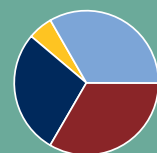


The Affordable Care Act and Property-Casualty Insurance



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Executive Summary

The property-casualty insurance industry is likely to become the target of significant additional cost-shifting by hospitals, physicians, and other medical providers responding to the cost-containment provisions of the Patient Protection and Affordable Care Act (ACA). The ACA dramatically alters healthcare markets and health insurance systems in the United States. Although the property-casualty insurance industry is not directly included or targeted by the act, it is not entirely immune to its effects. As a purchaser of healthcare services and as a participant in healthcare markets, the property-casualty industry finds itself in a changed environment, where the medical providers with whom they engage and the claimants they serve are themselves confronted by major changes related to the ACA. Increased cost-shifting could have potentially significant and long-lasting consequences for property-casualty insurance. Cost-containment efforts by other public and private health insurance systems are likely to result in higher billings and higher utilization when property-casualty insurance claims are involved in the months and years ahead, as medical providers seek to offset lost revenue from health insurance sources. Strengthening the tools available to property-casualty insurers to address higher charges and higher utilization of medical services should be considered. The following chart summarizes our assessment of each potential pathway by which the act could affect the property-casualty industry.

Figure 1

How the Patient Protection and Affordable Care Act is Expected to Affect Property-Casualty Insurance Claim Costs

| Possible Pathway for Affecting Property Casualty Claim Costs | Expected Direction of Cost Impact | Potential Magnitude of Cost Impact |
|---|-----------------------------------|------------------------------------|
| Cost shifting to property-casualty insurance | ↑ | <i>major</i> |
| Claim shifting to property-casualty insurance | ↑ | <i>minor</i> |
| Less opportunistic fraud due to fewer uninsured | ↓ | <i>minor</i> |
| More fraud due to the diversion of career criminals to property-casualty business | ↑ | <i>moderate</i> |
| Lower future medical damages | ↓ | ? |
| Healthier populations | ? | ? |
| More appropriate utilization | ? | ? |

Signed into law on March 23, 2010, the ACA was the most far-reaching and controversial piece of social legislation enacted since the creation of the federal Medicare program in 1965. The ACA was not the first legislative attempt since then to adopt sweeping changes to the nation's healthcare and insurance system, though. A similar measure, the Health Security Act of 1993, included provisions to significantly expand health insurance coverage and access to healthcare services. Unlike the ACA, the 1993 legislation was defeated after months of divisive debate. Also unlike the ACA, the 1993 proposal included provisions directly targeting the property-casualty insurance industry. The most prominent provision would have combined the medical portion of workers compensation insurance coverage with general health insurance coverage, creating a so-called "24-hour" approach to health insurance. In contrast, the ACA does not generally apply to property-casualty insurance.¹

However, by virtue of the ACA's profound and wide-reaching changes in health insurance products and markets, in how medical providers are reimbursed, and in the financial incentives that influence the behavior of healthcare consumers and medical providers, property-casualty insurance will be affected in one or more possible ways. The objective of this analysis by the Insurance Research Council (IRC) is to identify some of the pathways by which property-casualty insurance may be affected by the ACA. The focus is on how the behavior of claimants and medical providers may change in response to the ACA. In this analysis, because of the uncertainties in predicting provider and claimant behavior and the complex interaction among the different provisions of the act, we are not attempting to estimate the cost impact of individual effects of the act or of the act as a whole. We do, however, provide our assessment of the likely direction and the potential magnitude of each effect.

Cost Shifting From Health Insurance Systems to Property-Casualty Insurance Systems

The ACA will likely prompt significant changes in the behavior of medical providers as new cost containment efforts and initiatives by public and private health insurers begin to affect providers financially. To offset anticipated reductions in revenues from health insurance systems, medical providers may seek to increase revenues from other payers, such as property-casualty insurers, by seeking higher reimbursements from other payers and by increasing the volume and mix of services provided to patients covered by other payers.

¹ An important exception is Section 1556 of the Act, addressing benefit eligibility in the federal Black Lung program.

In addition to cost containment efforts already underway, the ACA includes several new initiatives and provisions aimed at controlling Medicare and Medicaid program costs:

- Beginning in 2014, payments to hospitals for treatment provided to indigent patients are reduced by 75 percent.
- Payments to Medicare Advantage plans have been revised and tied to fee-for-service reimbursement levels.
- Future payments to hospitals will be reduced for hospital readmissions of Medicare patients and for hospital-acquired conditions.
- Affordable-care organizations were created with the express purpose of improving the quality and reducing the cost of medical care.
- An Independent Payment Advisory Board was created to recommend ways to achieve reductions in Medicare spending.
- Medicare will experiment with bundled payment approaches to provider reimbursement, replacing traditional fee-for-service reimbursement with a global fee that encompasses all the care associated with a specific medical condition.

These and other initiatives will create additional incentive for medical providers to shift costs to other revenue sources, including property-casualty insurance, to replace lost revenues from health insurance providers. Private passenger auto insurers are already prime targets for such cost-shifting behaviors, as reported in a 2010 IRC report examining hospital charges and diagnostic imaging costs for auto injury claims. IRC estimated that hospital cost shifting for auto liability claims in states with tort-based auto injury insurance systems resulted in \$1.2 billion in excess charges in 2007.² The total of cost-shifting in all property-casualty claims with medical expense is likely much higher.³

The fragmented nature of healthcare markets and the uncoordinated manner in which prices for medical services are determined leaves some payers, including property-casualty insurers, particularly vulnerable to cost-shifting efforts by hospitals and other providers. The prices that are charged and that are ultimately

² Insurance Research Council, *Hospital Cost Shifting and Auto Injury Insurance Claims* (Malvern, Pa.: Insurance Research Council, 2010), p. 43.

³ There is considerable debate among health economists regarding the reality of cost shifting. See, for example, Chapin White, *Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates*, Health Affairs, May 2013, content.healthaffairs.org (accessed February 3, 2014), and Cost shifting is still not a thing, The Incidental Economist, March 7, 2013, theincidentaleconomist.com (accessed February 3, 2014). These assessments, however, do not examine cost-shifting as it applies to property-casualty insurance claims, which are uniquely vulnerable to cost-shifting efforts by hospitals and other medical providers.

paid for medical services often are different, sometimes dramatically, across payers. Large health insurers, of which Medicare is the largest, are able to negotiate or impose lower prices or substantial discounts for medical services provided to plan participants. At the other extreme, individual, uninsured purchasers of healthcare services typically pay the highest prices with little or no discounts because of relatively weak bargaining positions. Other payers, including property-casualty insurers, are somewhere in the middle. The authority and ability of property-casualty insurers to negotiate reimbursement levels varies significantly across states. Medical fee schedules specifying the prices to be paid for medical services have been adopted by thirty-seven states for workers compensation and seven states for private passenger auto insurance. Even among the states with medical fee schedules, however, reimbursement levels vary greatly—from slightly above Medicare reimbursement rates to 200 percent or more of Medicare rates.

Medical providers may also raise revenues by increasing the volume and number of services provided to patients. Insurance systems and programs with relatively weak utilization controls are especially vulnerable to such efforts. Property-casualty insurance often lacks the kind of precertification and concurrent utilization review controls that are frequently applied in public and private health insurance programs. This is especially true of automobile insurance, which typically relies on the application of “reasonable and necessary” standards to review and, if possible, question the appropriateness of treatment. Reasonable and necessary standards are often based more on historical practice styles in local medical communities than what clinical research indicates is appropriate treatment.⁴ Reasonable and necessary standards also are difficult to apply where third-party liability insurers often aren’t aware of the medical treatment being provided until after the fact. The ability of workers compensation insurers to monitor medical utilization and challenge inappropriate and excessive utilization is somewhat stronger in states that authorize insurer involvement in the management of claims and the medical treatment involved.

To the extent the cost containment provisions of the ACA negatively affect medical provider revenue, then efforts by providers to increase revenue from other sources, including property-casualty insurance, should be expected. Most medical providers involved in the treatment of injuries covered by property-casualty insurance products are likely to be affected by the cost containment efforts of public and private health insurers. For this reason, we believe the impact of these changes could potentially have a significant long-term effect on property-casualty insurance claims experience and costs.

⁴ Jonathan Skinner and Elliott Fisher, *Reflections on Geographic Variations in U.S. Healthcare*, The Dartmouth Institute for Health Policy & Clinical Practice, March 31, 2010, www.dartmouthatlas.org/downloads/press/Skinner_Fisher_DA_05_10.pdf (accessed February 11, 2014).

Claim Shifting From Health Insurance Systems to Property-Casualty Systems

The cost shifting discussed above involves changes in *provider* behavior—namely, hospitals, physicians, and other treating providers responding to the cost containment efforts of public and private health insurers by seeking to increase revenues from other payers, including property-casualty insurance companies. Another potential effect of the ACA is to prompt individuals with injuries to file a property-casualty insurance claim instead of a health insurance claim because the ACA may have made it more expensive or more difficult for them to file a health insurance claim.

The ACA accelerates a trend already underway to increase cost-sharing in health insurance plans. Under the ACA, many employers have replaced previous plans with plans including much higher deductibles and coinsurance provisions that will increase out-of-pocket costs for many insured individuals receiving treatment for injury or illness until such time as the health insurance policy's maximum annual out-of-pocket amount has been reached. While increased cost-sharing may decrease health insurer outlays, it also may encourage individuals with health insurance to assert coverage for injuries under property-casualty insurance where the opportunity is present to do so. The motivation of claimants would be to avoid incurring costs due to health insurance deductibles and cost-sharing requirements, and the effect would be a shifting of claims from health to property-casualty insurance systems.

Public and private health insurers may also become more aggressive under the ACA in refusing to provide coverage for certain diagnostic procedures and treatments where evidence-based research indicates the procedure or treatment is unwarranted. This may be especially likely if the Patient-Centered Outcomes Research Institute (PCORI), created by the ACA to conduct research on the comparative quality of different medical treatments, produces research drawing into question the appropriateness of diagnostic procedures or treatments frequently associated with accidental injuries. If insured individuals know or suspect that desired procedures or treatments will not be reimbursed by their health insurer, some may claim that the injury involved is covered by property-casualty insurance. In some cases, the claim may be legitimate, but would have been previously filed as a health insurance claim. In other instances, the claim is not legitimately covered by property-casualty insurance but is fraudulently represented to be covered by property-casualty insurance coverage. In either case, claim shifting has occurred. We believe that claim shifting behavior in the manners described above is plausible and potentially significant.

Fewer Property-Casualty Claims Due to Fewer Uninsured

The primary objective of the Affordable Care Act is to reduce the number of individuals in the United States without health insurance. In 2010, the year of the ACA's enactment, approximately 49 million nonelderly Americans did not have health insurance coverage.⁵ When injured or ill and confronted with the prospect of hefty medical bills, and where the circumstances presented the opportunity to do so, some uninsured individuals would file workers compensation or automobile insurance claims. These claims were fraudulent because they either were not work-related, in the case of workers compensation claims, or they were unrelated to an automobile accident covered by the auto insurance policy involved, in the case of auto insurance claims.

The frequency of fraudulent claims where the primary motive is to secure coverage for medical treatment because the individual involved has no health insurance coverage is often debated. However, there is substantial evidence that fraudulent claims of this nature are fairly common. In a 2008 study, the IRC found suspicion of fraud in approximately one in ten first-party no-fault auto insurance claims. In 29 percent of these claims, the claimed injury was unrelated to the accident reported in the claim.⁶

By reducing the number of uninsured, the ACA could potentially reduce the number of fraudulent claims previously submitted under these circumstances. There is little basis, however, for estimating the magnitude of this effect. First, it is unclear how many individuals will no longer be uninsured as a result of the ACA. During the first three months of activity, 2.2 million people enrolled in coverage through the marketplace mechanism created by the act.⁷ This number does not include those who are newly covered via the expansion of state Medicaid programs, but does include many who lost previous coverage as non-qualifying policies were cancelled, forcing those affected to seek replacement coverage. In any event, the actual impact of the ACA on the uninsured population remains highly uncertain.

If the impact of the ACA on the uninsured population is significant, then the potential impact on property-casualty claim frequency could also be significant.

⁵ *Key Facts about the Uninsured Population*, The Kaiser Commission on Medicaid and the Uninsured, September 2013, www.kff.org/uninsured/ (accessed January 17, 2014).

⁶ *Fraud and Buildup in Auto Injury Insurance Claims*, 2008 Edition (Malvern, Pa.: Insurance Research Council, 2008), pp. 9-10.

⁷ Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, *Health Insurance Marketplace: January Enrollment Report*, January 13, 2014, aspe.hhs.gov (accessed February 7, 2014).

In a 2012 study, researchers at the RAND Institute for Civil Justice examined the impact of health insurance reforms in Massachusetts that had much the same effect as ACA seeks—significantly reducing the number of people without health insurance. The researchers attributed a 5–7 percent reduction in workers compensation emergency room bill volume to a 40 percent decrease in the number of uninsured presenting in Massachusetts emergency rooms. The study did not examine the impact of reforms in Massachusetts on overall claim costs.⁸ Nor did it examine the impact on auto injury claim outcomes.

Although reducing the number of uninsured could potentially reduce the frequency of property-casualty insurance claims, opposing forces could moderate this effect. For example, many of those previously uninsured individuals who obtain health insurance coverage will continue to face strong financial incentives to file property-casualty insurance claims, much as before. As noted earlier, many individuals purchasing coverage in the insurance marketplace created by ACA are purchasing high-deductible coverage with high annual out-of-pocket costs. For some, the incentive to assert coverage under a property-casualty insurance policy will continue to exist.

More Fraudulent Claims Due to Increased Fraud Fighting Emphasis

In an October 2013 paper, the National Insurance Crime Bureau (NICB) predicted that the frequency of fraudulent property-casualty insurance claims will increase as fraud-fighting provisions of the ACA are implemented.⁹ Unlike fraudulent claims that are associated with actual injuries but for which health insurance coverage is not available, these claims are entirely profit-motivated. According to NICB, because property-casualty insurance is not covered by the ACA, career criminals and unscrupulous medical providers will shift their attention to the property-casualty business to avoid increased scrutiny from health insurers. No estimate of the magnitude of the effect is made, but NICB suggests several steps insurers could take to address the potential increase in fraud, including the following:

- Closely monitoring and evaluating orders and referrals for durable medical equipment (DME) and other services to confirm the eligibility of the provider(s) involved.
- Monitoring DME billings that require physician evaluation and authorization to protect against fraudulent schemes.

⁸ Paul Heaton, *The Impact of Healthcare Reform on Workers' Compensation Medical Care, Evidence from Massachusetts*, RAND Institute for Civil Justice, www.rand.org (accessed January 20, 2014).

⁹ National Insurance Crime Bureau, *Anticipated Effects of the Patient Protection and Affordable Care Act on P&C and Workers' Compensation Carriers*, 2013.

- Remaining aware of federal moratoriums on accepting new medical providers and the regions involved, so that monitoring efforts can be focused on those regions and any diversion of criminal activity to property-casualty claims will be more likely to be detected.
- Adopting anti-fraud bill review processes and claim reimbursement standards similar to what is required of public health insurance programs.

Lower Future Medical Damages (and General Damages) in Some States

The ACA may potentially reduce the value of future medical costs included in the calculation of damages in third-party liability claims. Before the ACA, future medical costs were calculated based on estimates of billed charges for the medical care expected to be required in the future. Some have argued that guaranteed health insurance coverage with no exclusions for preexisting conditions and no lifetime limits on benefits paid will provide claimants access to medical treatment where reimbursement is based on much lower rates negotiated by public and private health insurance plans. As a result, the actual damages involved should be significantly less than what past practice would suggest.¹⁰ Some have gone so far as to suggest that the calculation of future medical costs should be limited to the cost of premiums for health insurance coverage plus any out-of-pocket costs.¹¹ In addition to reducing damages for future medical costs, to the extent that general damages are calculated in relation to economic damages incurred by the claimant, then general damage amounts might also be lowered.

Efforts to reduce future medical damages in third-party liability cases would face strong opposition from claimants' attorneys seeking to maximize the amount of damages awarded in major liability cases.¹² In addition, efforts to apply new standards and methods in the calculation of future medical damages could face serious challenges in states with strict adherence to the collateral source rule. Also, whatever the impact ACA might have on future medical calculations, lowering the specified damages involved is unlikely to deter health insurers, including Medicare, from pursuing subrogation actions to recover whatever amounts they expect to pay in the future for treatment costs.

¹⁰ H. Thomas Watson, *Using the PPAC to reduce future medical expense tort damages*, Horvitz & Levy, LLP, www.horvitzlevy.com (accessed January 15, 2014); and Ann S. Levin, *The Fate of the Collateral Source Rule After Healthcare Reform*, www.uclalawreview.org/pdf/60-3-4.pdf (accessed January 15, 2014).

¹¹ Joshua Congdon-Hohman and Victor A. Matheson, *Potential Effects of the Affordable Care Act on the Award of Life Care Expenses*, College of the Holy Cross, Department of Economics, www.holycross.edu (accessed January 15, 2014).

¹² Bruce G. Fagel, *The Collateral Source Rule under the Affordable Care Act*, Plaintiff, www.plaintiffmagazine.com (accessed January 15, 2014).

Healthier Populations

The ACA includes several provisions aimed at improving the health and fitness of the general population. Most importantly, preventive services must be provided to plan participants without cost sharing. Significant financial incentives also are created to encourage employers to provide wellness programs for employees. Some of these incentives, in turn, are pushed down to employees to encourage their participation in health and fitness programs. It certainly seems possible that a healthier population will be less prone to injury—either at work or in their cars. However, that any of these initiatives will affect the frequency and cost of injuries covered by property-casualty insurance programs should not be assumed. In the property-casualty arena, less serious injuries do not always promise lower claim costs. In numerous studies of auto injury claims, the IRC has documented a steady decline in the seriousness of injuries involved, but that decline was coupled with a steady increase in average claimed medical expenses and payments by property-casualty insurers.¹³

More Appropriate Utilization Due to Clinical Research

As mentioned earlier, the goal of the PCORI is to conduct research comparing the clinical effectiveness of different medical treatments. Medical treatment provided for injuries associated with property-casualty insurance claims is often characterized by overutilization and wide variation in the type of treatment provided, as documented in a 2013 IRC study.¹⁴ We believe there is significant opportunity to improve the quality of care provided to property-casualty liability claimants, and an entity like PCORI could prove instrumental in that regard. However, the chief obstacle to improving the quality of care provided to property-casualty insurance claimants is not the lack of knowledge of how best to treat compensable injuries. Instead, the chief obstacle is changing the behavior of medical providers so that the treatment provided is more closely aligned with what is already known about how best to treat compensable injuries.

Past efforts to change provider behavior typically relied on the development and use of treatment guidelines developed by government agencies and insurance companies and used as standards against which provider behavior was assessed. In the mid-1990s, a federal agency, the Agency for Health Care Policy and Research

¹³ Insurance Research Council, *Auto Injury Insurance Claims: Countrywide Patterns in Treatment, Cost, and Compensation* (Malvern, Pa.: Insurance Research Council, 2008).

¹⁴ Insurance Research Council, *Interstate Differences in Medical Utilization in Auto Injury Claims* (Malvern, Pa.: Insurance Research Council, 2013).

(AHCPR), developed a set of guidelines addressing the treatment of back pain. Back and neck sprains and strains are common conditions in property-casualty injury claims, accounting for very large portions of claims and claim costs. Opposition to the AHCPR guidelines from the orthopedic medicine community was fierce and nearly resulted in a complete defunding of the agency.¹⁵ The provision of the ACA creating PCORI expressly directs the new agency to ensure that its research findings “not be construed as mandates for practice guidelines, coverage recommendations, payment or policy recommendations.”¹⁶ This provision of the ACA seriously undermines the value of PCORI and the value of its work. Therefore, we do not expect the activities of the new agency to have any significant impact on the property-casualty industry.

Conclusion

The property-casualty insurance industry will be touched in many ways by the ACA. We believe the most significant impact will be cost shifting by hospitals and other providers from public and private health insurers to property-casualty insurers. Cost shifting will occur in response to increased cost containment efforts by public and private health insurers, and will appear in the form of higher charges and a higher volume of billed services. Cost shifting will be particularly severe in state jurisdictions and with coverages where the differences between public and private health insurance reimbursement levels and property-casualty reimbursement levels are greatest. To mitigate this potential impact, property-casualty insurers should consider options to ensure that the prices paid as reimbursement for medical services are consistent with prices paid by public and private health insurers. Market-based fee schedules and bill review authority are among the tools often applied to address medical pricing issues. Property-casualty insurers also should consider alternatives for ensuring that only medically necessary and appropriate treatment is provided to property-casualty insurance claimants and reimbursed by insurers. Utilization review authority, evidence-based treatment guidelines, and the authority to deny reimbursement for unnecessary or inappropriate treatment are among the tools that should be considered.

¹⁵ Bradford H. Gray, et. al., “AHCPR and the Changing Politics of Health Services Research,” *Health Affairs*, June 2003, pp. W3 283-W3 307.

¹⁶ Public Law 111-148, 124 Stat. 735 (2010).



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