CLM Claims & Litigation Management Alliance™

ADVANCING ETHICS, COOPERATION AND EDUCATION

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The Impact of the Affordable Care Act On the Insurance Industry, Litigation and Medicare: What Does the Future Hold?

I. ACA Mandates and Requirements

Individual Mandate and Minimum Essential Coverage

The ACA's so-called "individual mandate," takes effect January 1, 2014 and requires every "applicable individual" to obtain "minimum essential coverage" or pay a penalty. The minimum essential coverage required must include "ambulatory patient services, emergency room services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative services and devices, lab services, preventive and wellness services and chronic disease management and pediatric services." See 26 U.S.C. § 1302(b). Furthermore, for these minimum coverage plans, the ACA limits the annual amount of out-of-pocket medical expenses that can be incurred. In 2014 the out-of-pocket limit for individuals is $6,350 and $12,700 for families.

Guaranteed Issue Requirement

The "guaranteed issue requirement" bars insurance companies from denying coverage to individuals with pre-existing conditions. It works in conjunction with the "community rating requirement," which prohibits insurance companies from charging higher rates to individuals based on their medical history. Insurers also are prohibited from placing lifetime and annual spending limits on the "minimum essential benefits" listed above. Moreover, health insurance carriers must provide coverage to dependent children until the age of twenty-six.

II. Claim and Cost Shifting

Cost Containment Provisions of the ACA

The ACA has cost containment provisions that may reduce revenue from health insurance systems. Consequently, medical providers may seek to increase revenue from other payors, such as property casualty insurers. The ACA also includes many new provisions designed to curtail Medicare costs:

- Payments to hospitals for treatment provided to indigent patients are reduced by 75%
- Payments to Medicare Advantage Plans have been revised and tied to fee for service reimbursement models
- 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.
  The Affordable Care Act and Property-Casualty Insurance, 2014, Insurance Research Council

Why Negative Effects on Medical Provider Revenue Result in Cost Shifting Onto the P &C Industry

A decrease in medical providers' revenue due to the cost containment provisions of the ACA may result in medical providers seeking increased revenue from other sources- including the property casualty industry. Medical providers may also seek to increase revenue by increasing the volume and number of services provided to patients. Consequently, liability and workers' compensation carriers should employ utilization review and precertification procedures to ensure the appropriateness of medical treatment.

How the ACA May Cause Individuals to File a Workers' Compensation or Liability Versus a Private Health Insurance Claim

Some plans purchased by employers under the ACA include higher deductibles and co-payments which increase out of pocket costs by employees. Individuals may be motivated to file claims under property casualty or workers' compensation policies versus private health insurance in order to avoid the higher costs associated with new plans purchased under the ACA. It is also reasonable to assume that public and private health insurance may also become more aggressive in refusing to provide coverage for certain medical treatments. If the insured individual is aware of this potential denial, they may be incentivized to file claims under liability or workers' compensation.

Potential Impact of the ACA on the Filing of Fraudulent Claims

Competing arguments exist for whether or not the filing of fraudulent claims will increase, or decrease, under the ACA. The primary purpose of the ACA is to decrease the number of uninsured individuals. With more individuals receiving health care coverage under the ACA, it follows claims filed fraudulently under workers' compensation or liability policies may decrease, since other (ACA) coverage is now available. In October 2013, however, the National Insurance Crime Bureau (NICB) predicted that the frequency of fraudulent property-casualty claims will increase as fraud-fighting provisions of the ACA are implemented. *National Insurance Crime Bureau, Anticipated Effects of the Patient Protection and Affordable Care Act on P & C and Workers' Compensation Carriers, 2013.*

According to the NICB, because property casualty insurance is not covered by the ACA, criminals and unscrupulous medical care providers may shift claims onto property casualty to avoid increased scrutiny from private health insurance carriers.

III. Practical Considerations for the Claims Practitioner

Tips for the Claims Handler

A critical but obvious starting point is to know the law in your jurisdiction. Under the common law rule, collateral source payments, such as private health insurance, employee benefits and gratuities cannot be used to mitigate damages. Consequently, it is important to select the "right" cases- those with the most favorable fact patterns that truly further your argument in support of mitigation of future damages. Also, ensure the case fits with your overall strategy- be cognizant of making "bad law" that would put into jeopardy any future arguments you may advance in other cases supporting your position.

Strategic Perspectives for the Claim Manager

Make sure you have a clear and developed strategy around the arguments your company chooses to advance with respect to the collateral source rule and the plaintiff's duty to mitigate damages pursuant to the ACA. Identify counsel that can successfully espouse and effectively advocate this strategy and ensure your company's "message" is properly aligned with all members of your defense team. In addition, make sure your counsel is poised to preserve at trial all grounds for possible appellate review.

Identified Resources in Support of Effective Execution

Ensure you have a current state law compendium, consider national coordinating counsel, if necessary, and cultivate and develop amicus support ahead of the appellate stage.

IV. The ACA and the Collateral Source Rule

Collateral Source Rule-Definition

The common law collateral source rule prohibits a defendant from reducing damages based on payments made by a third-party to the plaintiff or a medical provider on the plaintiff's behalf as a result of the injuries sustained by the plaintiff. Under the common law rule, collateral source payments, such as private health insurance, employee benefits and gratuities cannot be used to mitigate damages.

How the ACA Changes the Collateral Source Rule

The enactment of the ACA arguably undermines some of the main arguments made in support of the common law collateral source rule. First, the ACA undermines the rationale that the common law collateral source rule was designed to hide from the jury whether the plaintiff has insurance. Now, given the "individual mandate," most jurors will assume that the plaintiff has insurance. Thus, the ACA essentially eliminates the evidentiary purpose of the common law rule. And second, the common law collateral source rule was intended to serve as a deterrent and to prevent a windfall to the defendant. As such, defendants were required to pay the full amount billed by the medical provider for the plaintiff's care. Now, however, most people will have insurance and their insurance company will be billed at a reduced rate.

Despite the elimination of some of the traditional rationales for the common law collateral source rule, barriers to obtaining offsets for future damages still remain. One potential problematic area is the level of proof necessary needed to obtain a collateral source offset. In some states, such as New York, the courts have been reluctant in the past to grant an offset for private health insurance because the

defendant failed to prove with reasonable certainty that the plaintiff's insurance benefits will continue for the duration of the jury award. That is because the plaintiff's health insurance was received through the plaintiff's employment and if the plaintiff loses or changes jobs, he or she could lose that insurance. If plaintiff lost that insurance, then he or she might not be able to get insurance because of a pre-existing condition. The ACA has now eliminated that concern. An injured plaintiff can now obtain insurance and that insurance is required to cover at least the minimum essential benefits required under the ACA. Furthermore, proper experts can show that other insurance plans are available and will be available that cover many of the items in the proposed Life Care Plan. That expert can also explain potential increases in premiums and out-of-pocket maximums.

V. Other Arguments for Reduction of Future Medical Awards

Plaintiff's Duty to Mitigate Damages

Given that a number of states still adhere to common law collateral source rule and have been reluctant in the past to grant offsets, defendants should expand their arguments beyond just the collateral source rule. One such argument derives from the plaintiff's duty to mitigate damages. Generally, a plaintiff has a duty to mitigate damages and render their injury "as light as possible." Under the current tort system, awards for future medical expenses are based on projections made by a life care planner and an economist. Some courts, however, have recognized that this endeavor is inherently speculative and cannot reliably be predicted. Until the implementation of the ACA there has not been a more reliable alternative.

Now under the ACA individuals are required to purchase health insurance or pay a penalty. If they fulfill that obligation and purchase insurance, it is highly likely that it will cover many, if not all, of the claimed expenses in a plaintiff's Life Care Plan. Arguably, therefore, an individual should not be permitted to inflate damages by requesting the speculative award of a jury where by law they are required to buy insurance and the defendant's cost to purchase insurance that would cover the care claimed would be less. Furthermore, even where there is a right to subrogation, limiting damages to those amounts actually paid by insurance would still lower the amount currently claimed as damages in many cases.

Defendants, therefore, can now argue that the plaintiff has a duty to mitigate, that duty is consistent with the purpose and goal of the ACA, and that awarding damages based on insurance will make damage awards more reflective of real world actual costs than the current system of reliance on the speculative Life Care Plan. Defendants can attempt to argue that the plaintiff can reduce the amount of damages by purchasing an insurance policy. The defendant then would only be responsible to reimburse the plaintiff for the premiums to maintain the policy, annual increases in those premiums and any other out of pocket expenses such as co-pays, deductibles or other expenses not covered by insurance. Under this argument, the defendant would most likely still have to prove which items in the proposed Life Care Plan would be covered by insurance, how much those premiums would be, the projected increases and whether that type of policy will likely be available throughout the duration of the plaintiff's medical needs.

Availability of Private Health Insurance and Settlement Negotiations

Notably, and even before trial, the availability of private health insurance may be more effectively raised in settlement discussions. For example, in catastrophic injury cases a defendant can now offer in settlement discussions (after a cost-benefit analysis) to (1) purchase the plaintiff the best plan available; (2) pay for the premiums with projected future increases; (3) pay for all uncovered expenses attributable to the defendant and (4) include future lump sums which can be invested or available in the event premium increases exceed the amount that has been projected.

Recovery of Medical Expenses: Amount Actually Paid/Incurred v. Billed Amounts

Alternatively, an argument can be made that the purpose of compensatory damages is to make the plaintiff whole for the losses actually suffered. In the area of medical expenses, a plaintiff suffers an economic loss by taking on liability for the costs of the treatment that he would not otherwise have incurred. Any reasonable and necessary charges, therefore, that the plaintiff has paid or will owe as a result of the accident are recoverable.

It is well known that there is a tremendous disparity between what medical providers often bill their patients and what is actually paid to those providers. Now with the ACA even less people will pay or ever be responsible for billed rates. In fact, virtually everyone will either pay the rates agreed between the medical provider and the insurer (Anegotiated rates@) or rates charged under Medicare, Medicaid or other government programs.

To that end, a number of states have already taken the view that the plaintiff's recovery for medical expenses should be reflective of the amount actually paid or incurred on behalf of the plaintiff. Some of those states include California, Iowa, Minnesota, Nebraska, New York, Ohio, and Texas. Other states, such as Hawaii, Illinois, Mississippi, South Carolina, South Dakota, Virginia and Wisconsin, have rejected the use of negotiated rates and continue to use Abilled rates@ as the proper measure of damages. Those cases, however, arose prior to the ACA, which now undercuts much of the rationale for the usage of billed rates as the proper measure of damages.

Defendants, therefore, can try to expand upon the successful arguments made in California and elsewhere. They can argue that the court should either find that (1) the collateral source rule does not apply because the difference between billed and negotiated rates does not reflect an amount paid on the plaintiff's behalf; (2) when awarding compensatory damages, the plaintiff should only be able to recover for amounts paid or that could be owed; and (3) even if the collateral source rule applies, the amount of the offset should include the amounts actually paid by a third-party on the plaintiff's behalf.

VI. The ACA and MSP Enforcement and Compliance

The ACA and the Medicare Program

The ACA contains important provisions related to prevention of Medicare fraud and abuse. The ACA also enhances benefits provided to Medicare enrollees. In addition, a reading of the ACA shows Congress's intent to extend the life of the Medicare trust fund and reduce Medicare spending. In fact, the July 28, 2014, news release from the Centers for Medicare and Medicaid Services (CMS) reported Medicare will remain solvent until 2030, four years beyond what was projected in the 2013 Medicare Trustees'

Report. The release quoted Marilyn Tavenner, administrator of CMS, as attributing the extension, in part, to the ACA:
"Thanks to the Affordable Care Act, we are taking important steps to improve the quality of care for Medicare beneficiaries while improving Medicare's long-term solvency. Specifically, we have made major progress in improving patient safety, decreasing hospital readmissions, and establishing new payment models such as accountable care organizations aimed at reducing costs and improving quality. These reforms slow the rise in healthcare spending while improving the quality of care for beneficiaries."

ACA Anti-Fraud and Enforcement Provisions

The ACA has many provisions designed to identify and prevent fraudulent claims. Those provisions include enhanced screening of medical providers and suppliers, stronger civil and monetary penalties on providers who commit fraud, and new penalties for submission of false data and false claims for payment.

Since 2006, CMS has been building the Integrated Data Repository (IDR), which is a database that would allow CMS to access certain Medicare and Medicaid data from one source. The ACA expands the IDR to include data from all federal healthcare programs, including Social Security and the Veterans Administration. The ACA also gives the Department of Justice and the Office of Inspector General more access to CMS databases.

In addition, the ACA expands Medicare's Fee-for-Service Recovery Audit Contractor (RAC) Program to Medicaid, Medicare Advantage (Part C), and Medicare drug benefit (Part D) programs. The RAC program is designed to detect improper payments in Medicare claims. The RACs are paid on a contingency-fee basis.

The ramp-up in enforcement and data collection is interesting in the context of Section 111 reporting and conditional payment reimbursement. Again, the ACA does not change any of the requirements for Section 111; Mandatory Insurer Reporting, also known as the MMSEA (Medicare and Medicaid SCHIP Extension Act of 2007); or conditional payment recovery. But will this greater accessibility to Medicare's databases lead as well to greater scrutiny of Section 111 reporting data?

The future landscape around this issue includes the collision of the seemingly competing purposes of the ACA. Those purposes include fiscal preservation of the Medicare trust fund, reduction of Medicare spending, no annual lifetime limits on healthcare, guaranteed issue of healthcare coverage, and no denial for preexisting conditions. This collision potentially creates the perfect storm of the government ramping up enforcement of Section 111 reporting and, consequently, conditional payment reimbursement as more people are insured under the ACA.

ACA's Changes to Section 111, MSA and Conditional Payment Requirements

The ACA's clear intent to preserve the fiscal integrity of the Medicare trust fund seems to be aligned with the original identical intent of the Medicare Secondary Payer Act (MSP). The question therefore becomes, what is the nexus between the ACA and the MSP? How does the ACA change the guidelines

for Medicare Set Aside (MSA) preparation and the regulations for conditional payment reimbursement and Section 111 reporting?

The short answer to this question is not at all. The ACA does not explicitly address MSAs, conditional payment reimbursement, or Section 111 reporting. An exploration of the long-range implications of the ACA, however, provides some insight into how Medicare compliance may be ultimately affected by the legislation.

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Another industry debate centers on whether the ACA circumvents the need for an MSA. The proposition is, since the ACA guarantees medical coverage and there are no denials for coverage based upon preexisting conditions, the workers compensation claimant may use ACA coverage to fund future medicals. Therefore, an MSA in a workers compensation (or liability, for that matter) claim may be unnecessary. That argument harkens back to when MSAs first came on the scene in workers compensation claims. Claimants would agree to sign an affidavit or other agreement promising to use their, or a spouse's, private healthcare coverage to fund future medical costs related to a claim rather than using Medicare. The fallacy in that argument, however, lies in the fact no contract can prevent claimants from exercising their legal right to enroll in the Medicare program. At that time, private health insurance benefits carried an element of uncertainty. For example, if the claimant or a spouse lost private health insurance benefits, that coverage for future medicals would no longer be available. Consequently, an MSA would still be necessary for the protection of Medicare's future interests.

Like Section 111 and conditional payment reimbursement, the ACA does not address nor change MSA guidelines.