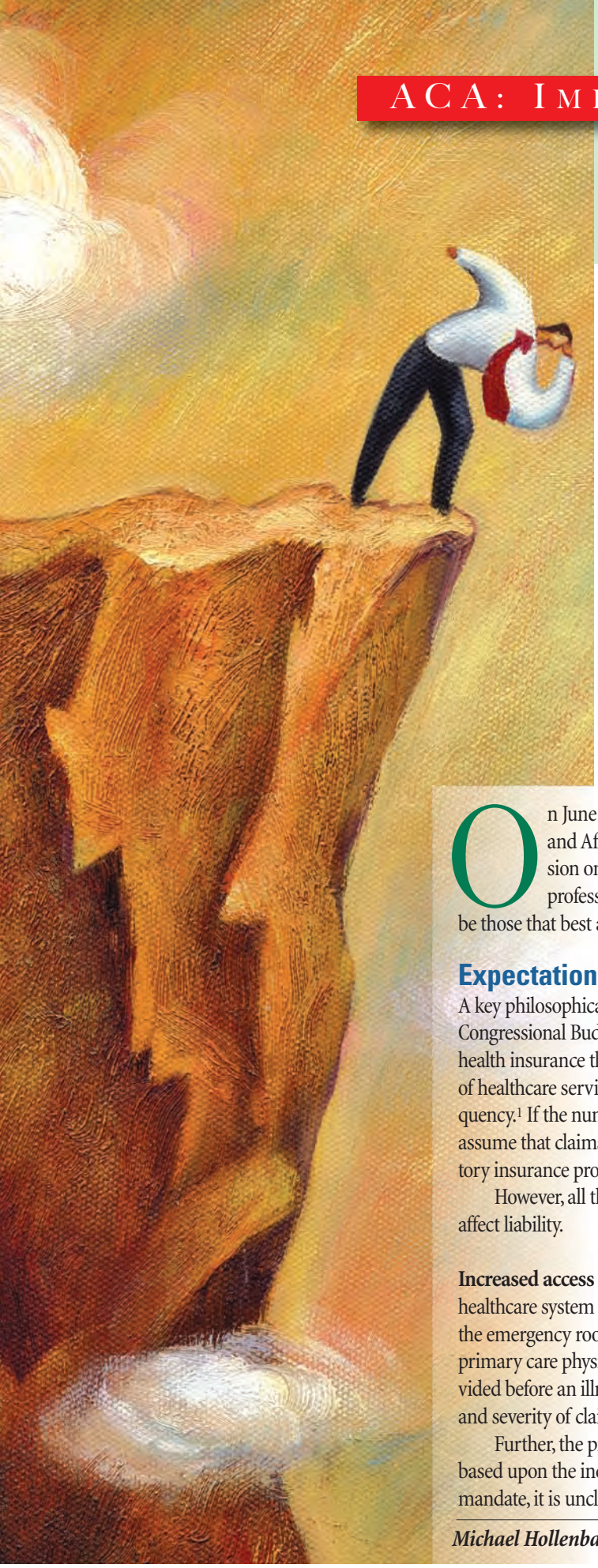
By Michael Hollenbach



Definitive Ruling, Uncertain Consequences

On June 28, 2012, the U.S. Supreme Court upheld, in the main, the Patient Protection and Affordable Care Act (the Act). Now, although the Court has made a firm decision on the essential legality of the ACA, a host of issues pertaining to medical professional liability remain unresolved. The most successful MPL insurers will be those that best anticipate, and react to, the changes in the MPL environment that do occur.

Expectations on MPL

A key philosophical underpinning of the Act is access to healthcare for all, or nearly all. The Congressional Budget Office (CBO) estimated an additional 32 million people will obtain health insurance thanks to the Act. The influx of new insureds will result in greater utilization of healthcare services. Greater utilization, all things being equal, results in greater claims frequency.[1] If the number of insureds were to grow by the anticipated 13%,[2] one might logically assume that claims frequency will increase by a similar percentage in 2014, when the mandatory insurance provisions take effect.

However, all things will not be equal. Let's look at some of the variables that could affect liability.

Increased access to healthcare. The premise that the new insureds are new entrants to the healthcare system is imprecise. These new insureds currently are consumers of healthcare via the emergency room. With the benefit of insurance, they more often will receive care from a primary care physician or clinic providing regular and preventive care. More treatment provided before an illness becomes acute may mitigate the anticipated increase in the number and severity of claims from this population segment.

Further, the projection of an additional 32 million insureds is inexact. This projection is based upon the individual mandate and more generous Medicaid eligibility. Even with the mandate, it is unclear how many currently uninsured will purchase health insurance. Failure

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to do so will result in the tax/penalty, but usually the tax/penalty will be less than the cost of the insurance, even for those eligible for the premium subsidies provided by the Act.[3] Thus, there will be economic incentives, particularly among the young and healthy, to simply pay the tax rather than purchase the health insurance.

The Supreme Court also left the door open for the states to opt out of the Medicaid expansion, and some may do so, potentially reducing the number of new insureds.

Many areas of the country already have shortages of doctors and other providers. The influx of new insureds may result in a disproportionately high increase in claims if an already stressed provider population takes on a greater number of patients. In addition, the increased numerical strain on healthcare providers is likely to result in greater use of mid-level providers, such as physician assistants and nurse practitioners, and an increase in convenience-oriented clinics such as CVS's Minute Clinic and in workplace clinical care. This trend has been underway for some time now but should accelerate due to the Act. The impact on liability from increased mid-level care and greater use of clinics remains to be determined.

Reimbursement changes. Conventional wisdom holds that "you get what you pay for": Lower provider reimbursements will result in poorer-quality care and more adverse claims experience.

The goal of the Act is to "bend the cost curve" downward. In a letter of July 24 to House Speaker John Boehner, the CBO stated that the impact of repealing the Act would increase Medicare spending by an estimated $713 billion from 2013 through 2022, implying that implementation of the Act will reduce spending by the same amount. Most of these reductions result from payments to providers such as home health providers (9%) and, largely, hospitals (35%). Another big chunk comes from reduced reimbursements of private Medicare Advantage plans (30%). None of the cost savings come from specified reductions in benefits.[4] If we are to pay providers less but expect the same services as before, a reduction in healthcare quality and an increase in liability, at least initially, seems a logical outcome.

However, a material part of the savings is anticipated to come from the implementation of outcome-based compensation. Integrated delivery through entities such as accountable care organizations (ACOs), or groups of providers such as hospitals and physicians, is encouraged. ACOs make providers jointly accountable for the care of their patients, with financial incentives for providers to both lower costs and meet quality, evidence-based benchmarks focused on prevention and managing chronic disease. The introduction of quality-care financial incentives should generate higher-quality care and a reduction in liability claims. Further, pursuing lower costs through evidence-based care may reduce utilization of inefficient procedures, with some corresponding reduction in the number of MPL claims.

Electronic medical records. Both the Affordable Care Act and the 2009 stimulus act encourage greater use of electronic medical records (EMRs). The aim is to improve care by giving medical providers immediate access to important patient information, help control costs by eliminating unnecessary and duplicative tests and procedures, and allow both greater coordination and measurement of care. It seems self-evident that the achievement of these goals should improve the quality of healthcare and thereby reduce liability for MPL in the aggregate, yet an electronic record of the care given to a specific patient may simply leave a roadmap for demonstrating provider negligence. Furthermore, use of EMRs creates new potential claim exposures resulting from issues such as data breach and technological mishaps.

Table 1 Impact on MPL liability from the PPACA

	Increased Liability	Decreased Liability	Impact Uncertain
More healthcare insurance	X		
More preventative care		X	
More mid-level care			X
Decreased provider reimbursement	X		
Incentives for cost savings	X		
Incentives for quality care		X	
More employed physicians			X
Greater coordination of care		X	
More evidence-based care		X	
Greater use of electronic records			X

Impact on physician insurers

Two principal consequences emerge regarding the MPL insurance landscape following the Supremes' ruling on the Act.

Pricing uncertainty. As noted above, there are a slew of factors that could impact MPL liability in uncertain ways (Table 1).

Claims payment is the insurance product. For a long-tail line of business such as MPL, determining the cost of product in normal times is difficult enough. Our best pricing tool, the actuarial process, relies on extrapolation based on loss trends that have already taken place. Since loss trends change over time, our actuary friends often find themselves trying to catch up to the correct answer.

With greater than usual uncertainty looming

over the future of liability trends, carriers will need to be more diligent and nimble than ever in assessing loss trends and pricing business accordingly. The best, if imperfect, approach probably remains to monitor loss trends frequently, assess them critically, and react appropriately (quickly, but not so quickly as to mistake momentary data blips for trends).

Meeting the needs of insureds. The changing healthcare landscape after the affirmation of most of the Act probably will accelerate the ongoing trend toward greater consolidation within the provider community. The nature of healthcare insureds is likely to change, and their liability insurers will want to be able to respond to their customers' new needs.

As physicians join hospital staffs, there will be pressure on physician insurers to develop or expand their ability to insure the hospital risk or lose a chance at insuring the consolidated exposure including their prior insured physicians. Many carriers have or are in process of expanding this capability, oftentimes with the help of reinsurers or other partners.

However, to borrow from Mark Twain, for a number of reasons, reports of the demise of the physician insurer may have been greatly exaggerated. It is reasonable to expect that there will always be a meaningful minority of doctors who prefer to work independently. Further, the acquisition of physician practices by hospitals is still a fairly specific geographic phenomenon and may not progress to a full national trend. In addition, there will be hospitals that do not wish to take on the risk and tie up the capital necessary to insure an influx of newly acquired physicians. Nonetheless, in the new world of integrated healthcare, it is reasonable to expect that the successful physician insurer will have evolved into a more multi-dimensional entity, with the capability to insure more integrated, institutional risks, or maintained a targeted physician focus, based on a particular brand, geography, sponsorship, specialty focus, or other niche.

A number of physicians who remain independent are likely to join ACOs or other integrated delivery vehicles. The focus of ACOs under the Act, for now, is on Shared Savings Program under fee-for-service Medicare. However, the Centers for Medicare & Medicaid Services has initiated the Pioneer program for private providers and health plans. Under the Pioneer Model, more risk taking by providers and, ultimately, a population-based, or capitated, payment

system is expected to develop. With such a model, participating providers will receive not only incentive payments for cost savings and quality care; they will also receive a fixed per patient compensation. The providers assume the risk that the costs of care will exceed the payments received.

Physician insurers who wish to write business beyond targeted niche areas will soon need to prepare for the possible blossoming of the ACO model. Taking a wait-and-see approach could put these carriers at a competitive disadvantage, without sufficient time to catch up to a market ready to meet the needs of ACOs and their provider participants. The traditional physician insurer will want to continue to insure the ACO physician participants, but it is likely that some of the larger, commercial insurers expected to vie for insure ACOs will seek to bundle the sale of coverages for both the ACO and the provider participants. Should this transpire, at least as a defensive measure, the physician insurer will need to be able to offer ACO coverage (Table 2).

Table 2 Coverages ACOs May Need

Potential ACO Coverages	
Medical Professional Liability	Cyber Liability
Directors & Officers Liability	Fiduciary Liability
Managed Care E&O Liability	Billing E&O Liability
General Liability	Provider Stop Loss
Employment Practices Liability	

Conclusion

The Supreme Court has ruled on and, for the most part, upheld the Patient Protection and Affordable Care Act. Notwithstanding this definitive ruling, many unknowns about the future evolution of the healthcare system and its fallout on MPL trends remain. Increased provider consolidation and integration of care seem likely.

Physician insurers will need to maintain vigilance in monitoring the liability consequences of these changes and react accordingly, while positioning themselves in the marketplace with the necessary client focus, and an appropriate selection of products to remain insurers of choice for their changing customer base. PIAA

For related information, see www.bmsgroup.com.

Footnotes

1. The frequency of claims is measured by comparing the number of claims to the number of providers with MPL insurance.
2. U.S. Census Bureau, 2010.
3. Supreme Court: Mandate penalty is a tax, CNNMoney, June 28, 2012; Premium and Cost-Sharing Subsidies in the Affordable Care Act. Community Catalyst, September 2010.
4. Klein, E. Ezra Klein's Blog, Washington Post, August 14, 2012.
5. AON Hospital and Physician Professional Liability 2011 Benchmark Analysis.