

US healthcare reform

Edward M. Wrobel and Jeffrey Levin-Scherz of Towers Watson discuss the medical professional liability implications that will arise from the

The Affordable Care Act, passed in March 2010, represents the most significant health insurance reform legislation in the US since Medicare was enacted in 1965. This legislation, even if amended significantly by the newly elected Congress, will likely accelerate shifts in the way healthcare is delivered. The Affordable Care Act is likely to lead to a greater number of insured Americans, lower provider-payment rates and more bundled payments. The importance of provider organisations will no doubt increase, and captive insurers can provide strategic support and incentives to their parent organisations and insureds to help enhance their competitive positions while lowering their overall risk.

We highlight below key provisions of the legislation and their potential implications for medical malpractice risks, and discuss opportunities for providers and their captives to drive risk-management efforts.

Decrease in the uninsured

Two-thirds of the currently uninsured will gain insurance - half through the expansion of Medicaid and the rest through the subsidised purchase of health insurance from newly created state health insurance exchanges. Many of the newly insured will be young and healthy, and it is likely that many will be unfamiliar with the healthcare delivery system.

The decrease in the number of uninsured could lead to earlier diagnosis and treatment, and an associated decrease in claims. Increased prenatal care can be especially effective at lowering adverse outcomes and high-cost lawsuits. However, there will be more units of service delivered which could exacerbate the existing primary-care shortage, increase fragmentation of care and

decrease patient satisfaction. If the benefits of preventive care and earlier diagnosis do not materialise and we have the same rate of malpractice claims per patient encounter, total malpractice costs could increase.

There has been a long-term trend toward increased use of non-physician practitioners such as nurse practitioners and physician assistants. Two factors will likely accelerate this trend: the increase in insured patients and the continued decline in physician trainees choosing primary care. Skilled non-physician practitioners are likely to follow algorithms and evidence-based practices, and can help relieve primary-care physician shortages, thereby mitigating liability costs. However, their lower level of expertise could lead to diagnostic errors.

Value-based payments and accountable care organisations

The Affordable Care Act promotes pay for performance and bundled payments, and providers can organise Accountable Care Organisations (ACOs) to co-ordinate

care and share in cost savings. Increased co-ordination and collaboration can lead to reduction in errors, improved communications, and lower malpractice risk. Non-payment for 'defective' care, such as hospital-acquired infection and 'avoidable' re-admissions, will provide incentive for patient-safety efforts.

Increased malpractice costs could result if plaintiff attorneys are able to assert that non-payment is verification of negligence. ACO quality data will be publicly available, and while that transparency can benefit those organisations doing well against the quality measures, defence against malpractice claims could be much more difficult for those that do not meet the quality standards. In addition, to the extent an ACO achieves savings but is construed as restricting care (a concern that arose in the early days of managed care) a new venue for liability claims could arise.

Excise tax for high-cost health plans

The Affordable Care Act includes a 40% non-deductible tax for health plans that cost more than \$10,200 (individual) and \$27,500 (family) in 2019. While these premiums seem high and 2019 might seem distant, some simulations show many employers at risk for exceeding these limits. Therefore, many employers are aggressively increasing member cost-sharing to keep

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their plans below this limit. As such, a large portion of the newly insured will have insurance with high deductibles. High deductible health plans increased to 10% overall in 2010, and among small businesses 20% of employees already have deductibles of \$2,000 or more.

Those insureds with high deductibles or more cost-sharing might wait until they have serious preventable illness before seeking medical care. This can lead to worse healthcare outcomes and could lead to financial distress for some healthcare systems that will not see the increased volume they were expecting.

Other noteworthy provisions

The Affordable Care Act includes other provisions that could have an impact on malpractice risk, including:

- Further incentives to adopt electronic medical records. With appropriate planning and excellent training for staff, these systems can prevent some medical errors. However, in the early stages of the learning curve, there is a risk that inadequate training or improper use can result in electronic documentation that could make legal defence difficult if there is an adverse medical outcome.
- Increased re-imbursement for primary care, including two years of federal re-imbursement to raise Medicaid primary-care office visit rates to the Medicare fee schedule. This can help delivery systems justify additional investment in primary care, which can offset the concern about the primary care shortage and potentially lower overall malpractice liability through earlier diagnosis.
- Comparative effectiveness research, renamed “patient-outcomes research.” While some physicians worry that this could interfere with professional autonomy, and that a clear community standard of care could create increased liability, better evidence-based medicine can lead to fewer bad outcomes. Providers should be certain to incorporate new knowledge into their decision support.
- A small amount of funding for state-liability reform pilots. A number of grants have already been made to promote patient safety and encourage disclosure and apologies. However, the Affordable Care Act does not include any significant tort reforms such as caps on damages. It remains to be seen whether the next Congress



will consider malpractice reform.

- Large cuts in Medicare Advantage funding. These cuts make it more likely there will be additional patient-physician relationships disrupted as some plan to leave this market.
- Public reporting on payment of malpractice claims. While some worry that this could prove to be a boon to plaintiff attorneys, it could also energise local efforts to avoid medical errors.

sation by using carefully designed premium incentives and risk-management grants that promote patient safety and risk reduction efforts.

Healthcare will be changed as a result of healthcare reform, regardless of legislative activities of the newly constituted Congress in 2011. While it is difficult to conclude whether malpractice costs will increase or decrease as a result, healthcare captives can use this opportunity to champion continuing efforts to systematically decrease patient harm and mitigate costs. ☺

Risk mitigation and captives

Provider organisations can mitigate the risks emanating out of the Affordable Care Act. For example, those that develop programmes to help patients navigate the healthcare system and implement electronic systems to increase provider adherence to evidence-based medicine are likely to have fewer cases of missed follow-up, experience improved patient communications, and have lower claims for ‘failure to diagnose’. Provider organisations that systematically track adverse outcomes and claims, and offer disclosure and apologies, also appear to lower their aggregate risk.

Captive insurance companies can drive these changes through an organi-

Edward M. Wrobel, FCAS, MAAA, has more than 20 years of consulting experience with captive insurance companies and other self-insurance mechanisms, providing ratemaking, reserving, strategic and financial planning services. Wrobel co-leads Towers Watson’s Healthcare Professional Liability practice.

Jeffrey Levin-Scherz, MD, MBA, brings over 20 years of experience in management of health care delivery and health care financing. Dr. Levin-Scherz works in the care management division of Towers Watson’s Health and Group Benefits practice.