State of Washington
Legislative Budget Committee

Options For Coordinating And Integrating Property/ Casualty Insurance With Certified Health Plans

Report 95-7

February 15, 1995

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Established by Chapter 44.28 RCW, the Legislative Budget Committee (LBC) provides oversight of state funded programs and activities. As a joint, bipartisan legislative committee, membership consists of eight senators and eight representatives equally divided between the two major political parties.

Under the direction of the Legislative Auditor, committee staff conduct performance audits, program evaluations, sunset reviews, and other types of policy studies. Study reports typically focus on the efficiency and effectiveness of agency operations, impact of state programs, and compliance with legislative intent. As appropriate, recommendations to correct identified problem areas are included.

Reporting directly to the legislature, the LBC generally meets on a monthly basis during the interim between legislative sessions.

State of Washington
Legislative Budget Committee

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OPTIONS FOR COORDINATING AND INTEGRATING PROPERTY/CASUALTY INSURANCE WITH CERTIFIED HEALTH PLANS

Summary

The Health Services Act of 1993 states that while immediate steps must be taken to stabilize the cost of health services and to provide access to services to all, a long-term plan of reform is also needed.

Background

The Act mandated numerous studies that were intended to inform the debate over the direction that long-term reform should take in the future. This is one of those studies. Many of the issues raised in this report have also been the subject of debate in proposals to reform national health care.

What is This Report About?

The Health Services Act mandated that the Legislative Budget Committee identify cost saving opportunities through coordinating or integrating the health services paid for through property/casualty insurance with certified health plans. This study estimates the cost savings of seven options, discusses their pros and cons, and recommends that the legislature address the policy issues associated with implementing them.

Report estimates cost savings of options

Property/casualty insurance compensates people for losses due to accidents and other mishaps. This study focuses on insured losses from health care expenses. Workers compensation, automobile, and homeowners are three of the most familiar forms of property casualty insurance.[1] This study excludes workers compensation,

[1]This study also includes the following types of property/casualty insurance that cover health care costs: General liability (including products liability), medical professional liability (medical malpractice), commercial multiple-peril and farmowners.

which is the topic of two other studies also mandated by the Health Services Act. In 1993, approximately $327 million was spent in this state on health care services and related administrative expenses under the coverages included in this study.

This state has both fault and no-fault p/c insurance

In Washington, property/casualty coverage can be divided generally into two types:

- First-party, no-fault insurance is insurance that people purchase to cover injuries to themselves ("first-party"). This insurance will pay for losses due to injuries no matter who caused them ("no-fault"). In this state, having such coverage does not preclude people from seeking damages from others ("third-parties") who may have caused the injuries. The most familiar form of first-party, no-fault insurance is automobile Personal Injury Protection (PIP).[2]

- Third-party, fault-based insurance is insurance that people, companies, and organizations purchase to cover their liability if they are at fault ("fault-based").

Certified health plans are the organizations through which access to health care will be provided to all Washington residents under the Health Services Act. These plans are required to provide health services through managed care.

What is the Difference Between Coordination and Integration?

Options for coordination assume that property/casualty insurance companies continue to be involved in selling policies that cover the costs of health services for injuries and illnesses due to accidents and other mishaps. This coverage will be largely duplicative of the coverage provided by certified health plans. Property/casualty companies coordinate with certified health plans by reimbursing those plans for health services costs (up to policy limits).

Options for integration assume that either the property/casualty insurance companies are prohibited from selling health care

[2]PIP also covers passengers and pedestrians, and may reimburse for economic losses other than health services costs (e.g., for wage loss).

coverage, or are limited in their ability to do so (e.g., they cannot duplicate the minimum coverage provided by certified health plans).

This study estimates the potential cost impacts of four options for coordination and three options for integration.

What are Some of the Tradeoffs Between Coordination and Integration?

Should p/c insurance companies continue to sell health care coverage?

Under this state's current, coordinated system, in which property/casualty companies sell health care coverage, individuals or businesses that cause injuries or illnesses pay higher premiums as a result of their actions. The risk of paying higher premiums may act as an incentive to engage in behaviors that reduce the likelihood of causing injuries or illnesses. Shifting the costs of this health care over to certified health plans could have the effect of weakening the linkage between individual behavior and costs.

Among options for integration, it is also possible that some individuals would subsidize others. For example, if the financial responsibility for treating automobile accident victims is shifted from auto insurance to health insurance, non-drivers could end up subsidizing drivers. One way to mitigate this effect of integration would be to place an additional tax on property/casualty insurance premiums, which could be used to offset the tax on health care services. Those who cause accidents would still pay higher premiums due to losses for property damage and settlements for pain and suffering. Thus they would also pay more in taxes on those premiums.

Options for integration have the advantage of eliminating duplication of coverage. This would result in savings from property/casualty insurance companies reducing their claim handling expenses, and from health insurers eliminating the administrative costs of seeking reimbursement from property/casualty insurance. (In this state, when there is duplication of coverage, property casualty insurance has the primary financial responsibility.) Options for coordination do not have the potential for this kind of savings.

MAJOR FINDINGS

Use of managed care can reduce cost of claims

The research conducted for this mandated study strongly suggests that the utilization of health services in managed care settings for injuries and illnesses currently covered by property/casualty insurance can significantly reduce the average cost of claims for health-related losses. This potential for significant savings exists under options for both coordination and integration. However, higher savings from reduced health care costs are associated with greater restrictions on consumer choice.

Higher savings related to greater restrictions on consumer choice

Although the universal ***access*** to managed care under the Health Services Act will contribute to reduced costs for treating injuries and illnesses, the major potential for health care savings comes from options in which actual ***utilization*** of managed care is required or otherwise encouraged.

The Health Services Act requires enrollment in certified health plans providing managed care, but there is no requirement that individuals always utilize these plans.

This is an important distinction, because there are incentives within our state's tort and insurance systems for people making claims for pain and suffering to have relatively high utilization of more expensive health services. These higher costs are reimbursed by property/casualty insurance companies, and are ultimately passed on to consumers in the form of higher premiums. As long as there is no mandate for utilization of managed care, some people will go outside of their managed care organizations for services.

The significance of the difference between providing access to managed care and requiring its utilization can be shown in terms of dollar savings:

> For example, we estimate that the effect of universal access to managed care will result in savings to consumers through reductions in property casualty insurance premiums of $6.7 million annually, with a one-time savings of up to $441,000. This assumes no changes to the current coordinated system. In comparison, we estimate that savings from mandating utilization of managed care would be $78.7 million annually,

with a one-time savings of up to $28.8 million.[3] Under all of the options discussed in this report, there are also possible savings from reductions in settlements and awards for general damages related to pain and suffering.

We are assuming that these savings from reduced health care expenditures would be passed on to consumers rather than taken as profits. Assuring that this would happen would require action on the part of the Insurance Commissioner in approving insurers' rates.

As currently written, the Health Services Act would result in savings to consumers in two ways:

Savings from Health Services Act equals $47.9 million per year

1. From reductions in costs due to universal access to managed care (as discussed in the foregoing example); and

2. Through partial integration. Under Section 455(5), property/casualty insurance companies will be prohibited from selling first-party, no-fault coverage that duplicates the minimum coverage provided by certified health plans. Because of the overlap in coverages, this would likely have the effect removing property/casualty companies from the business of selling first-party, no-fault coverage. Section 455(5) takes effect on July 1, 1999.

   The savings from Section 455(5) would occur in two ways:

   - Although utilization of managed care is not required, it is strongly encouraged by the fact that property/casualty companies would not, in most cases, be a source for reimbursements of costs of going outside of managed care.

   - There are savings from eliminating duplication of coverage.

   Under universal access to managed care, the savings from Section 455(5) would be $47.9 million annually ($46.5 million from property/casualty insurance and $1.4 million from health insurance), with a one-time savings of $6.9 million.

[3]These figures are calculated based on the amounts shown in Exhibit 1 in this report. The estimate for the effects of access are from Option 1. The estimate for the effects of mandated utilization are from Option 4 less the effects of universal access, calculated in Option 1. The above figures include direct health and related administrative expense savings only.

Some other options and savings are precluded by the Act

The current language of the Health Services Act also has the effect, however, of preventing the implementation of other options that also have the potential for savings. This report identifies the magnitude of the savings related to these options so that policy makers can weigh these savings against other factors associated with these options, such as limitations to consumers' choices. As examples:

- None of the savings identified in this study that would result from making the ***utilization*** of managed care ***mandatory*** would be permissible under the current wording of the Health Services Act. These options have relatively greater potential for savings than other options, but do so at the expense of limiting choice.

- One option identified in this study is based on a program offered in the State of Colorado wherein purchasers of personal injury protection (PIP) insurance can obtain reductions in premiums in return for agreeing to receive auto injury health services through managed care. This option provides an opportunity for reducing premium costs while maintaining a high degree of consumer choice.

  Although there are no legal barriers to automobile insurance companies offering a Colorado-type option in Washington, there is little incentive for them to do so between now and July 1, 1999, because at that time they will be effectively prohibited from selling PIP. Also, even without the Section 455(5) prohibition, few people may be willing to purchase PIP coverage if it is duplicative of their health insurance coverage.

  To some extent this is already occurring. Some consumers who have health insurance are choosing not to purchase duplicative coverage from their automobile insurance. Thus they are shifting costs from property/casualty insurance to health insurance, and realizing an individual savings. Of course, if everyone with health insurance were to cancel their PIP, individual savings would be less because everybody's health insurance costs (costs to drivers and non-drivers alike) would increase. Nevertheless, there would still be an overall reduction in health care related expenditures because duplication of coverage would be largely eliminated.

A Colorado-type option would have savings less than those indicated for the effects of Section 455(5) of the Health Services Act; and as mentioned, would not be possible after July 1999, in any event. However, the cost savings advantages of Section 455(5) assume that universal access to managed care will become a reality. If there are legal or other barriers to achieving universal access, a Colorado-type option would then become more attractive.

This study provides new information for Washington State policymakers for deciding the direction that should be taken in this area of health care reform. This report also provides information that can be of value to consumers in making individual decisions regarding eliminating duplicative coverage; and to the Insurance Commissioner for providing information about choices to consumers.

RECOMMENDATIONS

The reports makes two recommendations, the text of which appear on page ix. The first recommendation presents three issues regarding property/casualty insurance options for the legislature to consider. The second recommendation directs the Insurance Commissioner to ensure that potential cost savings from the options are passed on to consumers in the form of lower premiums.

Issues for the legislature to resolve

ACKNOWLEDGMENTS

We wish to thank the members of the review panel who critiqued our model of health services and related costs under property/ casualty insurance (these members are listed on page 5 of this report). We are also grateful to the many staff from Washington State agencies and committees of the legislature who provided assistance. We particularly appreciate the many hours of background discussion and technical review provided by the Office of the Insurance Commissioner.

This study was conducted by Bob Thomas with assistance from Robert Williams, Project Consultant, and from Martin Chaw of the LBC staff. Ron Perry was the project supervisor.

Cheryle A. Broom
Legislative Auditor

On February 15, 1995, this report was approved by the Legislative Budget Committee and its distribution authorized.

Representative Jean Silver
Chair

RECOMMENDATIONS

Summary

Recommendation 1

The legislature should address the three following issues as part of its long-term planning for health care reform:

a. Should there be a requirement that any or all health services currently covered under property/casualty insurance be provided through managed care systems?

b. If health insurance, HMOs, and government take over financial responsibility for health services currently covered by property/casualty insurance, should an additional tax be imposed on property/casualty premiums to pay for this cost shift?

c. In the event that the Health Services Act's provisions for universal access to managed care cannot be fully implemented, should Section 455(5) of the act be modified or repealed?

Legislation Required:	Yes, if any option but the status quo is pursued.
Fiscal Impact:	Action on any of the options would result in savings to consumers.
Completion Date:	Before July 1, 1999.

Recommendation 2

Whatever policy direction the legislature takes, the Insurance Commissioner should be involved in ensuring that the cost savings from any option are passed on to consumers in the form of lower premiums, and that consumers are made aware of the options for reducing duplicative insurance coverage.

Legislation Required:	Only if the legislature wishes to give specific direction to the Insurance Commissioner.
Fiscal Impact:	Savings to consumers.
Completion Date:	Before July 1, 1999.

BACKGROUND

Chapter One

Overview

The Health Services Act of 1993 contained the following mandate:

> On or before December 1, 1994, the legislative budget committee, whether directly or by contract, shall conduct a study related to coordination of certified health plans and other property and casualty insurance products. The goal of the study shall be to determine methods for containing costs of health services paid for through coverage underwritten by property and casualty insurers.
>
> The study shall address methods to integrate coverage sold by property and casualty insurance companies that covers medical and hospital expenses with coverage provided through certified health plans.

WHAT ARE CERTIFIED HEALTH PLANS?

Under the Health Services Act, certified health plans are disability insurers, health care service contractors or health maintenance organizations, certified by the Insurance Commissioner, and providing benefits included in the uniform benefits package (UBP). The UBP defines the health services that must be offered to all Washington residents in managed care settings. Through a series of phase-in steps, by which larger and larger numbers of individuals become covered, all Washington residents are supposed to be members of certified health plans by July 1999. (This assumes that there are no legal or other barriers to full implementation of the Health Services Act.)

WHAT IS MANAGED CARE?

Managed care is a term used to characterize a continuum of care delivery systems. Its purpose is to efficiently allocate quality services through coordinating and managing patient care. Generally, at the most restrictive end of this continuum are health maintenance organizations (HMOs). Enrollees in HMOs receive comprehensive pre-paid benefits only through health care providers employed or associated with the HMO. Utilization of services and referrals to specialists are subject to approval. At the least restrictive end of this continuum are preferred provider organizations (PPOs) that are associations of providers. Enrollees in PPOs can use either providers within the PPO or outside of it. However, if they go outside, the PPO will reimburse costs at a lower rate. There are a number of hybrid types of managed care in between HMOs and PPOs.[1]

The Health Services Act defines managed care as a system of health services delivery that: "(1) assumes financial risk for delivery of services and uses a network of providers; or (2) uses such means of assuming risk and promoting the efficient delivery of services as capitation, prospective payments, resource-based relative value scales, fee schedules, or similar methods of limiting payments to health care providers."[2]

These means of delivering health services is in contrast to the traditional fee-for-services system in which individuals choose their health care providers, and those providers set their own fees.

WHAT IS PROPERTY/CASUALTY INSURANCE?

Property/casualty insurance indemnifies people for losses due to accidents and other mishaps. The types of property/casualty insurance that cover health care costs related to illnesses and injuries include:

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[1]In the broadest definition of managed care, almost any kind of cost-control mechanism, such as utilization review by insurance companies, would qualify as managed care.

[2]RCW 43.72.010 (16)

- workers compensation
- personal automobile
- commercial automobile
- general (other) liability (including products liability)
- medical professional liability (medical malpractice)
- commercial multiple-peril (including business owners)
- homeowners
- farmowners

Automobile insurance is an example of p/c insurance

These coverages can be further broken down into either fault-based or cause-based. Fault-based coverages, such as personal automobile bodily injury, *reimburse other persons* when the insured person is at fault. This is also called third party insurance. Cause-based coverages, such as automobile personal injury protection (PIP) and workers compensation, are no-fault systems that *reimburse the insured party* regardless of the cause (i.e., as long as the injury involves a car or takes place at work, respectively). This is also called first party insurance.

Two types of p/c insurance: fault and no-fault

Nationally, workers compensation accounts for approximately 47 percent of the $30 billion spent per year on health services under property/casualty insurance. In this state, property/casualty insurance companies have very little involvement in workers compensation. Coverage is either provided through a state fund, administered by the Department of Labor and Industries (L&I), or through self-insurance by some of the larger employers.

This study does not include the workers compensation portion of property/casualty insurance. The Health Services Act mandated two other studies related to workers compensation. One study, being conducted by the Health Services Commission with the assistance of L&I, includes a review of potential cost savings or other impacts of various options for coordination and integration. An interim report on this study will be completed on or before January 1, 1995. The final report is due by January 1, 1996.

The other study is a managed care pilot project overseen by the Department of Labor and Industries. It will be assessing the effects of managed care on the cost and quality of medical services provided to injured workers; and will attempt to gauge the level of employer and employee satisfaction with the program. The pilot project will be concluded by January 1, 1996, and its results presented to the governor and the legislature by October 1, 1996.

WHAT DO "COORDINATION" AND "INTEGRATION" MEAN?

Coordination means that property/casualty insurance companies continue to have the financial responsibility for the costs of health services resulting from the types of accidents and mishaps they cover. Under our state's laws, property/casualty insurance is deemed to be "primary." This means that in the case of duplicative coverage, between health insurance and property/casualty insurance, the property/casualty companies ultimately have to pay for the health services costs, up to policy limits. Thus a health insurer may provide services and incur a cost, but they can seek reimbursement of these costs from the property/casualty company.

Integration means that property/casualty companies are either: (1) prohibited from selling health care coverage; or (2) they are limited in their participation (e.g., they cannot duplicate coverage provided by the uniform benefits package).

HOW MUCH DOES PROPERTY/ CASUALTY INSURANCE SPEND ON HEALTH SERVICES?

$327 million spent in 1993

In Washington State, approximately $327 million was spent in 1993 on health services and related administrative expenses under the property/casualty coverages included in this study. Personal and commercial automobile insurance accounted for $263 million, or about 80 percent of the total.

WHAT WAS THE STUDY APPROACH?

This study involved two major research efforts: (1) estimating health service and related costs within property/casualty insurance,

and (2) identifying options for coordination and integration and their cost impacts.

Estimate of Health Services and Related Costs

We began by estimating the health services and related costs incurred under property/casualty insurance (excluding workers compensation). Our estimates are based on 1993 dollars. The approach we took generally follows the methodology and assumptions used by the Insurance Services Office, Inc. (ISO) in its 1993 publication entitled *Health Care Costs in the Property/ Casualty Insurance Industry*. Whenever we could, we used data specific to Washington State rather than the national data used by ISO. We also expanded on ISO's definition of costs by including all related insurance company administrative expenses. The ISO study includes only loss adjustment expenses.[3]

Estimates in report are representative of actual costs

We were assisted in this endeavor by a review panel consisting of: the two largest in-state companies selling property/casualty insurance (SAFECO and PEMCO); the three largest out-of-state insurance companies doing business in this state (State Farm Insurance, Farmers Insurance Company, Allstate Insurance Company); three national insurance organizations (the American Insurance Association, the Alliance of American Insurers, and the National Association of Independent Insurers); two attorney organizations representing opposing sides in insurance claims (the Washington State Trial Lawyers Association and the Washington Defense Trial Lawyers); and the Office of the Insurance Commissioner.

Panel members critiqued our preliminary cost estimates and made valuable suggestions for improvement. We believe that our cost estimates, which serve as the starting point for the remainder of this study, are representative of actual costs.

Identify Options and Estimate Their Cost Impacts

Our second research effort involved three steps: First, we identified options for coordinating or integrating the health services that are

[3]Loss adjustment expenses are for such things as claims adjusters salaries, litigation costs, and payments for expert witnesses. Other kinds of expenses we included were sales commissions, brokers' fees, taxes and licenses.

provided under property/casualty insurance and certified health plans. Next, we selected seven of these options that would be representative of the broad array of possible options. Finally, we estimated the potential cost impacts of the seven selected options.

We found that existing data, research, and analysis on the topic of coordination and integration of these health services are very limited. The cost impacts included in this report are, therefore, best estimates based on available information. Sensitivity analyses of our estimates are included in Appendix 4, which follows a discussion of major assumptions in Appendix3.

Cost impacts of options can be compared

Although there are limitations to the data, it is nevertheless possible to reach some conclusions after comparing the options. The conclusions one can draw concerning how and why the cost impacts differ, and the magnitude of those differences, are not very sensitive to changes in the major assumptions. What is meant by this can be explained as follows: Under certain assumptions, hypothetical Option X has twice the savings as hypothetical Option Y. By changing the assumptions, the amounts of savings under both options changes. Nevertheless, the relationship between them (Option X still has twice the savings as Option Y) remains the same.

To reiterate what we feel is important to be understood about our estimates: (1) We have a high degree of confidence in our estimate of 1993 health services and related costs under property/casualty insurance. (2) Our estimates of potential cost impacts of options for consolidation and integration are generally more tentative, but they are illustrative of the magnitude of the costs at issue, and they allow for a comparison of alternatives.

This cost model can be used by Washington State policy makers and other interested parties for examining a variety of different policy alternatives.

COST CONTAINMENT OPTIONS

Chapter Two

Overview

There are many ways of coordinating or integrating property/casualty health services with the system of managed care established by the Health Services Act. We learned of several possibilities by referring to an earlier version of the Health Services Act that mentioned specific options for review by the LBC. We also consulted with the Insurance Commissioner's Office, surveyed other states, and reviewed a proposal that was submitted for inclusion within President Clinton's proposed Health Security Act.

Again, options for ***coordination*** assume that property/casualty insurance companies continue to be involved in selling policies that cover the provision of health services up to policy limits. Thus the financial responsibility for injuries and illnesses remains with these companies.

Options for ***integration*** assume that either the companies are prohibited from selling health care coverage, or are limited in their ability to do so (e.g., they cannot duplicate the coverage of the uniform benefits plan). This would result in a transfer of financial responsibility from property/casualty insurance to certified health plans.[1]

Options can also be categorized as to the extent to which they result in actual utilization of managed care.

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[1]The term "integration," in addition to being used in the Health Services Act, is the same term used in President Clinton's proposed Health Security Act (Title X, Subtitle C, Sec. 10201). In the debate over national health care reform, the shift of financial responsibility from property/casualty insurance to health plans has also been referred to as "merger."

WHAT ARE THE OPTIONS?

The seven options we have selected are summarized on the following pages. As an aid to understanding, each option is preceded by an example of how the option would apply in the case of personal automobile insurance.

Option 1: Effects of Universal Managed Care

Estimated annual system savings total $6.7 million

Example from Personal Automobile Insurance

This option does not assume any changes to the existing automobile insurance system. Due to the Health Services Act, however, more auto insurance policyholders will be enrolled in managed care. The cost control mechanisms within managed care will lower the cost of health services paid for by auto insurance. This will result in lower premiums to consumers.

Availability of managed care will reduce costs...

Under the Health Services Act, all residents of the state are required to be enrolled into certified health plans no later than July 1, 1999.[2] Certified health plans are to provide health services through managed care.[3]

...but incentives still exist to utilize higher cost care

Option 1 was chosen in order to show the savings in property/casualty insurance that would result from universal managed care. It should be noted, however, that the Health Services Act requires only enrollment in certified health plans. It does not require that each individual will elect to receive health services exclusively within a managed care setting. This is an important distinction, because in the case of illnesses and injuries covered under property/casualty insurance, there are incentives for high utilization of health services. These incentives would lead some people to choose to go outside of managed care organizations for their care.

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[2]RCW 43.72.210. There are exceptions to this requirement if people object to enrollment based on religious beliefs or if they are employed by out-of-state employers.

[3]RCW 43.72.100.

For instance, when individuals covered by property/casualty insurance are injured due to the actions of others, they can sue for two types of losses: economic (which include health services costs) and non economic. Payments made for economic losses are called special damages. Payments for non economic losses, such as for pain and suffering, are called general damages. The amount of general damages that insurance companies pay is usually related to the severity of an injury and the perceived degree of pain and suffering it causes. A case may be made that an injury is of greater severity if more health services are utilized. For example, the need to receive several exams and dozens of treatments for a back sprain may suggest that the injury is more severe than an injury that receives only one exam and two treatments.

Higher health care costs can lead to higher general damages awards

In some cases, too, the amount of general damages is related to how much is spent on health care services. Thus not only is there is an incentive to utilize more services, but also higher cost services as well.[4]

For purposes of estimating the cost impacts of Option 1, we have initially assumed that 69 percent of property/casualty injury claims will have reduced costs due to universal access to managed care. Sixty-nine percent corresponds to our estimate of the percentage of claims at present that do not have extraordinarily high costs. We have assumed that the remaining 31 percent of claims would respond to the incentives for high utilization of more expensive services. The basis for this assumption is discussed in detail in Appendix 3. The use of 69 percent makes our estimate of the effects of universal access to managed care conservative. The use of a much higher percentage, given the fact that access will not always mean utilization, might overstate the effects of the Health Services Act. Appendix 4 includes a scenario in which 100 percent is used for the sake of comparison.

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[4]There are debates over the extent to which general damage settlements are negotiated as a multiple of economic losses, and whether there is any reliable rule of thumb (such as general damages are usually three times special damages). One study has suggested that a main reason why it is hard to say anything definite about general damage multiples is that different companies may use different multiples. And as we have seen, insurance company practices may also vary by state. See John E. Rolph, et al., *Automobile Accident Compensation: Volume I: Who Pays How Much How Soon?*, Rand Corporation, the Institute for Civil Justice, 1985.

Option 2: Voluntary First Party Managed Care

Estimated annual system savings total $28.1 million

> Example from Personal Automobile Insurance
>
> Under the present automobile insurance system, companies must offer you the option of purchasing no-fault insurance that will cover injuries to yourself (first party) regardless of who causes the injuries. You are not required to purchase this coverage.
>
> Under Option 2, if you decide to purchase no-fault insurance, your insurance company will agree to charge you a lower monthly premium if you, in turn, agree that you will receive health services, related to an auto injury, from a managed care organization. If you do not choose this option, you will be charged the regular price.

Voluntary restriction of choice can result in savings to consumers

First party coverage, here, refers to the insurance that individuals, or employers on behalf of employees, purchase on a no-fault basis. The typical form of such insurance in this state is offered under automobile insurance and is called Personal Injury Protection, or PIP.[5] In Washington, automobile insurance companies must offer PIP coverage, but there is no obligation for anyone to purchase it. In some other states PIP coverage is mandatory.

Option 2 is based on a program offered in the state of Colorado. Under this program, purchasers of no-fault PIP can receive a reduction in their automobile insurance premium if they agree that in the event of an injury they will receive their health services from a managed care organization designated by the insurance company. Some of the insurance companies offering this program in Colorado have indicated that it is important that the companies choose the managed care organization. We have not assumed any difference in savings related to whether the insurance company or the policyholder makes the choice.

[5]PIP usually covers passengers and pedestrians in addition to the driver, and covers economic losses, such as lost wages, in addition to health services costs. Another form of no-fault automobile coverage that is also offered in this state is called Medical Payments. It does not cover other forms of economic loss.

An important distinction between this option and Option 1 is that the decision of whether managed care will be utilized is made *in advance* of an injury. Once an injury occurs, participants in the program must use managed care in order for their costs to be covered by their PIP policy.

For purposes of illustration, we have assumed a participation rate of 75 percent when we estimate cost impacts. This means that 75 percent of people currently purchasing no-fault insurance will decide to enroll in this program.[6]

It should be noted that as larger percentages of people obtain health care, through the universal coverage mandated by the Health Services Act, fewer people may choose to purchase duplicative no-fault coverage. Thus, this option would likely not be viable under a system of universal coverage. Even absent universal coverage, this option would probably be beneficial primarily for people who drive but do not have health insurance.

Option 3: Mandatory First Party Managed Care

Estimated annual system savings total $35.2 million

Example from Personal Automobile Insurance

All individuals who elect to purchase no-fault coverage for themselves must receive health care services related to auto injuries from managed care organizations if they wish to have the costs paid by their PIP coverage.

This is the same as Option 2, exeept that it assumes that participation in such a program by no-fault PIP purchasers is required by law. However, there is still a voluntary decision on the part of automobile insurance purchasers whether they want no-fault PIP coverage.

[6]Based on information from a limited number of insurance companies in Colorado, the percentage of new policyholders who choose to enter the program ranges from 50 percent to 90 percent, depending on what company is offering the program. The percentages of existing PIP policyholders opting for the program varies widely, from "very minimal" to 90 percent.

Option 4: Mandatory Managed Care for Both First Party and Third Party Coverage

Estimated annual system savings total $78.7 million

Example from Personal Automobile Insurance

If you have injuries that are the result of an auto accident, you must receive health care services related to those injuries from a managed care organization. This option applies to injuries regardless of who causes them, and regardless of who purchased the insurance covering the injury.

For example, the law currently requires that all drivers carry bodily injury insurance. This insurance covers injuries to others when you are at fault. Under Option 4, if you cause injury to others, the other person must receive care for their injuries from a managed care organization. Your insurance company will reimburse the managed care organization for these services, up to policy limits.

Eliminating choice results in the highest savings

This option applies to all persons insured under the property/casualty policies included in this study. Thus it is much broader in application than Options 2 and 3, which cover only those people who purchase first party, no-fault insurance.[7] Another important distinction between this option and Options 2 and 3 is that it includes many individuals who:

- Have injuries or illnesses caused by a third party (i.e., not themselves);
- Did not purchase the insurance covering the injury or illness, but would nevertheless be compelled to receive health services in managed care settings.

[7]The way that insurance data is reported, it was not possible to show numbers of persons insured under each type of coverage.

Option 5: Integration of First Party Coverage: Voluntary Managed Care (Section 455(5) of the Health Services Act of 1993)

Estimated annual system savings total $47.9 million ($46.5 million from property/casualty insurance and $1.4 million from health insurance)

Example from Personal Automobile Insurance

You can no longer purchase no-fault insurance for yourself. The uniform benefits package offered by your certified health plan provides the same coverage that you used to have under your first party, no-fault auto policy. All individuals are enrolled in certified health plans.

If you are injured in a car accident and it is your fault, you can either use the services of your certified health plan, or go outside of the plan and pay more.

Savings from the Health Services Act equal $47.9 million per year

Section 455(5) of the Health Services Act contains the following language:

> After July 1, 1999, no property or casualty insurance policy issued in this state may provide first party coverage for health services to the extent that such services are provided under a uniform benefits package covering the resident to whom such property or casualty insurance policy is issued.

This is the first of the remaining options considered in this report that involve some degree of integration. That is, they would either take property/casualty insurance companies out of certain lines of business of covering health services, or would limit the companies' participation. Under this particular option, integration is only partial. First party, no-fault coverage is integrated, but third party, fault-based coverage is not. Fault-based coverage pays for 73 percent, or $239 million, out of the total $327 million spent by property/casualty companies directly related to health services costs.

We do not know what health services will be covered by the uniform benefits package in 1999. In this and the remaining options, we have assumed that current property/casualty coverage will be fully duplicated by the uniform benefits package.

The implementation date of July 1, 1999, for Section 455(5) is the same date that all Washington State residents are expected to be enrolled in certified health plans. Therefore, they will not only have access to managed care (assuming successful implementation of the Act), but they will have an incentive to utilize managed care: services outside of managed care would not be paid for by PIP insurance. A resulting higher utilization of managed care would lead to additional savings in health care costs.

There are also some efficiencies that would result from this and other integration options that would not occur under the coordination options: Some expenses of property/casualty insurance companies related to handling claims for losses due to injuries and illnesses would be reduced, because they would be out of the business of insuring against such losses under first party coverage. Some of the expenses of health insurers and health maintenance organizations, which are related to claiming reimbursements from property/casualty insurance companies, would also be reduced.

Option 6: Integration of Both First Party and Third Party Coverage: Mandatory Use of Managed Care

Completely eliminating duplicative coverage ads more savings

Estimated annual system savings total $125.9 million ($121 million from property/casualty insurance and $4.9 million from health insurance)

Example from Personal Automobile Insurance

Nobody can purchase automobile insurance that pays for the costs of health services related to auto accidents. This includes health services for injuries of others that you cause, and injuries to yourself caused by others.

You are enrolled in a certified health plan, and you must receive care from this plan if you are in an auto accident. You cannot go outside of your certified health plan for services, even if you are willing to pay more for those services.

This is similar to Option 4, but has additional savings by eliminating duplicative coverage through integration. All injured and ill parties would be included, and all would share in the benefits of reduced costs through managed care.

Option 7: Full Integration Combined with a Pure no-fault System

Estimated annual system savings total $1,256.8 million ($1,251.9 million from property/casualty insurance and $4.9 million from health insurance)

Example from Personal Automobile Insurance

Nobody can purchase automobile insurance that pays for the costs of health services related to auto accidents. This includes health services for injuries of others that you cause, and injuries to yourself caused by others.

You are enrolled in a certified health plan, and you must receive care from this plan if you are in an auto accident. You cannot go outside of your certified health plan for services, even if you are willing to pay more for those services.

Furthermore, you can no longer sue for general damages.

This option would prohibit litigation for general damages

Option 7 is based on a proposal submitted by the Insurance Commissioner of the state of California to President Clinton's health care team. It would result in a full integration, and would simultaneously combine this integration with a pure no-fault law. Full integration means that all of the financial responsibility for illnesses and injuries is shifted to health insurance, HMOs, and government programs. A pure no-fault law means that all litigation for general damages is prohibited.

(Note: Many states have no-fault laws, but in most cases this means that there are certain verbal or monetary thresholds that must be crossed before litigation is allowed. Verbal thresholds are descriptions of the extent or kinds of injuries for which general damages can be sought. Monetary thresholds are amounts of economic losses that must be sustained before a claim for general damages can be brought.)

Our version of this option includes not only automobile insurance, but the other property/casualty coverages as well.

With the inclusion of a pure no-fault system, this alternative goes beyond issues of coordination and integration. *We have included it as an option because it has been a subject in the debate over national health care reform, and it is the only option that would completely capture all of the potential saving from general damages.*

COST ESTIMATES

Chapter Three

Overview

Exhibit 1 on the following page displays estimates of the potential cost impacts of the seven options. Appendix 4 shows the results of sensitivity analyses in which we changed major assumptions to see what influence they have on cost estimates and on relative differences in impact among options. Explanations of the components of our estimates follow.[1]

Components of the Estimates

Column A: Direct savings from property/casualty insurance

The amounts in this column derive from reductions in the amount of incurred losses from claims due to the use of managed care and/or related reductions in insurance company administrative and claims handling costs.

Options 2 through 7 include the effects of Option 1.[2]

Column B: Health insurance expenses

Health insurance companies, HMOs, and government providers of health care are eligible for reimbursement when their clients suffer injuries or illnesses that are covered by property/casualty insurance. The legal term that describes both the right to reimbursement and the process used to pursue it is called subrogation.

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[1]Double recovery, which is sometimes cited as a major cost component, is not included in our estimate. Appendix 3 discusses why we concluded that double recovery of losses by injured persons is not a significant cost in Washington.

[2]If one wants to identify the net effects of any of the Option 2 through 7, the amount shown for that option should be reduced by the amount for Option 1.

EXHIBIT 1
ESTIMATED COST IMPACTS

OPTION		Column A DIRECT P/C	Column B HEALTH INS ADMIN	Column C MAXIMUM ONE-TIME SAVINGS	Column D MAX POTENTIAL GEN DAMAGE SAV
	Coordination				
1	Universal Managed Care	$6,749,588	$0	$440,962	$12,779,607
2	Voluntary First Party	$28,053,903	$0	$5,306,024	$29,472,552
3	Mandatory First Party	$35,203,472	$0	$6,927,696	$35,036,767
4	Mandatory All Coverage	$78,676,637	$0	$28,752,202	$162,255,914
	Integration				
5	Sec 455(5)	$46,522,918	$1,364,467	$6,927,696	$35,036,767
6	Full Integration: Mandatory	$121,023,209	$4,852,924	$29,193,165	$162,255,914
7	Full Integration / Pure No-fault	$1,251,867,985	$4,852,924	$139,963,726	$0

Amounts displayed are annual unless indicated as one-time

Under the options for integration, there would be no need for subrogation and its associated expenses. The financial responsibility for claims would be shifted to the health insurance companies, HMOs, and government providers.

Owing to the limited data available for this analysis,[3] the amounts shown in Column B should be considered rough estimates of health insurance savings that would result from options for integration.

Column C: Maximum one-time savings

Property/casualty insurance companies establish loss reserves to cover all of the expected future costs of a claim from the date of injury. For 1993, a conservative estimate of the overall property/casualty ratio of reserves to incurred losses would be approximately 2.3 to 1.[4] This translates into total loss reserves for health services in Washington of about $635 million.[5]

The practice of establishing reserves in health insurance is different. Health insurance companies and HMOs have reserves only large enough to cover the delay between when discrete services are rendered and premiums are paid. This might amount to only two or three months of medical costs.

If this state were to pursue an integrated approach to providing health services, there would be a question of how the property/casualty reserves would be controlled and spent. An article that deals with this subject, and discusses some of the options for spending down the reserves, is included as Appendix 5.

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[3]Overall health care expenditures for Washington must be estimated based on data for national expenditures. Also, not all sources of expenditure (e.g., health insurance, Medicaid, Medicare) have the same potential for subrogation. Further, the information we have for subrogation expenses comes from only one insurer.

[4]We call this a conservative estimate because the reserves associated strictly with losses from health services costs may be higher ratios than for other types of losses. Our data sources did not break down the type of losses for which reserves are established.

[5]Direct losses related to health services (not including any related expenses) were $271 million in 1993, so estimated reserves for these losses were $635 million. We based this estimate on nationwide averages. Since the national data is not broken down between fault and no-fault automobile coverage, we used the reserve ratios from one company who had this information available.

There are potential excess reserves that could be captured as savings

There is also a question of what to do with excess reserves. For example, if Option 6 (Full integration: Involuntary managed care) were to be implemented on July 1, 1999, and if property/casualty reserve practices remained the same until then, there would be excess loss reserves equal to the percentage cost reduction resulting from Option 6 times the reserve amount. That is, if Option 6 were to result in health services savings of 23 percent, then 23 percent of the amount in reserves would be in excess. This excess would be a one-time savings.

Under all options there is the potential for one-time savings. The only reason these savings would not be fully realized would be if there were a policy decision to exempt certain claims. For instance, a person under Option 6 who is injured on June 30, 1990, might be covered by a grandfather clause. All of their future health claims associated with that injury might be made exempt from mandatory managed care.

Because there might be policy and other practical limitations on capturing all of these one-time savings, we have identified the maximum amount of the possible range. The estimates shown in Column C are the reserves for the amounts shown in Column A. Potential one-time savings from Column D are not included.

Column D: Maximum potential savings from general damages

This column displays the general damages and related expenses associated with the health care costs identified in Column A. These are labeled maximum potential savings because, except in one case, we do not have a way of reasonably estimating what the savings would actually be.[6] ***Therefore, the amounts in Column D should be viewed as the upper limits to ranges whose bottom limits could be relatively small amounts.***

It should also be noted that although some initial savings from managed care should be expected on the general damages side, such savings might only be transitory. To the extent that general damages are awarded or settled as multiples of economic losses, an overall lowering of economic losses may eventually lead to a higher multiple for general damages.

[6]See pp. 23-24 for further discussion of this matter.

The one exception to the foregoing caveats pertains to Option 7. Since a pure no-fault system would eliminate all general damages, we have defined these savings as direct savings. That is why the amount shown in Column E is $0, and one reason why the amount shown in Column A is relatively large.

Exhibit 2 summarizes some of the information so far given about the options included in this report.

Costs to State Government

Presently there is a tax of 2.1 percent on property/casualty insurance premiums. We have excluded any savings for this in Exhibit 1 *(e.g., assumes that the tax would be adjusted to continue to maintain tax collections at the current amount).*

Effects on Insurance Premiums

Of likely interest to consumers would be the effects that the various options would have on insurance premiums. This would be difficult to show in an exhibit, however, because of limitations to the data and to the comparability of coverages.[7] Nevertheless there are some examples we can give that indicate the percentage savings that consumers might expect.

Options 2 and 3

The experience of automobile insurers in Colorado, with the program for voluntary, first party managed care, was that they were able to offer the participants reductions of 20 to 25 percent on their PIP rate. However, since PIP is only a portion of the cost of automobile premiums, the percentage reduction on the entire premium would be lower.

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[7]For example, we can calculate an average percentage premium savings for Option 2, but this percentage would apply to all policy holders, not just the individuals who would choose to participate in the program.

Also, some lines of coverage include much higher proportions of property damage coverage than others. Showing savings as a percent of the total premium may not result in useful information about how options compare.

EXHIBIT 2

CHARACTERISTICS AND ESTIMATED COST SAVINGS OF THE OPTIONS

FINANCIAL RESPONSIBILITY TO PROPERTY/CASUALTY INSURANCE (COORDINATION) OR CHP'S (INTEGRATION)?	DEGREE OF CONSUMER CHOICE CONCERNING UTILIZATION OF MANAGED CARE MORE CHOICE ⟷ LESS CHOICE		
COORDINATION (Health Ins. and P/C Ins.)	**OPTION 1** - (Estimated Annual Cost Savings = $6.7 million) **OPTION 2** - (Estimated Annual Cost Savings = $28.1 million)	**OPTION 3** - (Estimated Annual Cost Savings = $35.2 million)	**OPTION 4** - (Estimated Annual Cost Savings = $78.7 million)
INTEGRATION (Health Insurance Only)		**OPTION 5** - (Estimated Annual Cost Savings = $47.9 million)	**OPTION 6** -(Estimated Annual Cost Savings = $125.9 million) **OPTION 7** - (Estimated Annual Cost Savings = $1,256.8 million)

KEY

1ST PARTY COVERAGE - Coverage of the insured party
3RD PARTY COVERAGE - Coverage of parties other than the insured party, when the insured party is at fault

OPTION 1 - Effects of universal managed care
OPTION 2 - Voluntary managed care for first party property/casulty coverage
OPTION 3 - Mandatory managed care for first party property/casulty coverage
OPTION 4 - Mandatory managed care for both 1st and 3rd party property/casulty coverage
OPTION 5 - 1st party coverage integrated into certified health plans, managed care voluntary
OPTION 6 - Both 1st and 3rd party coverage integrated into certified health plans, managed care mandatory
OPTION 7 - Both 1st and 3rd party coverage integrated into certified health plans, managed care mandatory, pure no-fault

Options 4 and 6

This example also uses personal automobile insurance. Options 4 and 6 apply to all policy holders, not just PIP purchasers who participate in a program. Managed care, under both of these options, is mandatory. The average reductions to total personal auto insurance premiums from the direct effects (Column A effects) of these options would be 3 percent and 5 percent, respectively. Under less conservative assumptions about the effects of managed care on third party claims, the percentages would be higher. Note that these are percentages of total premiums, which include large amounts for property damages and losses due to general damages.

Option 7

Under Option 7, which eliminates general damages, the average premium reduction for personal automobile insurance would be 45 percent.

WHAT EXPLAINS SOME OF THE DIFFERENCES BETWEEN COST IMPACTS?

Many of the differences between the estimated cost impacts shown in Exhibit 1 are likely to be apparent from the discussion of the options so far. Here we will reemphasize some of the major reasons why the cost impacts differ, and provide some additional information and explanations about some of the major assumptions we used in making these estimates.

Estimating the Effects of Managed Care

In estimating the cost impacts of the options, we made distinctions between the general effects of managed care (reduction to overall health care expenditures) and how managed care would specifically effect the costs of health services under property/casualty insurance.

The Health Services Commission has estimated a range of savings attributed to the general effects of universal managed care of between 0 to 10 percent. This would be the percentage reduction on health care premiums once all state residents are enrolled in

certified health plans providing managed care. This range is lower than the reduction percentages commonly attributed to managed care because the base premium against which it is calculated already includes a substantial degree of participation in managed care.[8] The upper limit of this range, 10 percent, would result if all residents were enrolled in the most restrictive models of managed care. The Health Care Commission is assuming that premiums will be reduced by an average 4 percent in the earlier phase-in stages of universal enrollment.

Our basis for assumptions about managed care impact

Both the range of 0 to 10 percent and the initial assumption of 4 percent for Washington are consistent with the results of studies that have looked at the question from a national perspective.[9] We used 4 percent in our estimate of the effects of universal ***access*** to managed care. These effects are shown in Option 1. Again, we assumed that access does not necessarily lead to utilization. We assumed (under Option 1) that for a portion of claims, the injured parties would go outside of their managed care organization for health services. This portion is approximately 31 percent.

When we estimated the cost impact of a higher ***utilization*** of managed care for injuries and illnesses covered by first party, no-fault insurance, we assumed a 22.5 percent reduction. This is based on the midrange of the actual cost savings experience of automobile insurance companies in Colorado. The managed care provided in the Colorado model does not, for the most part, require financial participation (copayments and deductibles) by injured parties. If such financial participation were included, cost savings would be higher.[10] A further discussion of our reasons for using 22.5 percent as an initial assumption is included in Appendix 3.

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[8]Washington is characterized as having a high participation rate, between 50 and 75 percent, depending on how managed care is defined.

[9]These studies are discussed in Appendix 3.

[10]When we speak of policyholder financial participation resulting in greater savings, we are not referring to reduced premium amounts that result from people being partially self-insured by paying deductibles. Instead, we are referring to the more conservative use of services that results when people experience a direct relationship between their extent of service utilization and their out-of-pocket costs.

For options in which all the health services paid for by property/casualty insurance are provided through managed care, regardless of whether there is first party or third party coverage, we used a very conservative estimate of a 22.5 percent reduction in health services costs. This is the same assumption used for cost reductions under first party coverage alone. We consider this to be very conservative for the following reasons:

- While only 40 percent of the injuries covered under first party, no-fault insurance are eligible for general damages claims, 100 percent of third party, fault-based claims are eligible. It should be recalled that first party, no-fault coverage in this state simply means that the costs of the insured injured party will be covered, regardless of who is at fault. There is no prohibition against a person with this type of coverage from pursuing a fault-based claim against a third party. We estimate that 40 percent of injuries covered by first party coverage are eligible for such claims.

  Within the property/casualty coverages included in this study, the fault-based claims far outnumber the no-fault claims. Liability claims can result in settlements or awards for general damages. As such, they are particularly subject to the incentives for higher utilization of more expensive health services.

- Claims that have attorney representation typically, and on average, experience higher health services costs. Attorney representation of fault-based claims is almost double that of no-fault claims.

Why our assumptions are conservative

A good case can be made for much higher assumption than 22.5 concerning the effects of managed care in reducing costs when all injuries and illnesses covered under property/casualty insurance must receive health services through managed care.

As stated previously, the estimates derived from these assumptions should be considered tentative. We recognize that arguments can be made for using higher or lower numbers. Appendix 4 shows the results of sensitivity analyses in which we employ different numbers. As will be seen, the rankings of the options by the amount of cost savings would remain the same regardless of changes to the major assumptions.

Direct Savings From Property/Casualty Insurance

The difference between Options 2 and 3 is explained by our assumption of 75 percent voluntary participation under Option 2 versus 100 percent involuntary participation under Option 3.

Option 4 savings are larger than those for Option 3 because all coverages under Option 4 include mandatory managed care. Option 3 pertains to first party, no-fault coverage only. Option 5 savings are higher than for Option 3 because there are additional savings associated solely with integration. Options 3 and 5 have the same level of participation in managed care.

Part of the reason why the estimated cost impact of Option 7 is such a relatively large number is that we assumed that most lost adjustment expenses (claims adjusters, legal costs) would be eliminated in a pure no-fault system. For all of the other options, we assumed that most of the loss adjustment expenses were fixed. (See below for a discussion of general damages in relation to Option 7.)

Health Insurance Expenses

There are no savings from Options 1 through 4 (coordination options) because subrogation would still take place between health insurance and property/casualty insurance. Differences between the remaining options (integration options) are due to whether the options pertain to all claims or only to first party no-fault claims.

Maximum Potential Savings From General Damages

With the exception of Option 7, each of the estimated maximum savings from the reduction in general damages payments is derived from ratios of general damages to special damages (which include economic losses such as health services costs). The maximum potential amounts are estimated as multiples of health services cost savings (not including expenses). For example, if savings related to health services were $10 million, and the multiple of general damages to economic losses was two, the potential maximum saving from general damages would be $20 million.

Option 7 is calculated differently. The amount of the reduction attributed to general damages is based on all health services costs (not just the amount saved due to managed care). This is because there would be no general damages associated with these costs within a pure no-fault system. This estimate also includes a reduction of general damages related to other economic losses such as wage loss.

WHAT ARE SOME OF THE MAJOR TRADEOFFS BETWEEN OPTIONS?

In the course of this study we have become aware of many complex and well-reasoned arguments, pro and con, concerning the advisability of implementing the kinds of options we have selected. While we cannot hope to do full justice to these conflicting points of view within the confines of this report, we at least want to touch on some of the major trade-offs between options.

Choice Versus Savings

Higher degrees of restriction on choice in decisions of whether to utilize managed care result in higher savings to consumers. Among the options considered in this report, restrictions occur in four ways. These are listed below in ascending order of cost impact. They are also described graphically in Exhibit 2.

Restrictions on choice result in higher savings

1. Consumers can choose whether to purchase first party no-fault insurance. If they decide to make a purchase, they can further choose to agree to receive future health services through managed care in return for a lower insurance premium.

   In this case there can be a restriction in source of health care, but there are two voluntary decisions that lead to this point.

2. Consumers who have chosen to purchase first-party, no-fault insurance have to receive services through managed care unless they want to pay for additional services out of pocket.

   In this case there is one voluntary decision that can lead to a restriction in the source of health care.

3. Consumers have access to managed care, but they can no longer purchase first-party insurance. If they receive services outside of managed care, they have to pay out of pocket.

4. All injured parties, regardless of the cause of injury, must receive health services through managed care.

   In this case there is no choice involved at any point.

Linkage Between Behavior and Cost

Integration could have undesirable side effects...

Under the current property/casualty insurance system, individuals or companies that cause injuries or illnesses pay higher premiums. The risk of paying higher premiums may act as an incentive to engage in behaviors that reduce the likelihood of causing injuries or illnesses. Options for integration have the potential to weaken this linkage.

...that could be mitigated by a change in the tax structure

Among the options for integration, some individuals would subsidize others (e.g., non drivers will subsidize drivers).[11] One way to at least reduce the degree of subsidization is to place an additional tax on property/casualty insurance premiums. This may also be a way to restore some of the linkage between behavior and cost. People or business who cause injuries and illnesses will have higher premiums due to property losses and general damages to the injured parties. If a tax is placed on the premium, behavior that causes higher premiums will result in a higher tax payment. The proceeds from this tax could be used to reduce the tax on health insurance and HMOs.

It should be noted, however, that the situation described above occurs even presently, without integration. Many individuals who have health insurance do not purchase no-fault automobile insurance. As participation in certified health plans increases, more people may decide to forego or to drop their no-fault automobile insurance.

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[11]This kind of subsidy is already occurring to the extent that people have health insurance but do not carry PIP or Medical Payments. If they are injured in an automobile accident and are at fault, the health insurer cannot subrogate, and must pay for the costs of the health services rendered.

Coordination Versus Integration

Options for integration have additional savings related to property/casualty insurance companies reducing their claims handling expenses, and the elimination of subrogation expenses for health insurers, HMOs, and government programs. However, coordination maintains a stronger linkage between behavior and cost, and avoids the necessity of an additional tax to mitigate subsidization.

Pros and Cons of Reducing or Eliminating General Damages

Option 7 goes beyond health care reform and enters the realm of tort reform. In exchange for substantially reduced insurance premiums, consumers would no longer be entitled to remedies for pain and suffering; and individuals and entities whose negligence or carelessness has caused harm to others may not be held financially responsible. Other sectors of our economy would also be affected: for example, plaintiff's attorneys typically receive 30 percent of liability awards.

Most states have not implemented pure no-fault systems.[12] Instead, even the so-called no-fault states typically allow for litigation for general damages once certain monetary and/or verbal thresholds are crossed. The advantages and disadvantages of even these limited no-fault systems are the subject of much debate and of conflicting opinions. These debates center around the issues of limiting individuals' access to justice, and whether the various no-fault systems result in reductions to insurance premiums.

[12]Michigan is the only state we have seen referred to as having a pure no-fault system. According to the Washington State Trial Lawyers Association, this state's system has been modified several times and is facing another major change this year in the form of a referendum.

FINDINGS AND RECOMMENDATIONS

Chapter Four

Overview

The Health Services Act of 1993 states that while immediate steps must be taken to stabilize the cost of health services, reduce the demand for unneeded services, and provide access to services for all, a long-term plan of reform is also needed.

The Act mandated numerous studies that were intended to inform the debate over the shape that long-term reform would take. This report provides information that state policy makers did not have available in 1993.

Utilization of managed care can significantly reduce costs

The research conducted for this study strongly suggests that the utilization of health services in managed care settings for injuries and illnesses covered by property/casualty insurance can significantly reduce the average cost of claims for health-related losses. Although universal access to managed care under the Health Services Act will contribute to reduced costs within these coverages, the major potential for health care savings comes from options that encourage or require individuals to receive their health services from managed care rather than through other sources. Options for either coordination or integration can encourage or require higher utilization.

Overall, we have identified six options for either coordination or integration with savings ranging from $7 million to as much as $126 million annually. There is also a seventh option, a pure no-fault option that includes tort reform, that could save as much as $1.3 billion.

Under the Health Services Act, there is a requirement for enrollment in certified health plans providing managed care, but no requirement that individuals always utilize the services provided by these plans.

Although options that involve mandatory managed care can produce the greatest savings, they do so largely at the expense of consumer choice. Exceptions to this rule allow consumers to decide if they want to purchase the kind of coverage that restricts their choice of health services.

Three policy issues need to be addressed:

Based on the results of our analysis, we see three policy issues that need to be resolved. They are:

- Limit choice?

1. Should there be a requirement that any or all of the health services currently covered under property/casualty insurance be provided through managed care systems?

- Change tax structure?

2. If health insurance, HMOs, and government take over financial responsibility for health services currently covered by property/casualty insurance, should an additional tax be imposed on property/casualty premiums to pay for this cost shift?

   A cost shift would occur because some of the costs currently borne by property/casualty insurance would, under integration options, have to be covered by health insurance, HMOs, and government programs.

   There would also be a question of how or whether to make up for lost revenue from the tax on property/casualty insurance premiums.

- Modify Health Services Act?

3. In the event that the Health Services Act's provisions for universal access to managed care cannot be fully implemented, should Section 455(5) of the act be rescinded or modified?

Currently, the Health Services Act addresses the first issue by stating its intent that individuals and businesses have the option to purchase any health services they may choose in addition to those included in the uniform benefits package or supplemental benefits.[1]

The second issue is not addressed.

As for the third issue, the legislature included language in Section 455(5) of the Act that prohibits the sale of first party coverage that would duplicate services provided under the uniform benefits plan.

[1]RCW 43.72.005.

This prohibition becomes effective on July 1, 1999. Thus by this language, the Health Services Act takes a step in the direction of integration of services.

If no changes were made to the Health Services Act, overall annual savings related to the health services covered by property/casualty insurance would be those indicated under Option 5 in this report. Option 5 combines the effects of making managed care accessible to all, encouraging higher utilization of managed care, and of eliminating certain claims handling and administrative costs.

However, one effect of the current language of the Health Services Act is that it prevents the implementation of other options also having the potential for savings. As examples:

Some options and savings are precluded by the Act

- None of the savings identified within the options that would result from making the ***utilization*** of managed care ***mandatory*** would be permissible under the current wording of the Health Services Act. These options have relatively greater potential for savings than other options, but do so at the expense of limiting choice.

- Although there are no legal barriers to automobile insurance companies offering a Colorado-type option in Washington, there is little incentive for them to do so under Section 455(5) of the Health Services Act, which severely limits the sale of such coverage after July 1, 1999. Other states are pursuing this kind of option because of the opportunities it has for reducing premium costs while maintaining a high degree of consumer choice.

  However, these states have not provided for universal access to health care. It should be noted that the health care coverage offered under PIP may be duplicated by the uniform benefits package. Since all individuals will be enrolled in plans that provide services at least equal to the uniform benefit package, few people may choose to purchase PIP. To some extent this is already occurring. Some people who have health insurance are choosing not to purchase duplicative coverage from their automobile insurance.

  As competing alternatives, Section 455(5) has a cost-saving advantage over the Colorado option. However, some of the

savings from Section 455(5) result from having universal access to managed care. If universal access to managed care does not become a reality, retaining the limitation within Section 455(5) on the sale of first-party, no-fault insurance would be disadvantageous to some consumers (those who drive but would not have health insurance).

Thus for a Colorado-type option to be viable in this state, PIP coverage might have to be made mandatory.

This study provides new information for Washington state policy makers for deciding the direction that should be taken in this area of health care reform. This report also provides information that can be of value to consumers in making individual decisions regarding eliminating duplicative coverage; and to the Insurance Commissioner for providing information about choices to consumers.

RECOMMENDATIONS

Recommendation 1

The legislature should address the three following issues as part of its long-term planning for health care reform:

a. ***Should there be a requirement that any or all health services currently covered under property/casualty insurance be provided through managed care systems?***

b. ***If health insurance, HMOs, and government take over financial responsibility for health services currently covered by property/casualty insurance, should an additional tax be imposed on property/casualty premiums to pay for this cost shift?***

c. ***In the event that the Health Services Act's provisions for universal access to managed care cannot be fully implemented, should Section 455(5) of the act be modified or repealed?***

Recommendation 2

Whatever policy direction the legislature takes, the Insurance Commissioner should be involved in ensuring that the cost savings from any option are passed on to consumers in the form of lower premiums, and that consumers are made aware of the options for reducing duplicative insurance coverage.

SCOPE AND OBJECTIVES

Appendix 1

The goal of this mandated study is to determine methods for containing costs of health services paid for through coverage underwritten by property and casualty insurers.

The study will address methods to coordinate and integrate coverage sold by property and casualty insurance companies that covers medical and hospital expenses with coverage provided through certified health plans.

AGENCY RESPONSE

Appendix 2

- **Washington State Insurance Commissioner**

DEBORAH SENN
Washington State Insurance Commissioner

December 22, 1994

Ms. Cheryle Broom, Legislative Auditor
Legislative Budget Committee
P.O. Box 40910
506 16th Avenue S.E.
Olympia, Washington 98501-2323

Dear Ms. Broom:

Thank you for your letter regarding the recommendations of staff regarding the report titled, "Options for Coordinating and Integrating Property/Casualty Insurance With Certified Health Plans." As you probably know, Legislative Budget staff met with my staff several times in the preparation of the report. The report itself contains multiple recommendations to the Legislature that will have differing outcomes.

However, I would agree with the intent of Recommendation 2 on page 30 of your report. "The Insurance Commissioner should be involved in ensuring that the cost savings from any option are passed on to consumers in the form of lower premiums, and that consumers are made aware of the options for reducing duplicative insurance coverage." I believe this is less than a clear mandate ("be involved") to take specific action, and further clarification will need to take place in order to clarify my role in the process at some future date.

Sincerely,

DEBORAH SENN
Insurance Commissioner

DS:PM:bc

Insurance Building, P.O. Box 40255, Olympia, WA 98504-0255 Phone: (206) 753-7300

COST MODEL ASSUMPTIONS

Appendix 3

Introduction

The appendix includes information about the major assumptions used in our cost model. It also provides explanations of some of the assumptions that are of lesser importance, but may be of interest to the reader.

A familiarity with the assumptions discussed in this appendix will aid in understanding the results of the sensitivity analysis included in Appendix 4.

General Effects of Universal Managed Care

Of the many studies available concerning the cost-effectiveness of managed care, three in particular address the issue of how current costs of health care, which include some degree of managed care, will compare to costs once managed care is universally available. They are:

- Congressional Budget Office, *The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures*, August 1992 (revised).

  This study presents a range of estimates of the potential effects of universal managed care on national health care expenditures. The range of estimated potential savings is .5 to 10.8 percent, depending on the kinds of managed care that will be provided.

- Lewin-VHI, Inc., *The Financial Impact of the Health Security Act*, December 9, 1993.

  Lewin's estimate is part of its well-regarded study of the Clinton plan. For 1998, with full implementation of the proposed plan, the estimate for savings in health care spending is 2.34 percent.

- Washington Health Services Commission conducted study.

  The Foster Higgins Company is estimating the potential impact of universal managed care for Washington State under the Health Services Act. They estimate a range of savings on premiums of 0 to 10 percent, depending on the kinds of managed care that will be provided. They estimate that 40 percent of the potential maximum of 10 percent (i.e., 4 percent) will be realized at first.

We used Foster Higgins' estimate of 4 percent as an initial assumption. We then made an adjustment to this assumption when we estimated the effects of universal managed care on health services costs covered by property casualty insurance.

Mandatory Use of Managed Care for PIP Coverage

In 1991, the Colorado legislature made some changes to its insurance system. As a result of one of these changes, people who purchase Personal Injury Protection (PIP) from automobile insurance companies can now receive a reduction in premium if they agree to receive injury-related health service from managed care organizations designated by the insurer.

At first, many of the insurance companies set their reduced rates by consulting with managed care organizations and reviewing closed claims. They compared what unmanaged claims had previously cost to what the same claims might cost under managed care. They estimated reductions in the range of 20 to 25 percent and set rates that passed on these reductions to people who entered the program. More recently, some companies who started out at 20 percent have increased their reduction by a few percent based on experience.

Before deciding to use an assumption for savings in the range of 20 to 25 percent, we put this assumption to several tests:

Apart from what we have been told by individual companies, do the data reported by all companies show cost savings?

We were particularly interested in answering this question because we were concerned that self-selection by purchasers might only result in people choosing managed care who were already inclined to use managed care. Data reported by the companies to the National Association of Insurance Commissioners shows an increase in Colorado PIP average loss costs up to 1991, then a decrease in 1992 and 1993. While loss costs in Colorado have been going down, they have been going up countrywide.

Are there significant differences between the insurance, health, and legal systems in Colorado and Washington that would invalidate the use of Colorado cost reduction figures for our state?

From what we were able to determine, these two states share much in common, and their differences do not appear to be such that we would reject the PIP cost reduction range for use in our estimates. Certainly, there are other states that have much less in common with Washington. Listed below are some of systems features we looked at.

No-fault medical benefit limits

WA = $10,000 to $30,000 plus
CO = $10,000 to $50,000

Negligence Rules

Some states have *contributory* negligence rules, which are based on common law. Generally, these rules mean that defendants are not liable if the plaintiffs are also negligent. Most states now have *comparative* negligence rules, in which the relative negligence of each party to an accident is taken into account. A study by the Rand Corporation concluded that more accident victims were likely to receive compensation for their injuries under comparative rules than under contributory negligence rules.[1] Both Washington and Colorado have comparative negligence rules, but they differ as follows:

WA = Pure form. The amount of money for which a defendant is liable is reduced in proportion to the plaintiff's negligence.

CO = 49 percent rule. The defendant is not liable if the plaintiff was at least 50 percent negligent. If the defendant is liable under this rule, they then must pay based on their percentage of negligence.

The Rand study referenced above was unable to conclude that there was any difference in claim payment amounts under states with different *comparative* negligence rules.

Fault/No-fault

Colorado is a called a no-fault state. As with most other no-fault states, what this means is that there is a tort threshold that has to be crossed in order for someone to bring a damage claim against another person. Colorado has both monetary ($2,500) and verbal thresholds.

[1]James K. Hammitt, *Automobile Accident Compensation: Volume II: Payments by Auto Insurers*, the Rand Corporation, the Institute for Civil Justice, 1985, p-p. 48-52. See also Volume IV of this series on state rules.

Washington is a called an add-on state. There are no thresholds for bringing claims against third parties, but first party, no-fault coverage (Personal Injury Protection and Medical Payments) is also available. In WA this coverage is optional. In some other states it is mandatory.
While Colorado's monetary tort threshold results in some injuries not resulting in claims against third parties, the threshold also presents a target for economic losses such as medical expenses. There are incentives for people to utilize more expensive medical services more frequently to reach the target.

Attorney Representation

In 1993, 32 percent of automobile insurance claims in Colorado had attorney representation, while in Washington the figure was 31.3 percent.

Participation in Managed Care

Both states are characterized as having high participation levels.

Would any data specific to this state suggest whether the range of 20 to 25 percent is a reasonable range for Washington?

We approached answering this question by first trying to understand why the savings from the Colorado option would be so much higher than the 4 percent we are assuming to be the general effect of managed care. A large part of the answer appears to be that there are many claims that have extraordinarily high health services costs compared to other claims related to similar injuries. If the costs of these claims can be brought down to the average cost of claims that are not extraordinarily high, significant savings can result.

We used attorney representation as a surrogate for estimating the number of claims with extraordinarily high costs. Many studies over the years have demonstrated that claims with attorney representation have higher economic losses (which are mostly health care costs). For 1993, the average amount of economic loss for auto accident claims with attorney representation was 3.56 times that of non-represented claims.[2] Of course, the fact that there is this relationship, by itself, does not explain what causes the relationship.

One study that we reviewed looked at the loss amounts in claims for the same kinds of injuries, but divided these claims into two categories: represented and non-represented. It found that claims with attorney representation have costs that were 3.84 times that of non-represented claims. These claims were judged to have had similar levels of severity

[2]Insurance Research Council, *Paying for Auto Injuries: A Consumer Panel Survey of Auto Accident Victims*, May 1994, Figure 4-7, p.31.

because none of them caused the victims to lose time from work. This study also suggested that represented claims in which the severity of injuries is difficult to determine have higher multiples of losses than claims where the severity of the injury is more definite.[3]

In Washington, approximately 19 percent of no-fault claims are represented and 81 percent are non represented. We assumed that the 19 percent of represented claims would have health care losses that were 3.56 higher than non represented. Using the represented claims as a surrogate for claims with extraordinarily high costs, we reduced the cost of these claims to the average for the non-represented claims, and then reduced the cost of all claims by 4 percent.

We further adjusted our estimate to account for two important factors:

The no-fault claims data for Washington includes the claims by passengers and pedestrians who are covered by PIP policies. In Colorado, passengers and pedestrians are not obligated to receive health services from managed care even if the purchaser of the PIP policy has obligated himself. The Assistant Attorney General, who assisted us in this study, has concluded that the same situation would exist under the laws in this state.

With one exception, the insurance companies offering this program in Colorado do not require financial participation by the accident victim in covering the costs of managed care. That is, they do not require copayments or deductibles. The 4 percent overall reduction we used does include some degree of financial participation on average.

No combination of the assumptions we used yielded an estimate of cost savings under PIP coverage lower than 20 percent. Even when no adjustments were made to account for the two factors indicated above, the estimate was 35 percent. Most combinations of assumptions resulted in estimates within the 20 to 25 percent range.

Mandatory Use of Managed Care for All Property/Casualty Health Services Coverage

The average reduction in health services costs resulting from the utilization of managed care is certainly to be greater for all coverages combined than it is for no-fault coverage alone. Here are some of the major reasons why:

No-fault coverage accounts for only 27 percent of the health services and related costs of property/casualty insurance.

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[3]All-Industry Research Advisory Council, *Compensation for Automobile Injuries in the United States*, March 1989, pp. 77-121.

All of the remaining coverage (73 percent of costs) is fault-based, and all the claims under this coverage are eligible for general damages. Only about 40 percent of no-fault claims are eligible for general damages.

Claims eligible for general damages have incentives for higher utilization of more expensive services.

Making use of managed care mandatory for all property/casualty services coverage would increase the percentage of claims eligible for general damages.

Our initial assumption of a 22.5 percent reduction in health services costs, when all claims are covered under managed care, is the same assumption we previously used for no-fault claims only. Thus this is a very conservative assumption because of the reasons mentioned above: that is, when all claims are covered under managed care, there are more claims for which incentives for higher utilization of more expensive services exist.

When we calculated the effect on third party claims costs using attorney representation as a surrogate for extraordinarily high cost claims, we arrived at a cost reduction of 35 percent. This was calculated the same way that we used attorney representation in a test of whether 22.5 percent was a reasonable cost reduction for PIP in Washington. We have used 35 percent in one of the sensitivity analyses in Appendix 3.

Specific Effects of Universal Managed Care on the Costs of Health Services Covered by Property/Casualty Insurance

As discussed throughout this report, we have assumed that universal access to managed care does not necessarily mean that people will always choose to utilize managed care services. As long as incentives exist for people to go outside of their managed care organizations for services, some people will do so. In such cases, there may be little or no cost reduction effect from managed care.

An assumption of a 4 percent reduction from managed care that would apply to all health services costs under managed care would overstate the effects of managed care. This would happen because the 4 percent assumes 100 percent utilization of managed care. If attorney representation is used as a surrogate for those claims to which the 4 percent would not apply, 31 percent of claims would involve the utilization of health services outside of managed care. This results in a more conservative estimate of the effect of managed care than would result if we had used 4 percent across-the-board. In the cost estimate for Option 1 in Exhibit 1, we used the conservative estimate of 69 percent utilization of managed care. The sensitivity analysis in Appendix 4 shows the results of 4 percent applied to the health services costs of all claims (i.e., 100 percent utilization).

Double (or Multiple) Recovery

Double recovery occurs when an individual recovers more than the total amount of his losses. This would happen, for example, if a health insurer reimbursed an accident victim for health care losses, and then the victim received recovery again from his automobile insurance company. To the extent that such double recovery occurs, all insured people pay higher premiums.
There have been some studies that have looked at this issue based on experiences within individual states, and they have concluded that double recovery is a significant problem. However, these analyses are based on data for states that have different court rules and laws concerning double recovery, and apparently different insurance industry practices in those states concerning subrogation.

From our discussions with representatives from the Office of the Attorney General, the Washington State Trial Lawyers, and subrogation specialists for the state Medicaid program, and for health and auto insurers, we have the following understanding of the issue of double recovery in this state.

Double recovery ***within*** property/casualty insurance (e.g., auto-to-auto) in Washington State would be very rare, and if it occurred by design it would constitute fraud. The state and private sector attorneys we consulted were unaware of any situations in which one might expect it to occur. Subrogation between property/casualty insurers is commonplace, and so routine that it is automatic in almost all claims for which there is subrogation potential.

Between property/casualty insurance and health insurance or HMOs, double recovery is also rare and would likewise constitute fraud if it occurred by design. There is an issue concerning the coordination of benefits between these two systems of coverage, but it is mainly one of cost shifting rather than double recovery. In Washington State, property/casualty insurance is primary. To the extent that health insurers and HMOs do not recover costs for injuries covered under property/casualty insurance, there is a cost shift. This cost shifting can be reduced through efforts to identify subrogation potential and to pursue recovery.

Subrogation Expenses

Health insurers, HMOs, and government programs have expenses associated with seeking and obtaining reimbursements when the injuries and illnesses of their clients are covered by property/casualty insurance. We found it difficult to make a firm estimate of these costs statewide for the following reasons:

> The proportion of subrogation expenses to claim expenses among health insurers, HMOs, and government agencies may vary widely.

Not all sources of health care (e.g., health insurance, Medicaid, Medicare) will have the same potential for subrogation.

We did not have actual overall health expenditure data for Washington State. This information does not exist. Instead, we used the Office of Financial Management estimates that are derived from nationwide data.
We had detailed information on subrogation expenses from only one insurer.

Therefore, as indicated in the main text of this report, the figures we cite as potential savings under this category should be considered rough estimates.

Accidents Involving Other State's Residents

We used information provided by the Department of Transportation Traffic Data Center. This information showed the percentage of traffic accidents with injuries in Washington during 1993 involving people from out-of state. From this, we estimated the number of Washington State residents that are involved in accidents out-of-state. (This percentage was assumed to be somewhat less because Washington is a tourist destination state, and more accidents involving out-of-state residents can be expected here than accidents out-of-state involving Washington State residents.)

Of the total number of accidents, approximately 83 percent involved a collision between two or more motor vehicles.[4] We assumed that Washington residents would be at fault in about half of these accidents. Based on all of this information, we assumed that 3 percent of claims costs would be exempt from any cost reduction effects from managed care. Since our major cost-reduction assumption, 22.5 percent applied when managed care is mandatory, was based on actual experience, we assumed that the exemption of 3 percent of claims was already taken into account. The 3 percent exemption, therefore, was applied only to Option 1.

[4]Insurance Research Council, *Paying for Auto Injuries*, May 1994, Appendix 1, Table 2-1, p. 37.

SENSITIVITY ANALYSIS

Appendix 4

The four tables included in this appendix show the effects on our estimates of cost impacts of changing some of the major assumptions. The results of these changes should be compared to the estimates from our initial assumptions, which are displayed in Exhibit 1, Chapter 3.

Scenarios (A) and (B)

As discussed in Chapter 3 of this report, we used 4 percent in our estimate of the effects of universal access to managed care in reducing property/casualty health care costs. Scenario (A) assumes that the reduction is 1 percent, while Scenario (B) assumes that it is 10 percent. These changes to our initial assumption represent the likely lower and upper limits of the effects of universal access.

Scenario (C)

This scenario maintains the initial assumption of 4 percent for the cost-reduction effect of universal access to managed care, but it assumes that 100 percent of property/casualty injury claims will experience these reduced costs. We initially assumed that 69 percent of claims would be subject to the 4 percent reduction.

Scenario (D)

When we estimated the cost impact of required utilization of managed care for injuries and illnesses covered by first party, no-fault insurance, we assumed a 22.5 percent reduction in health care costs. This assumption was based on the actual experience of automobile insurance companies in the state of Colorado.

For an initial assumption, we also used the 22.5 percent to estimate the effect of required utilization on third party, fault-based insurance. This was a very conservative assumption because the incentives for high utilization of more expensive services are greater, on average, for third party claims. Scenario (D) shows the effect of using 35 percent for the cost-reduction impact of required managed care on fault-based claims. Thirty-five percent was derived by multiplying 22.5 percent by:

percentage of attorney-represented third party claims/
percentage of attorney-represented first party claims.

SCENARIO (A)
ESTIMATED COST IMPACTS
1% GENERAL REDUCTION FROM MANAGED CARE

OPTION		Column A DIRECT P/C	Column B HEALTH INS ADMIN	Column C MAXIMUM ONE-TIME SAVINGS	Column D MAX POTENTIAL GEN DAMAGE SAV
	Coordination				
1	Universal Managed Care	$1,687,594	$0	$27,560	$3,194,902
2	Voluntary First Party	$23,100,492	$0	$4,892,622	$19,887,847
3	Mandatory First Party	$30,250,061	$0	$6,514,294	$25,452,061
4	Mandatory All Coverage	$73,723,226	$0	$28,752,202	$152,671,209
	Integration				
5	Sec 455(5)	$41,678,089	$1,364,467	$6,514,294	$25,452,061
6	Full Integration: Mandatory	$116,069,797	$4,852,924	$28,779,763	$152,671,209
7	Full Integration / Pure No-fault	$1,246,914,574	$4,852,924	$139,963,726	$0

Amounts displayed are annual unless indicated as one-time

SCENARIO (B)
ESTIMATED COST IMPACTS
10% GENERAL REDUCTION FROM MANAGED CARE

OPTION		Column A DIRECT P/C	Column B HEALTH INS ADMIN	Column C MAXIMUM ONE-TIME SAVINGS	Column D MAX POTENTIAL GEN DAMAGE SAV
	Coordination				
1	Universal Managed Care	$16,873,574	$0	$2,756,013	$31,949,017
2	Voluntary First Party	$37,960,725	$0	$7,621,075	$48,641,962
3	Mandatory First Party	$45,110,295	$0	$9,242,747	$54,206,177
4	Mandatory All Coverage	$88,583,459	$0	$28,752,202	$181,425,324
	Integration				
5	Sec 455(5)	$56,212,576	$1,364,467	$9,242,747	$54,206,177
6	Full Integration: Mandatory	$130,930,031	$4,852,924	$31,508,215	$181,425,324
7	Full Integration / Pure No-fault	$1,261,774,807	$4,852,924	$139,963,726	$0

Amounts displayed are annual unless indicated as one-time

SCENARIO (C)
ESTIMATED COST IMPACTS
4% ACROSS-THE-BOARD GENERAL REDUCTION FROM MANAGED CARE

OPTION		Column A DIRECT P/C	Column B HEALTH INS ADMIN	Column C MAXIMUM ONE-TIME SAVINGS	Column D MAX POTENTIAL GEN DAMAGE SAV
	Coordination				
1	Universal Managed Care	$12,428,680	$0	$855,017	$25,878,049
2	Voluntary First Party	$33,611,176	$0	$5,720,079	$42,570,994
3	Mandatory First Party	$40,760,746	$0	$7,341,751	$48,135,209
4	Mandatory All Coverage	$84,233,910	$0	$28,752,202	$175,943,145
	Integration				
5	Sec 455(5)	$51,958,372	$1,364,467	$7,341,751	$48,135,209
6	Full Integration: Mandatory	$126,580,482	$4,852,924	$29,607,220	$175,943,145
7	Full Integration / Pure No-fault	$1,261,109,054	$4,852,924	$139,963,726	$0

Amounts displayed are annual unless indicated as one-time

SCENARIO (D)
ESTIMATED COST IMPACTS
35% REDUCTION ON FAULT-BASED CLAIMS SUBJECT TO INVOLUNTRAY MANAGED CARE

OPTION		Column A DIRECT P/C	Column B HEALTH INS ADMIN	Column C MAXIMUM ONE-TIME SAVINGS	Column D MAX POTENTIAL GEN DAMAGE SAV
	Coordination				
1	Universal Managed Care	$6,749,588	$0	$440,962	$12,779,607
2	Voluntary First Party	$28,053,903	$0	$5,306,024	$29,472,552
3	Mandatory First Party	$35,203,472	$0	$6,927,696	$35,036,767
4	Mandatory All Coverage	$108,227,139	$0	$60,404,856	$246,095,827
	Integration				
5	Sec 455(5)	$46,522,918	$1,364,467	$6,927,696	$35,036,767
6	Full Integration: Mandatory	$145,124,781	$4,852,924	$60,845,818	$246,095,827
7	Full Integration / Pure No-fault	$1,275,969,558	$4,852,924	$196,395,518	$0

Amounts displayed are annual unless indicated as one-time

ARTICLE ON LOSS RESERVES

Appendix 5

The $100 Billion Question

Casualty insurers could lose control of more than $100 billion of loss reserves if the Administration's health care reform proposal is enacted. Where would the money go?

By L. Howard Wizig*

L. Howard Wizig is a consultant in the Kansas City office of Tillinghast. He specializes in managed health care consulting, including managed workers compensation and 24-hour coverage, and has extensive experience in the design, development and implementation of managed care products. Mr. Wizig is a graduate of Washington University in St. Louis.

More than $100 billion of casualty insurance loss reserves may be up for grabs if the Clinton Administration's anticipated health care proposal reaches Congress in its current form. The Administration has indicated that its health insurance plan will cover medical services now provided by workers compensation (WC), auto and other liability insurance. So far, little public attention has focused on the fate of an estimated $105 billion of reserves set aside for WC, auto and other liability medical care payments.

Who will control this money if health care reform passes? is an intriguing question. The answer could depend on how current differences in financing medical services under WC, auto, liability and health insurance are resolved.

When Is a Claim Incurred? In workers compensation, a claim is "incurred" at the date of injury. Therefore, the payor (e.g., insurer or self-insured) is responsible for all claim payments associated with the injury, regardless of when medical services are rendered. Accounting for injuries on a date-of-injury basis conforms to a principle of workers compensation, that employers are liable for all future costs stemming from a compensable workplace injury.

Auto and other liability insurance occurrence policies follow the WC approach by using the date of injury as the incurred date. Because costs associated with a particular injury can extend over many years, payors establish sizable reserves to cover these future payments.

Medical loss reserves at the end of 1994 for WC, auto and other liability coverages are estimated to be $105 billion. This represents approximately 2.3 years' worth of payments in 1994 dollars.

Date of Service. Health insurance operates quite differently from WC, auto and other liability insurance. Employers offer group health insurance to cover the current non-occupational medical expenses of employees and their families.

Group health insurance pays only for health care services rendered during the period the employee is covered by the program. Therefore, except for preexisting conditions and limited extension of benefit provisions, health insurance considers a claim incurred at the date treatment is delivered. It does not reserve for future services associated with today's injuries or illnesses because these are covered by the benefit plan (if any) in place at the time of service. Thus, health insurance establishes reserves but only to cover the natural delay between the time medical services are rendered and claims are paid — usually only two to three months of medical costs.

If Congress passes the unified medical plan now under discussion, a single definition of an incurred claim would probably be chosen for all future health care services. Adopting a strict date-of-injury definition would require that every group health claim in the first year of the new definition be treated as a "new" claim. The cost of paying these claims plus funding the reserves for all future treatment of these injuries would initially be very expensive. The experience of WC, auto and other liability coverages indicates that a transition from date of service to date of injury could triple the first-year premium costs. It is unlikely that the nation would support such an increase. Hence, it is more likely that a date-of-service claim definition for future medical claims will be adopted.

*Cecily Gallagher (San Antonio) and Tim Quinn (Minneapolis) contributed to this article.

Type of Coverage	Estimated 1994 Medical Loss Payments	Medical Reserves at 12/31/94
WC	$25.6B	$56.7B
Auto	15.9	27.3
Other Liability	3.5	21.1
Total	$45.0	$105.1

Accountable Health Plans (AHPs), organized networks of health providers, a cornerstone of Clinton's health care reform proposal, would increase premiums beyond current group health rates to cover medical services formerly paid for under WC, auto and other liability insurance. AHPs would also subject these costs to the claim management and premium competition mechanisms fundamental to the Administration's anticipated health care reform program.

Although it is probable that a date-of-service definition would eventually be applied to all future injuries, three basic options are available to handle the one-time $105 billion transition from date of injury to date of service. Who would control the reserves set aside for these services? The answer depends on which option is chosen.

Total Runoff. This option would require the existing payors to retain responsibility for medical services related to past injuries. The current reserves would be used to fund this cost. The AHPs would be responsible for all future injuries, on a date-of-service basis.

At present, the premiums charged by casualty insurers are intended to fund all current and future medical services related to an injury. Under the Total Runoff option, the AHPs would not have to fund the future services, and many current services would be paid from the reserves of casualty insurers. Most claims would be paid in the first five years, but the full transition could take more than 20 years.

During the transition period, total premiums would be reduced approximately by the amount funded in each year from the prior reserves ($105 billion total impact, excluding any other effects of health care reform). The $105 billion would be a permanent premium savings because these reserves would not need to be funded in the future using a date-of-service definition of a claim.

Furthermore, to the extent the new medical system is successful in reducing medical costs, the current reserves could be overstated. Thus, current reserve holders will benefit from AHP-negotiated provider payments and medical management programs. Of course, the AHPs would need to increase premiums in future years as they assume responsibility for services that were previously paid from these reserves.

Immediate Conversion. Alternatively, responsibility for all future costs could be transferred immediately. Under this approach, health plans would cover all ongoing medical services, including those associated with previous WC, auto and other liability occurrences. Therefore, medical reserves now being held for WC, auto and other liability injuries would no longer be needed by those holding the reserves (since they would no longer be responsible for these claims). If these reserves are released, then the terms on all existing insurance contracts would have to be retrospectively redefined.

Delayed Conversion. This option involves a partial transition. For example, prior payors could be responsible during the first 24 months for all costs related to injuries before adoption of the health care reform package. AHPs would take responsibility for all claims thereafter.

Containing elements of both the first and second options, Delayed Conversion also has a one-time impact of $105 billion (absent the other cost implications of health care reform). This is a result of the blending of the savings in the total AHP and casualty premiums for services that the prior payor will fund, and the potential reserve release for the remaining services that the prior payor will not be required to fund.

Under the first option, Total Runoff, virtually all of the reserves would remain with the current payor. Under the second and third options, a decision must be made concerning how much of these reserves belong to the current insurer, the insured, the self-funded employer, the federal or state governments or the AHPs responsible for future payments.

However the transition to a date-of-service definition is accomplished, the one-time impact from the Administration's health care reform program will likely total more than $100 billion. The public should consider the implications of such a change when judging the advantages and disadvantages of the Clinton proposal. □