

About the Author
Peter S. Rauner
FCAS, MAAA

Mr. Rauner is a Senior Consultant with Pinnacle Actuarial Resources, Inc. and manager of its Chicago, Illinois office. He is a Fellow of the Casualty Actuarial Society (CAS) and member of the American Academy of Actuaries (AAA). He is a member of the AAA's subcommittee on Medical Professional Liability and former member of the CAS' Committee on Health Care Issues. He holds a M.S. degree in Actuarial Science from Ball State University and a B.S. degree from Earlham College.

Mr. Rauner has provided formal Statements of Actuarial Opinion in the United States as well as several offshore domiciles. His clients come from a broad range of industries including healthcare, education, technology, construction and retail, among others. To this end, he has gained valuable insights and developed strong relationships with captive owners and managers, brokers, regulators and auditors.

During his career, Mr. Rauner has presented on a variety of topics including alternative risk financing, medical professional liability and workers compensation.

Mr. Rauner may be contacted at
 630 · 457 · 1296
prauner@pinnacleactuaries.com

The Impact of PPACA on Liability Insurance

By Peter S. Rauner, FCAS, MAAA

For the past several decades, the government has been at a cross roads with the state of healthcare in America. With rising costs, an aging population, restricted access to care, wide coverage disparities and declining overall health, the US healthcare system was picking up momentum on a downhill road to a disastrous failure absent major changes. On March 23rd 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA or ACA), a voluminous legislative work focused on changing the quantity, quality and manner in which healthcare is delivered in the United States.

How will the reforms ultimately change healthcare in America? No one knows for sure, but one thing is certain: the ACA reforms will have an effect on many industries including the liability insurance market. This discussion is not intended to give a comprehensive overview of the ACA. Instead, we explore what is currently known about some of the primary components of the new healthcare law and how they may impact liability insurance costs in the future.

Healthcare Reform Goals

The three stated goals of the ACA include increasing access to the estimated 50 million currently uninsured Americans, re-aligning provider incentives to improve the quality of healthcare delivered and controlling the steeply rising costs of healthcare. To be sure, once the dust settles on the hotly contested and currently ill-defined provisions of the new law, the manner in which

healthcare is delivered and consumed in America will be changed forever.

Goal #1 – Increased Access

Many believe, and Congress has agreed, that access to healthcare services should be a right granted to all Americans, not a privilege bestowed on those fortunate enough to gain access through their employment or wealthy enough to afford it. We begin our discussion by looking at how the ACA breaks down the barriers to access that currently exist in our healthcare system.

Key Points

- **The Situation:** The Affordable Care Act represents broad scoping legislation expected to result in a paradigm shift in the delivery of healthcare in the US.
- **The Upshot:** Some of the changes will have an impact on liability insurance risks in the near and long term.
- **Next Steps:** Healthcare providers and insurance carriers will have to adjust their strategies to address the new age of risks.

Probably the most controversial provision in the entire reform package, the "Individual Mandate" is intended to ensure that each and every American has access to healthcare, as well as provide additional funding to pay for the broad extension of benefits enacted by the new law. However, many parties believe that to require the purchase of health insurance is an unconstitutional extension of Congress' powers.

In addition to the individual mandate, other coverage expanding provisions of the new law include:

- Requiring all health plans to cover dependents to age 26, regardless of marital status, if they have no access to another employer plan.
- Eliminating pre-existing condition exclusions for children ages 19 and under (further extended for all ages in 2014).
- Eliminating lifetime limits on “Essential Health Benefits” (further extended to eliminate annual limits in 2014).
- Under the new law, Medicaid will expand its eligibility requirements to include an estimated 11 million more participants by 2014.



Goal #2 – Improve the Quality of Care

Recent studies have indicated the need for quality improvement in the delivery of healthcare services as demonstrated by an estimated 40,000 to 100,000 deaths in America annually attributed to preventable “medical errors”. The new law contains several provisions intended to address the second goal of healthcare reform, improving the quality of healthcare delivered in America.

First, the law specifically promotes standardization of healthcare through Evidence-Based Medicine. Evidence-Based Medicine integrates the latest research into the clinical practice of medicine, reducing wide variations in practice patterns that currently exist for treatment of similar medical conditions.

Second, the law requires extensive reporting and analysis of medical treatment and outcomes data. The intent is to develop clinical practice norms and performance benchmarks aimed at reducing the number of Healthcare Acquired-Conditions (HACs) including

pressure ulcers, catheter-related infections, surgical site infections, among others.

The Center for Medicare-Medicaid Services (CMS) first authorized the formation of Accountable Care Organizations (ACOs) as a Medicare pilot program in 2009. With the enactment of healthcare reform, ACOs have become the model of choice for the new generation of managed care in America. The ACO model is very similar to previous managed care models (HMOs, PHOs, IPAs) in that its focus is on cost-effective delivery of healthcare, but different in that it ties provider reimbursements to quality outcomes. ACO physicians are accountable for the medical outcomes and expenditures of their assigned population and can be granted bonuses or assessed penalties depending on how they compare to a set of performance benchmarks.

Consistent with incentives built into the ACO model, the concept of the medical home is gaining momentum across the country. Simply put, medical homes are community-based, interdisciplinary teams of medical providers brought together to support primary care practices within hospital service areas for a capitated fee. The overall goal is to create a “patient-centric medical home” where the patient and family doctor work together to coordinate all aspects of a patient’s health.

Goal #3 – Control Costs

And third, the ACA’s goal of controlling costs in the new world created by healthcare reform is very likely the biggest challenge of the three. To accomplish this lofty goal, the new law will launch a national pilot program beginning January 1, 2013 focused on the integrated care of eight (8) yet to be determined conditions. Providers will receive a set fee to cover each episode of care defined as the three (3) days prior to inpatient admission and continuing for thirty (30) days following discharge. Some have speculated that the care and management of chronic diseases that plague Americans such as diabetes, heart disease, asthma, mood disorders and hypertension may well be included. It has

been estimated that these five chronic diseases are responsible for one-third of the total cost of healthcare spent in America.

In addition to the integrated care pilot program, the new healthcare law incorporates a “pay-for-performance” model to compensate medical providers which

contrasts with the traditional fee-for-service model. Despite the lack of consensus on how to define or measure “quality” in healthcare outcomes, the new law considers provisions which will reward providers who meet certain quality standards and penalize those who do not.

Paradigm Shift in Healthcare

| | | |
|--------------------|---|---------------------|
| Fee-For-Service | → | Pay-For-Performance |
| Silos of Care | → | Coordinated Care |
| 50M Uninsured | → | Universal Coverage |
| Disparate Coverage | → | Standard Coverage |

Another cost component of the new law is aimed at controlling health insurance companies operating expenses. The goal of the minimum Medical Loss Ratio provision is to ensure that healthcare insurers operate as efficiently as possible and thereby transfer as much of the premium dollar as possible into paying for medical expenses as opposed to transactional costs.

The Impact of PPACA on Liability Insurance Costs

Enactment of the ACA has initiated a dramatic paradigm shift in the manner by which healthcare will be delivered in America. Many believe that there will be several side effects from these changes that will impact liability insurance costs in the post-reform era including:

- Changes in the supply and demand for healthcare providers.
- Potential shifts toward enterprise liability theories as a result of consolidations in the healthcare provider market.
- Changes in the “standard of care” which forms the basis for negligence actions.
- Additional costs resulting from the new Medicare reporting requirements.
- The expanding use of new technologies that may increase or introduce new liability exposures to healthcare providers and organizations.

Provider Supply-Demand

Healthcare reform has basically guaranteed that an additional 30 to 35 million Americans will be covered for healthcare benefits. Coupled with the rapidly increasing number of Americans over the age of 65 and a decreasing trend in the number of medical school graduates, the increase in demand for healthcare services is expected to put even greater pressure on an already tight supply of medical providers. (Figure 1)

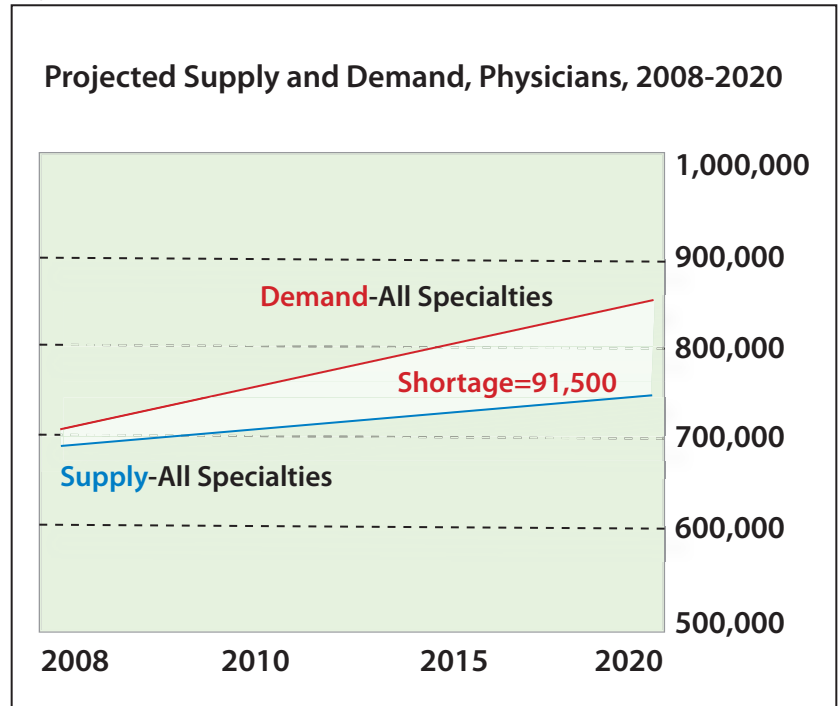
According to a report by the Association of American Medical Colleges (AAMC), a growing and aging U.S. population will face a shortage of approximately 91,500 physicians by 2020 and 130,000 by 2025. The potential impacts of this supply-demand crisis may include:

- Increased workloads on an already over burdened physician population that could lead to an increase in avoidable medical errors, rather than a decrease;
- A shortage of physicians available and/or willing to provide certain services to high risk individuals at acceptable compensation levels;
- Increased patient waiting times and decreased face time with medical providers will likely lead to increased customer dissatisfaction producing more frequent legal action.

Shift to Enterprise Liability

There are many factors today leading physicians toward a shift away from the sole practitioner model toward participation in larger group practices or fully employed status. Some practicing physicians are even transitioning to alternate career paths including hospital administration, insurance industry professionals and attorneys, further reducing the number of active healthcare providers.

Figure 1



Source: AAMC Center for Workforce Studies

One factor contributing to these trends is the “new generation” of physicians who desire a better work-life balance than is available to independently practicing physicians today. With the high costs of liability insurance, increasing administrative responsibilities and unpredictable income, today’s sole practitioner can hardly find time to spend with their patients let alone take a personal leave. As a result, newly practicing physicians are attracted more today than ever to an employment relationship.

In concert with changing physician attitudes, hospitals are again acquiring medical group practices to develop better pipelines for admissions and build foundations for the ACO and medical home continuum of care models.

As the number of employed medical professionals increases, healthcare entities can expect a shift in the nature of claim allegations away from vicarious liability theories toward direct negligence theories.

In addition, as the insured’s average asset base increases with these consolidations, the need for greater protection in terms

of limits of liability insurance also increases. The higher the limits of insurance, the bigger and more frequent the target in tort actions and the larger the average size of award or settlement. Consequently, the shift toward enterprise liability theories will have a distinct impact on a healthcare entity's malpractice claims profile resulting in an increase in the frequency and severity of payments.

Standard of Care

In order to implement the ACA's "pay-for-performance" incentives, one must define the benchmarks or standards by which healthcare outcomes will be measured. While medical professional negligence standards have historically been determined based on a "local rule" (that is, the highest quality of care delivered by a physician practicing in the same community and specialty), with the push toward evidence-based medicine, the post-reform trend will likely be toward regional or national standards of care by practice specialty.

Although currently not finalized, the CMS will establish approximately 65 benchmarks spanning 5 quality domains (Patient Experience of Care, Care Coordination, Patient Safety, Preventive Health, and At-Risk Population/Frail Elderly Health) by which an ACO's performance will be compared in order to participate in shared savings programs. It's not much of a stretch to consider that some of these quality measures may form the basis for prima facie evidence in a medical negligence lawsuit. Depending on how the final set of quality measures is set, these benchmarks may raise the bar for the standard of care doctrine in many communities.

Medicare Reporting Requirements

Medicare Secondary Payer (MSP) statutes have been around and posed a significant contingent liability exposure to both health and liability insurance companies as well as self-insureds for a long time. In fact, Medicare considers all insurance (including self-insurance) to be "primary payers" and any payment that Medicare makes to a beneficiary or claimant is considered conditional on the existence of collateral sources.

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) imposes mandatory reporting requirements for group health plan arrangements and for Liability Insurance (including self-insurance), No-Fault Insurance, and Workers' Compensation. Whether payments are made directly or indirectly to a Medicare beneficiary, it must be reported.

Why is this just now becoming an issue? Although Medicare has had the right to recoup payments made to beneficiaries, they haven't had the infrastructure in place to identify and pursue collateral source payments from the "primary" payers.

With the aging population and broad expansion of benefits enacted by healthcare reform, the government is getting serious about finding alternate sources to offset the huge projected increase in costs of the Medicare and Medicaid programs.

There are at least three components of the new Medicare reporting requirements that may lead to additional costs to the liability insurance industry.

MMSEA Reporting Costs

First, there will be costs associated with the additional programming/infrastructure needed to comply with the reporting requirements. Current liability claim systems used by most P&C carriers do not capture the data necessary to identify and track payments made to Medicare beneficiaries. At the very least, compliance with the Act will require additional resources to capture, identify and report the required data elements to CMS.

There will be the need for additional time and resources needed to train staff on how to comply with new laws as well as the actual task of reporting. In case you wonder if the investment is worthwhile, consider that CMS has the right to levy fines of \$1,000 per day, per unreported claim for non-compliance.

CMS Quality Domains

- Patient Experience
- Care Coordination
- Patient Safety
- Preventative Health
- At-Risk Populations

Medicare Liens

A Medicare lien stems from the Medicare Secondary Payer Act and represents pre-judgment medical expenses incurred by Medicare beneficiaries. The problem is that CMS (or more accurately CMS' service contractor, MSPRC) calculates the amounts on a post judgment basis making it difficult to reserve for the ultimate amount of the award or settlement subject to Medicare take-backs. In the current environment, it takes approximately 3-4 months to get a response back from MSPRC.

It is quite possible that the mere existence of a Medicare lien on a liability claim may prolong the settlement process as well as increase the plaintiff's demand to compensate for lost benefits.

Medicare Set-Asides

Medicare Set-Asides are future expenses incurred by Medicare beneficiaries for post-judgment medical treatment. Currently, there is no official word from CMS on the applicability of MSAs to liability insurance payments and no official process to approve the amounts. However, it is more than likely that CMS will ultimately apply MSAs to liability payments to Medicare beneficiaries to offset the additional costs generated by the scheduled program expansions.

As with Medicare Liens, Medicare Set-Asides are likely to increase settlement lags and amounts for liability claims.

However, due to the increased uncertainty in estimating future medical expenses, Medicare Set-Asides represent the most volatile costs associated with Medicare reporting requirements.

Cyber Liability Risks

Finally, the potential growth in exposure and costs related to cyber liability risks may well become a major issue for healthcare providers in the post reform era.

In order to manage a patient's health across the continuum of care as outlined in the ACO pilot program, a healthcare organization will need to develop a comprehensive IT solution complete with state-of-the-art security protocols. To achieve this seamless transfer of data, one can expect a broad expansion in the use, access and distribution of Electronic Health Records (EHRs). In light of the strict penalties imposed under HIPAA privacy laws, this proliferation in the collection, distribution and storage of sensitive PHI data also creates a significant exposure to potential risks from data breaches and resultant third-party liability actions.

Because commercial general liability insurance policies only cover BI/PD and several courts have found that electronic data is not "tangible property", many of the costs related to data breach may not be covered under typical commercial insurance policies. Thus, anyone collecting, storing and/or distributing protected data may not be covered or may have only limited coverage in the event of a data breach.

Due to these factors, cyber liability risk has been described as the next significant emerging risk since employment practices liability (EPL). As you may recall, EPL exposures were initially covered under the Directors' & Officers' (D&O) insuring agreement until certain high-profile cases and subsequent changes in social attitudes toward workplace behavior

prompted a significant increase in exposure to such claims. In response, the insurance industry reacted by adding an EPL exclusion to the D&O policy and creating a separate EPL policy form which is now the norm.

Initially a throw-in benefit provided at little or no cost on many medical professional liability policies, cyber liability may experience the same fate as EPL. As the exposures increase, become more clearly defined and the industry settles on what is insurable, EPL may eventually migrate to become a standalone policy.

In terms of costs, given that cyber liability is still an emerging exposure we can only report on what has happened to date with an eye to where the costs may go in the future. According to Ponemon Institute's March 2011 report on data breaches in the US:



- the average organizational cost of a data breach event has risen to \$7.2 million;
- data breach events cost their companies an average of \$214 per compromised record;
- direct costs of data breach events including enforcement activities and notification expenses accounted for an average \$73 per compromised record – in addition to fines and penalties.

To date, 46 US states, the District of Columbia, Puerto Rico and the US Virgin Islands have all passed laws mandating timely notification of individuals affected by data breach. And, in addition to notification and third-party liability costs, an organization's exposure to reputational damage can result in the loss of customers and revenue which can be very real costs despite being difficult to estimate.

Conclusion

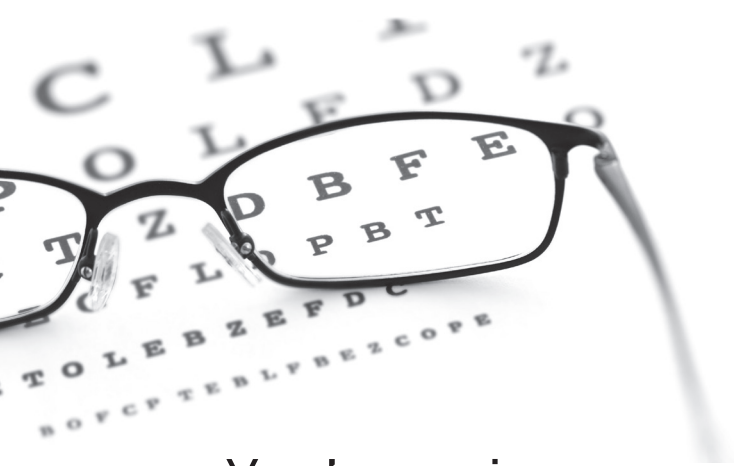
The Affordable Care Act will have an impact on the cost of liability insurance for healthcare providers and institutions. Liability costs will be pushed upward coincident with:

- increased physician workloads;
- shortages of healthcare professionals in certain regions;
- increased patient waiting times;
- shifts towards enterprise liability for healthcare providers;
- new standards of care being used to raise new and innovative theories of negligence;
- burdensome MMSEA reporting requirements and the increased risk of fines and penalties;
- longer lags for liability claims settlements due to Medicare liens and Medicare Set-Asides;
- growth in electronic health records management resulting in greater cyber liability risks.

How much will liability costs increase as ACA is implemented? Stay tuned.

For more information contact Peter Rauner at 630 • 457 • 1296 or prauner@pinnacleactuaries.com
Experience the Pinnacle Difference!

Peter S. Rauner, FCAS, MAAA



You're unique. We see that clearly.

The healthcare industry is an extremely dynamic landscape and no two providers are the same. At Pinnacle, our medical professional liability experts spend time learning what makes you unique, then work to create tailored actuarial services that meet your needs.

As our relationship grows, you'll find we anticipate and respond to your needs and can be counted on time and time again. We are a team of world-class experts — yet are small enough to be flexible, timely and cost-effective.

Seeing you clearly — it's just part of the Pinnacle Difference!

- ALTERNATIVE MARKETS
- ENTERPRISE RISK MANAGEMENT
- LOSS RESERVING
- LEGISLATIVE COSTING
- PREDICTIVE MODELING
- REINSURANCE
- PRICING AND PRODUCT MANAGEMENT
- LITIGATION SUPPORT

