Health Insurers Need to Quickly Assess Operational Costs for Medical Services Under Healthcare Reform

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Need for action

Health insurers have a short window for understanding the operational details of their medical loss ratio (MLR) calculations. The Patient Protection and Affordable Care Act (PPACA) requires these insurers to meet minimum ratios by product line—large group, small group, and individual medical. Insurers will need to meet these requirements most likely on a state-by-state basis during 2011 and later and will need to provide rebates to insureds to the extent that the minimums are not met.

These ratios represent the proportion of an insurance carrier's spending on member medical care (the ratio numerator) divided by premium revenues (the denominator). Medical care includes certain expenses in addition to claims incurred, while revenue will be able to be reduced for specified taxes and regulatory fees. The PPACA requires plans to meet targets of 85% or higher for large group plans and 80% or higher for small group and individual medical to avoid penalties.

Although most health insurer operational costs are not likely to be considered medical care costs under PPACA rules, the law permits certain health plan functions to be included in the numerator. Making the most of this opportunity by clearly differentiating allowable from non-qualified expenses can provide insurers with critical flexibility in designing products that meet customer needs and potentially allow for greater profits.

Recommendations by the National Association of Insurance Commissioners (NAIC),[1] which are likely to significantly influence final federal regulations, list certain expenses as allowable insurer medical expenses. These include:

- Direct interactions to improve patient outcomes
- Preventing hospital readmission
- Improving patient safety and reducing medical errors
- Wellness and health promotion
- IT expense for medical care quality initiatives

While the MLR regulations pose many actuarial issues in developing final calculations, insurers should now begin developing information that supports modeling the impact of MLR regulations on benefit design and product pricing for the upcoming year. This detailed operational assessment will permit insurers to determine the need for modifications in submitting products and pricing for regulatory approval and in developing marketing strategies. Such assessments will likely be a new activity for most plans. Prior to the MLR requirements, information at this level of granularity was simply not needed to manage operations or estimate costs in regulatory submissions.

Identification of health plan medical expenses in some areas may be relatively straightforward. For example, certain healthcare quality improvement functions might be easily classified as medical costs. A wellness initiative for which a single business unit is fully responsible could be an example of a program that may be fairly simple to assess.

In other instances, the plan may need to disentangle costs allowed under the MLR rules from broader programs. For example, the health carrier's core information system may support administrative, cost containment, and healthcare quality improvement activities. Similarly, provider services and claim and medical management programs, among other areas, have the potential of supporting both medical and administrative functions under the rules.

Collecting the appropriate level of detail among departments can be complex; as a result, to meet end-of-year deadlines, plans need to quickly initiate efforts to obtain the needed level of cost detail. To complicate matters further, although the MLR rules constitute a new regulatory reporting requirement, initial guidelines may lack sufficient clarity for straightforward application to plan operations. As a result, the government regulators may continue to issue clarifications throughout at least the initial year and expect plans to be meeting the requirements specified in such clarifying guidance. Therefore, detailed information and documentation to support plan decision-

1 National Association of Insurance Commissioners, Health Reform Solvency Impact (E) Subgroup (June 18, 2010). Supplemental health care exhibit, pts. 1-3.

making and adjust to refined definitions becomes imperative in a fluent regulatory environment.

A ROAD MAP FOR COLLECTING THE RIGHT INFORMATION

Plans need to follow a clear and documented plan for comprehensive operational and IT cost information in each organizational area. The results of this effort will be to specify and quantify activities that could be classified as medical losses under the MLR guidelines. This process is important both in developing MLR calculations and in defending decisions that the plan makes to categorize its expenditures.

Steps to collect and document insurer MLR decisions include the following:

1) Conduct a baseline audit and assessment.

This step provides a starting point for identifying which programs and resources have significant potential for allocation to allowable healthcare improvement costs. It results in a high-level inventory of these programs, where they are administered, and the resources associated with supporting the operations.

Major plan areas for a baseline audit in relation to MLR requirements could include:

- Claim administration
- Provider administration
- Member services
- Medical and quality management
- Finance and accounting
- Information systems
- General administration

2) Identify and quantify potentially qualified operational units, programs, and costs.

This step drills down into the organization, its processes, and resource allocations. It provides a clearer delineation of opportunity areas and the information for developing crosswalks between program costs and interpretations of what may qualify as allowable healthcare improvement costs. It results in detailed information required for the carrier's finance and actuarial departments to assess applicability and develop the appropriate ratios.

Especially in areas with potential savings but in which medically related activities are difficult to separate out, such as certain medical management, provider education, and information technology functions, plans may consider detailed evaluation efforts involving:

- Interviewing business unit managers to clarify program goals and the nature of the medically related activities
- Analyzing annual department budgets and other cost documentation
- Delineating tasks that have the potential for supporting medically related program goals within each functional area
- Planning to demonstrate with audit intensity the justifications for reporting the expenses of qualifying healthcare improvement activities from non-qualifying tasks
- Estimating average daily time required by task in relation to program goals
- Determining number of qualifying tasks performed in a day by a single staff member
- Calculating total task direct costs
- Allocating appropriate proportion of information technology budget to task area
- Allocating appropriate portion of remaining overhead attributable to tasks
- Distributing the activity costs to the appropriate product lines

3) Document methods and findings.

Throughout the process, organizations should carefully document the activities undertaken for determining program costs and the rationales for allocations used to create estimates of activities that represent allowed medical costs. Allocations will likely be needed on a state-by-state basis for each of the three insurance markets. In this step, plans should carefully review this documentation to assure that the processes and calculations would be credible to an external reviewer.

4) Prepare MLR allocations.

The plan's financial, actuarial, and underwriting departments then need to incorporate this detailed information into the calculation of the company's MLR by product line.

5) Prepare for a regulatory audit of the reported values.

Carriers may be subject to a regulatory audit of the reported values used in their MLR calculations. The frequency and methods for this audit have yet to be specified. One way to prepare, however, is to obtain an external review of the calculations, in particular the determination of healthcare quality improvement expenses included in the calculations's numerator. Such a review would include making sure that the definitions of quality improvement expenses meet with the guidance provided by the NAIC, the expense allocation methodologies used are reasonable and defensible, and the expenses are auditable. This includes expenses deemed to be quality improvement IT costs. Ideally, the audit firm or external reviewer should have both strong financial understanding of the issues and clinical knowledge to support the claim that the services are for quality improvement. This review can be done before or after the actual final calculation, but is best before the filing date.

TARGETING OPPORTUNITIES

Expected federal guidelines appear especially likely to support allocating operational costs for quality improvement initiatives related to medical claim costs. A number of departments and resources in health insurance companies could be involved in these activities.

A key area for an assessment, however, would likely be costs associated with certain care management, quality improvement, and health promotion programs. Programs that target specific populations and quality improvement needs and use proactive interactions with members to improve quality may be especially likely to fit the characteristics that meet the federal guidelines.

Working with financial and actuarial staff responsible for MLR allocation calculations, the insurer's program and operations leaders can evaluate the potential for applying costs associated with these programs to the numerator of the MLR formula. The more costs that can justifiably be included in the numerator, the more likely it will be that the carrier will not need to pay rebates or reduce premiums in order to meet MLR requirements. The table in Figure 1 outlines examples of care and quality management programs and resources that could be considered.

GOING FORWARD

Health insurance carriers may reasonably expect MLR requirements to be part of the regulatory landscape for some time to come, although specifications and interpretations may evolve. Therefore, plans will need to continue to monitor and integrate regulatory changes and consider conducting operational audits annually that document and support compliance efforts.

Given the effort required simply to meet regulatory needs, insurers may also seek to add value through using the resulting information to improve operational efficiencies and plan performance, including operational functions in addition to those defined as medical services. Insurers could also benefit from comparing assessment findings to cost trends and external benchmarks. Furthermore, plans may consider initiatives that more closely align organizational structures to program definitions under MLR regulations and thereby minimize future challenges to MLR cost allocations.

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FIGURE 1: CARE AND QUALITY MANAGEMENT INITIATIVES, EXAMPLE PROGRAMS FOR REVIEW

OPERATIONAL AREA	POTENTIAL PROGRAMS
QUALITY MANAGEMENT	• PATIENT SAFETY AUDIT AND INTERVENTION • QUALITY EVENT TRACKING AND INTERVENTION • PROSPECTIVE PRESCRIPTION DRUG UTILIZATION REVIEW • ACCREDITATION AND CERTIFICATION ACTIVITIES
CARE AND DISEASE MANAGEMENT	• READMISSION PREVENTION PROGRAMS • MEDICATION AND CARE COMPLIANCE INITIATIVES • CARE GAP OUTREACH • PROACTIVE CASE AND DISEASE MANAGEMENT • COMORBIDITY IDENTIFICATION AND REDUCTION
WELLNESS AND HEALTH PROMOTION	• PREVENTIVE CARE OUTREACH • HEALTH IMPROVEMENT PROGRAMS
SYSTEMS AND ANALYTICS	• QUALITY FLAGGING AND EVENT MEASUREMENT • PATIENT SAFETY MEASUREMENT AND REPORTING • PREDICTIVE MODELING AND RISK SCORING • EVIDENCE-BASED CARE GAP MEASUREMENT

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