example, Kindred HealthCare requires that the nursing home pay all costs associated with arbitration (e.g., the professional fees, costs of the arbitrator, and cost of meeting rooms, etc.).

[5] *See, e.g., Howell,* 109 S.W.3d at 734-35 (Tenn. App. 2003), described more fully in footnote 2 above.

We are all looking to reduce costs to the system in some way or another. Arbitration agreements substantially reduce litigation costs – both to consumers and providers. Arbitration agreements have contributed to dramatically reducing provider litigation costs, resulting in lower cost growth in both the Medicare and Medicaid programs. Slower cost growth translates into a higher percentage of public funds being used to provide care and services and to lower demand to increase Medicare and Medicaid payments to nursing homes.

Let me briefly touch upon three other bills that have recently been reported by this committee that we oppose. House Bills 1095 and 2202 would expand the types of damages that can be recovered and the persons who can sue to recover them. These bills would significantly increase liability insurance costs.

House Bill 1444 would permit a jury to hearing closing arguments on the amount of damages, both economic and non-economic, in civil cases. This change in current law will increase the cost of litigation and damages by appealing to the emotional aspects of a jury.

Conclusion: Excessive litigation and damage awards result in higher consumer prices and decreased availability of services, such as medical care. The high legal costs paid by Pennsylvania health care providers, employers, and governments inhibit job growth, increase health care costs, and limit access to medical care. These bills, and others like them, will only increase the cost of litigation and the amount of damages that hospitals, physicians, nursing homes, businesses, governmental entities and individuals have to pay in liability cases. More importantly, these bills will worsen Pennsylvania's already contentious legal climate, drive up health care costs and threaten access to care.

I hope my testimony has been helpful to the Committee, and that you now better understand how long term care providers in Pennsylvania operate and the challenges they continue to face with respect to medical liability and tort reform. I would be happy to answer any questions you may have.