Statement
of
The Property Casualty Insurers Association
of America
to
The National Committee on Vital and
Health Statistics (NCVHS)
Subcommittee on Standards

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My name is Keith Bateman, Vice President for Workers Compensation for the Property Casualty Insurers Association of America (PCI). PCI is a national property casualty insurance trade association with over 1,000 member insurance companies. In 2010, PCI members wrote 44.0 percent of private passenger automobile insurance in the United States, 46.0 percent of commercial automobile, 42.6 percent of workers compensation, and 30.7 percent of commercial liability (commercial multi-peril, other commercial liability, product liability, and medical malpractice insurance).

This hearing is held pursuant to section 10109 of the Patient Protection and Affordable Care Act which instructed the Secretary of Health and Human Services by January 1, 2012, to "seek input" about whether the administrative simplification standards and operating rules should apply to health care transactions of automobile insurance, workers compensation and other programs or persons not described in 42 U.S.C.1320d-1(a).

The Property Casualty Insurers Association of America was asked to address the issue in the context of property casualty coverages. Because other presenters have been asked to comment on specific property casualty coverages, PCI's presentation will be a high level overview so that you are not receiving repetitive information.

The Health Insurance Portability and Accountability Act (HIPAA) and Property Casualty Coverages

In enacting HIPAA in 1996, Congress recognized that property casualty medical coverages differed from those of health and that our health transaction needs were not the same. Congress enacted 42 U.S.C.A. 300gg-91 of the Public Health Service Act to exclude health benefits provided by liability insurance, workers compensation insurance, automobile insurance, and other non-covered insurance in which medical benefits are secondary or incidental to other insurance benefits.

While section 10109 requires the secretary to "seek input", the Affordable Care Act did not repeal or amend the "excepted benefits" language of U.S.C.A. 300gg-91. PCI believes that Congress made the right decision in 1996, and it remains the correct decision today.

Property Casualty Coverages Differ From Health

Common Words Don't Have a Common Meaning

In the health world, a "claim" is a bill. In the property casualty world a "claim" is a demand for payment as the result of a covered event such as a workplace injury, injury from an auto accident, injury caused by a product, etc., and involves all payments made to or on behalf of any individual (and in some cases individuals) arising from an accident or exposure.

It's uncertain how NCVHS defines "first report of injury", but it's unlikely that the property casualty definition is the same as health because our definition is not a type of health transaction involving a provider and payer.

Property and Casualty Claimants Not Enrollees

Property casualty claimants may be insureds (first party) or they may be claiming against our insureds or policyholders (third party). Workers compensation and group health may both be (at least partially) employer financed, but they are very different. In group health, employees elect to enroll and premium is tied to those enrolled. In workers compensation, the insurer has no list of covered workers. They are all covered the minute they start work, and claims may be filed for a work injury or disease even after they leave employment – in some cases even decades later.

Property casualty insurers have no relationship with third party claimants until a claim is filed, which may be well after medical expenses have been incurred, and insurers may have little information about the claimant, the injuries, or treatment received.

Third party claimants (and their medical providers) may have little incentive to cooperate with property casualty insurers and may even be openly hostile. For example, if a back injury is claimed, they may want to hide a history of prior back complaints and treatment.

Property Casualty Coverages Involve Legal as Well As Medical Issues

Our claims have a causal aspect that plays little role in health unless it leads to subrogation. Liability in property casualty is limited to claims from those that qualify as claimants, whose medical care qualifies for payment (such as being reasonable and necessary and permitted by statute) and is the result of a cause covered by the policy.

In some cases, our responsibility may be less than 100 percent because of the involvement of non-covered conditions, partial responsibility on the part of another entity, or the claimant's degree of negligence.

Depending on the type of property casualty coverage involved, the insurer may need to know whether the provider is authorized to treat such injuries, whether treatment is in conformity with state treatment guidelines, whether the bill is consistent with the state fee

schedules, whether the insurer is being billed for duplicate treatment, and whether the treatment will help the condition or impede recovery.

Property Casualty Insurers Need Medical Information that is not Directly Related to the Treatment

Insurers need to determine causation (i.e., is the cause of injury covered by the insurance or are the injuries claimed consistent with the physics of the accident?)

Information is needed to determine the extent and nature of disability and impairment. Property casualty insurers need outcome information that goes beyond a bill for a treatment.

Because it may determine which carrier is responsible, insurers need to know whether the symptoms are the result of a new injury or a flare-up of a prior one. Property casualty insurers need information to determine whether any disability or impairment may be due to causes unrelated to the accident or exposure.

Medical information also is needed regarding comordibities to assess treatment options and the duration and extent of disability or impairment. For example, workers compensation insurers have had to pay for stomach stapling and banding so obese claimants with back problems could lose sufficient weight to be acceptable candidates for back surgery.

Furthermore, medical information is necessary to assess the need for additional services such as vocational and occupational rehabilitation.

Property Casualty Coverages Are Broader Than Health

Property casualty coverages are broader than health. Yet, the items we cover require medical information to administer these coverages. In addition to medical, some coverages pay for loss of income (and medical is needed to assure that the cause of income loss is injury related), vocational and occupational therapy, work-hardening, attendant care, dental, long term care, home and vehicle modification, etc.

Under some coverages, property casualty insurers pay for lifetime treatment. In health, a claim is a bill, so you may have multiple claims with the same patent identification number. In the property casualty environment, claims are specific to an accident. Property casualty insurers may be paying for medical on one claim when the same person claims a second injury involving the same policyholder. For example, a worker who suffers one injury at work and may return to work but still be receiving medical treatment suffers a second injury. Insurers need to have a unique identifier for each claim for a variety of reasons including that indemnity benefit entitlement may be governed by date of injury and if two policy periods are involved, loss-sensitive rating may require the ability to properly allocate claims. In addition, an insurer may have claims by the same

individual against a number of policyholders under different coverages (for example: workers compensation, private passenger automobile, product liability, etc.).

Property Casualty Insurers Less Likely than Health Insurers to have On-going Business with a Provider

First, property casualty insurers are less concentrated than payers of health insurance, even if the huge market share of Medicare and Medicaid is ignored. For example, the number of reporting entities that report as primary payers to CMS under the Medicare Secondary Payer section 111 reporting requirements that are non-group health entities is about 24,000 compared to 2,000 group health reporting entities.

Another example is the degree of market concentration as measured by the Herfindahl-Hirschman Index (HHI). Unfortunately, PCI could not find data for the large group market (which is difficult to analyze in terms of claims processing because of insurers operating as both insurers and claims administrators for self-insured employers). The Kaiser Family Foundation has recently published HHI concentration data for the individual and small group health insurance markets. The Kaiser publication stated that HHI scores over 2500 indicate a highly concentrated market. In the individual insurance market, only six states were below 2500 while 12 were above 5000. There were a few more states where the small group market had scores below 2500 – eleven – while nine were about 5000. By contrast, the workers compensation insurance market is much less concentrated. Excluding the four states where private insurers are not allowed to provide workers compensation insurance, there are only seven states with scores above 2500 and all seven are states that have state funds competing with private insurers. In 29 states, the HHI workers compensation score is below 500. Private passenger automobile insurance has similar results. In only three states is the HHI about 1000, and all are below 1300. In 10 states, the HHI is below 500.

Assuming that electronic billing and payment transactions are most advantageous when there are a limited number of providers and payers regularly exchanging large volumes of transactions, the concentration ratios suggest that health has a significant advantage over the less concentrated property casualty insurance industry.

Another reason that property casualty insurers have fewer on-going transactions with providers is that much of our coverage is third party so there has to be an accident to trigger the relationship with a provider. For example, in 2003, the California Workers Compensation Institute published a study "Provider Experience in Volume Based Outcomes in California Workers Compensation". The study looked at an eight-year span. It found that two-thirds of the providers that had the predominant responsibility for treatment had only treated 1-4 workers compensation cases over that span.

Given that so much of our medical is accident driven, it must be kept in mind that low coverage limits also reduces the duration of contact with providers. For example, many automobile no-fault limits are $5000 or less. If there is an emergency room visit, that $5000 will disappear quickly, so there will be limited insurer/provider contact.

Property Casualty Coverages Differ Significantly

It is important that NCHVS understand that there are significant differences in the nature of the variety of property casualty coverages. For example, workers compensation is mandatory so employers must purchase it or qualify to self-insure. At the other extreme, there are coverages whose purchase is entirely voluntary. Coverage requirements may be set by statute (workers compensation), statute and contract, or basically by contract (general liability). Property casualty coverages may be third party (claim against the insured) or first party (claim by insured). However, this is an over simplification. For example, there can be third party beneficiaries of first party coverage.

The medical coverage obligation also varies by the type of property casualty coverage. Some provide medical that is unlimited in duration or amount, others are limited by a dollar cap and/or duration. In some cases, a single insurer has responsibility. In others multiple insurers may be overlapping responsibility (joint and several or a workers compensation occupational disease claim). In certain states for certain coverages, the insurer rather than the claimant has the choice of provider. Depending on the coverage, the insurer may pay the provider, pay the claimant to pay the provider, or pay damages rather than pay for medical treatment. Also, there may be state specific requirements for transactions to meet state policy objectives that may or may not need to be reconciled with the administrative simplification transaction sets.

HIPAA Transaction Sets and Property Casualty Coverages – Allow Evolution

Property casualty insurers recognize that they are an extremely small percentage of the total health care dollar and volume of health care transactions and that providers will eventually push the industry to accept bills electronically using the health transaction sets (for those coverages for which it makes sense). According to Table 135 “National Health Expenditures by Source of Funds 1990-2009” of the Statistical Abstract of the United States, workers compensation was 1.6 percent of the national health expenditures. The other property casualty coverages are not identified, and PCI’s efforts to obtain such data has not been successful. An even better indicator when discussing electronic transaction sets is the volume of medical bills processed. According to the National Healthcare Anti-Fraud Association, four billion health insurance claims were processed in 2007. CMS estimates that for fiscal year 2012, its contractors will process a total of 1.245 billion Medicare Part A and Part B bills. The only PCI coverage for which PCI can estimate the number of bills processed is workers compensation. Based on 2009 data provided to PCI by the Workers Compensation Research Institute for the states of California, Florida, Illinois, and Pennsylvania, PCI extrapolated the volume of medical bills to a national figure of slightly over 40 million. While there has been some pressure from the provider community to move property casualty insurers towards electronic medical transactions,

there has been limited thought given to addressing how to align state program requirements and the HIPAA transaction sets and to assure that the infrastructure is created to permit the connectivity necessary for an operational trading partner arrangement.

Even when it makes sense to ultimately move to electronic transactions, most of the property casualty industry is not ready to move there today. It must be kept in mind that health insurance has had fifteen years to reach the point it is at today on electronic transactions, and eleven years to comply with the administrative simplication standards. Even today, there are, as NCVHS pointed out in its Ninth Annual Report to Congress, standard transactions that have yet to be adopted. There are concerns that the standards are not being fully applied in a uniform manner, and 100 percent electronic billing has not been achieved. For example, a January 2010 study by the American Health Insurance Plans (AHIP) entitled “Update: A Survey of Health Care Claims Receipt and Processing Times, 2009” looked at 227 million “claims” and found that 82 percent of these had been filed electronically. It has been particularly difficult for small provider practices to comply.

Workers compensation is the coverage moving most quickly to align itself with applicable HIPAA administrative simplification transaction sets. Three states have addressed electronic billing by statute - Texas, California and Minnesota. (The Minnesota mandate covers many property casualty coverages, not just workers compensation.) A number of other states are considering moving in that direction. However, the significant financial problems faced by many states may slow down the move forward. The three states all require workers compensation insurers to accept electronic bills, but differ as to whether providers must submit bills electronically. They range from California that doesn’t require providers to submit electronically to Minnesota that mandates that providers submit electronically.

As others will explain, the states and private insurers have been working with the standard setting groups to develop work-arounds and changes that will allow us to address our needs based on the characteristics of our coverages while aligning our e-billing transactions with the applicable HIPAA transaction sets.

In those states in which property casualty insurers have been required to make the investment to accept electronic bills, PCI members feel like someone that has given a party to which no one came. A small percentage of medical bills are being submitted to property casualty insurers electronically.

Given our members’ experience to date, PCI urges the NCHVS to avoid recommending that the HIPAA administrative standards be imposed on our members. Uniformity and electronic exchanges will best be achieved if the states and private payers are allowed to evolve in that direction.

<u>Limitations on Information Collected by Property Casualty Insurers</u>

One of the questions raised by NCVHS dealt with the information submitted by providers to property casualty insurers. As pointed out earlier, not all coverages pay medical bills. As for insurer claim files, depending on the coverage, even if a provider submitted a bill with ICD-9 code, it might not have been recorded in the insurers claim file. Some insurers only recorded a verbal part of body description and description of cause of injury. Now, with the section 111 Medicare Secondary Payer reporting mandate, systems have had to be modified to record ICD-9s. For many coverages, insurers had no personal identifier information such as Social Security Number or Medicare HICN. Most property casualty insurers are still struggling with properly reporting ICD-9s, and CMS will be requiring them to move to ICD-10s once ICD-10s are operational. Just to capture information which many insurers had never collected, but now need to report to CMS, has cost millions.

PCI Urges You Not to Recommend a Mandate that Property Casualty Insurers Use the Administrative Simplification Electronic Transaction Sets

The Minnesota experience demonstrates that mandating electronic transactions will not lead to electronic billing. The infrastructure necessary to provide the resources and connectivity needed for successful electronic exchanges must be established. Without that, a mandate is an exercise in futility. Given the small percentage of transactions likely to involve property casualty insurers and the few transactions small provider organizations are likely to have with given insurers, it is likely that organizations such as clearinghouses will focus their resources on trading relationships that will produce the most "bang for the buck". PCI conducted a non-scientific Internet survey to which members responded anonymously regarding the percentage of bills received electronically in Minnesota for workers compensation, automobile no-fault, and liability (including auto). The highest percentage reported was 15 percent for no-fault, 6.7 percent for workers compensation, and 5-10 percent for liability. Most responses were one percent or less. Two companies provide unsolicited but telling comments. A workers compensation carrier notes that no e-bills have been received by its clearinghouse for Minnesota providers. It believes that some providers may be submitting electronically to their clearinghouses but the bills are not being routed. An automobile insurer noted for liability (bodily injury liability cases) the bills are provided directly by the claimant or his attorney; it has no knowledge about how the provider submitted the bill. By contrast, the Minnesota health plan trade association reports that its members receive 93 percent of bills electronically.

The Texas experience appears to be somewhat better than that of Minnesota. In its financial impact statement included in its proposed 2011 amendments to its e-billing rules, the Division of Worker's Compensation (DWC) estimated that 41.2% of all medical bills were being submitted electronically. Individual carrier experience may deviate substantially from the average. For example, we have heard individual carrier reports of percentages that are less than one-tenth of the DWC percentage estimate.

PCI does not have sufficient information to determine why the experience in Texas appears to be so much better than that of Minnesota. However, there are differences that

ought to be considered. First, the Texas mandate only applies to workers compensation. Second, while it is mandatory for both providers and payees, Texas has exhibited a greater understanding that e-billing may not make economic sense for low volume providers and payers and has been willing to grant waivers. Third, the DWC early-on recognized that connectivity issues had to be resolved if the mandate was to have any meaning, and it worked with the parties to resolve problems. Lastly, the Texas health care delivery structure may differ from that of Minnesota. In a July, 2010 report, the Workers Compensation Research and Evaluation Group of the Texas Department of Insurance noted that the top 20 percent of physicians were responsible for more than 80 percent of the Texas workers compensation market's key activities.

The differing experience found in these two states reinforces that simply mandating use of health transaction sets will not lead to electronic interchange. Moreover, it suggests that there are differences in state law provisions and the health care delivery structure that are best addressed at the state level if national health care transaction standards are to reduce administrative costs.

The health industry has had over a decade to achieve administrative simplification, and it is not yet there. Do not expect the property casualty industry to do it in less time. Market forces and state legislatures will move the industry towards electronic transactions aligned with HIPAA transaction standards. PCI urges you to allow this evolution to take place.

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