

Reduce, Reassess, Reinvest

A game plan for medical loss ratio

Medical loss ratio (MLR) overview

The Patient Protection and Affordable Care Act (PPACA) establishes MLRs as the mechanism to ensure that insurers with health business spend a minimum level of premium revenue on clinical services and activities to improve health care quality. If an insurer fails to reach the minimum level, the insurer must provide a rebate to plan enrollees. Rebates are calculated using calendar year activity, based on a formula developed by the National Association of Insurance Commissioners (NAIC). The rebate calculation must be filed with the Secretary of Health and Human Services (HHS) by June 1 of the following year, with any rebates paid by August 1 of that year.

Minimum MLRs

- ▶ Large group (101 enrollees or more) – 85% of premium revenue
- ▶ Small group (1 to 100 enrollees) – 80% of premium revenue
- ▶ Individual – 80% of premium revenue

What goes into the calculation?

Earned premium is defined in the regulation adopted by HHS as all monies received from enrollees for coverage, including fees and other contributions to the health plan. If a portion of the business is reinsured through a quota-share arrangement or other type of reinsurance contract, the ceding entity should record the premiums received from the enrollee on a gross basis. However, if an entire block of policies are reinsured under 100% assumption reinsurance, all premiums for those policies are recorded by the assuming reinsurer for the reporting year. Earned premium is adjusted for the following to arrive at premium revenue:

- ▶ Amounts paid to and received from federal and state high-risk pools
- ▶ Premiums associated with group conversion charges
- ▶ Experience rating refunds paid and received
- ▶ Unearned premiums

In addition to these premium adjustments, premium revenue used in the MLR calculation is reduced by certain federal and state licensing and regulatory fees, including income taxes.

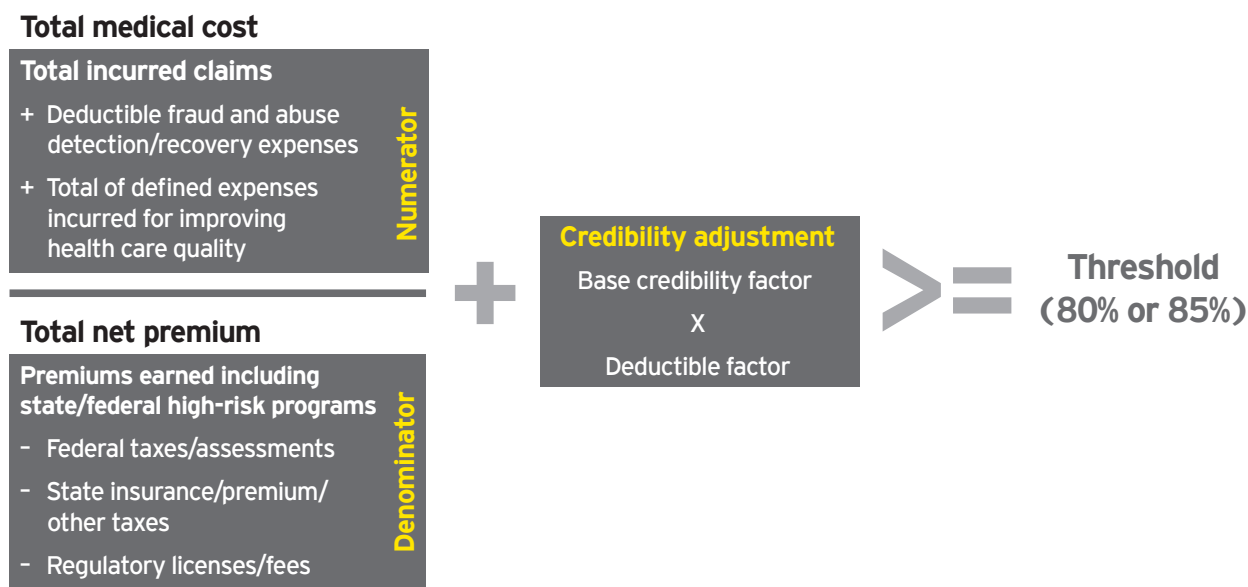
Expenses for clinical services include direct claims paid to providers, as well as claim reserves associated with claims incurred during the MLR reporting year. Activities that improve health care quality must be based on widely accepted best clinical practice and aimed toward individual enrollees or segments of enrollees. Any such activities also must be objectively measurable and provide verifiable results to enrollees. The regulation lists a number of activities to improve health care quality, including:

- ▶ Effective case management
- ▶ Comprehensive discharge planning
- ▶ Activities designed to lower the risk of facility-acquired infections
- ▶ Public health education campaigns in association with state and local health departments

Expenses that would not be considered quality improvement activities include:

- ▶ Cost containment activities
- ▶ Fraud prevention activities (with the exception of amounts recovered that reduce incurred claims)
- ▶ Activities paid for with grant money or that can be billed as clinical services
- ▶ Marketing expenses

Figure 1. MLR calculator illustrator



Fully insured plans are subject to MLR regulations, but self-insured and Medicare plans are not. States are permitted to set higher minimum MLR percentages than those established under PPACA. However, the US Department of Health and Human Services has the authority to reduce state MLR requirements if such an action is deemed necessary to prevent destabilization of the individual market.

The MLR provisions define target budgets for both medical and non-medical costs. Non-medical costs are targeted at \$.15 of each net premium dollar for large group plans and \$.20 of each net premium dollar for individual and small group plans.

Figure 2. Medical and administrative costs per premium dollar

Total net premium dollar – large group plans

Total net premium dollar – individual and small group plans



Managing the impacts of MLR

If your health plan's MLR is projected to be below target, there are generally four ways to improve the plan's MLR position: reducing administrative costs, reassessing the classification of certain administrative costs to determine if they can legitimately be moved to the health care or quality improvement side of the ledger, reinvesting savings into your membership's wellness and reducing premiums. In this paper, we'll examine the first three paths

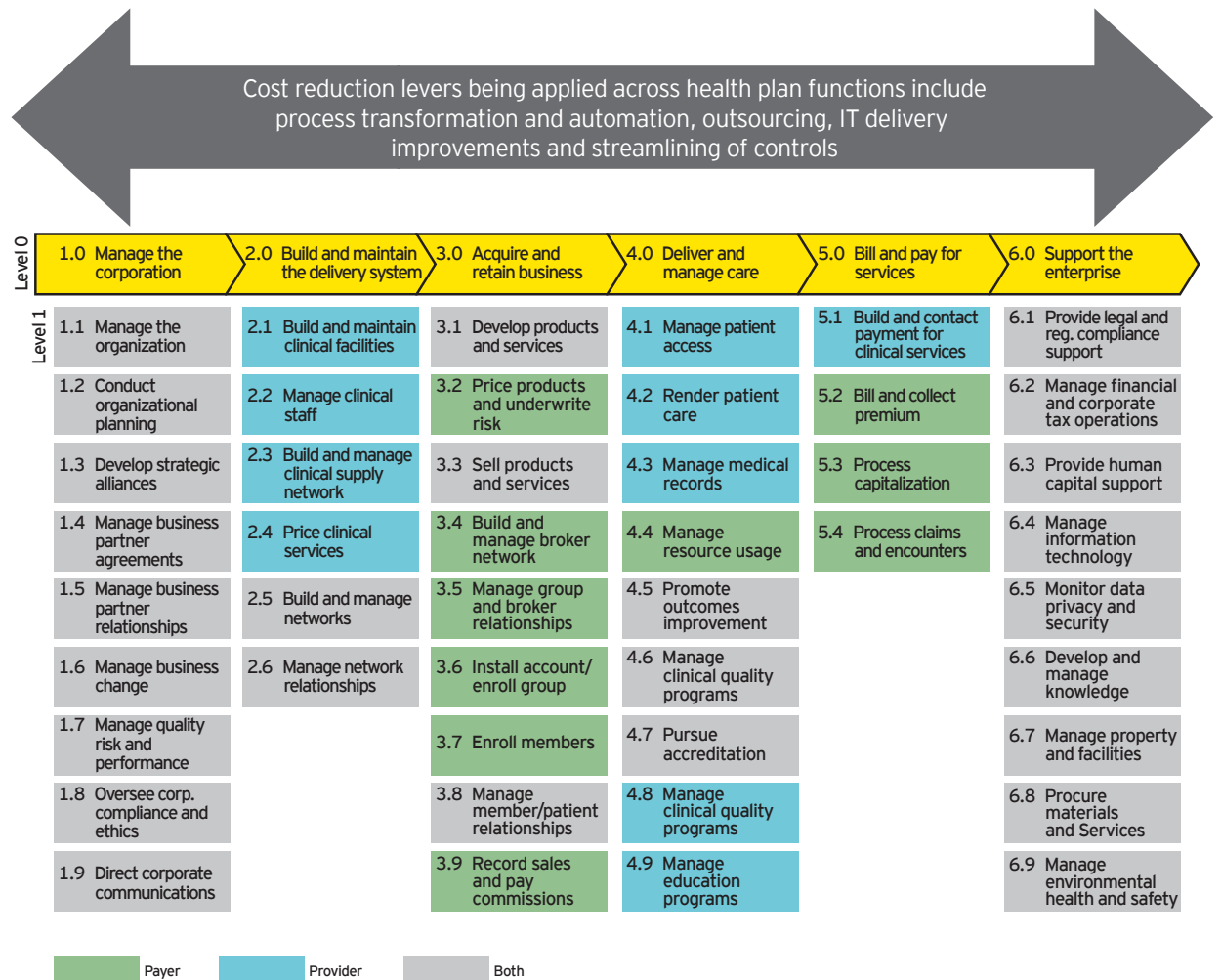
1. Reduce administrative cost

Reducing administrative costs can be a powerful way to improve your plan's MLR position and overall bottom line. Because the MLR requirement will limit your plan's administrative costs to 20% or 15% of total revenue, any savings you realize in this category will improve your margin.

Plans are looking to apply multiple cost reduction levers across their business functions, including:

- ▶ Enrollment
- ▶ Provider contracting
- ▶ Broker and agent commissions
- ▶ Claims
- ▶ Information technology
- ▶ Medical management
- ▶ Utilization management

Figure 3. Cost reduction assessments across business functions



Let's examine one such cost reduction approach in particular. Utilization management (UM) activities, including concurrent and retrospective review, are among the more significant components of administrative costs. Only prospective review can be included in the health care component of the MLR calculation and only to the extent that such review is intended to ensure appropriate treatment. Reassigning clinical staff to prospective review can not only improve your plan's MLR profile but also might empower it to obtain more accurate utilization data on patients with chronic (and often more costly) conditions. More accurate information on such patients has the added benefit of reducing the excessive variability of incurred-but-not-reported (IBNR) expenses. And reducing IBNR expenses can enable a health plan to project more accurate year-to-date costs and control its fiscal profile and compliance with regulatory requirements regarding cost allocations.

Another approach to administrative cost reduction includes the use of more cost-efficient modes of performing UM. For example, your plan may benefit from more robust concurrent review. Weakness in this area may lead to an increase in inpatient utilization, which could negate any cost reductions achieved from staff reductions or other initiatives. You could also lower administrative costs simply by ceasing retroactive reviews and merely paying the claims, but there is a risk that providers would adapt quickly by disregarding all prior-authorization processes.

One of the rate-limiting factors for options to reduce UM cost is the ongoing shortage of and labor costs for clinical reviewers. These costs vary regionally but still make up the largest cost component of a UM service. Health plans will need to increase their efforts in exploring more innovative and creative solutions for addressing this challenge if they are going to effectively address MLR requirements.

Other industries faced with a limited or costly skilled labor force have effectively addressed this challenge by finding these resources globally. Historically, the health care industry has only utilized offshore resources for basic business processing functions such as data entry and bill review. Now, however, more options exist for employing a global approach to address the need for higher clinical skill sets at a lower labor cost, and these options should be explored. One company which exemplifies this type of model is MediCall.

MediCall is a specialized clinical services provider that currently processes over 90,000 UM claims per month for health plans whose member population exceeds 20 million. US- and Philippine-licensed nurse teams, located in Utilization Review Accreditation Commission (URAC)-accredited operational centers, work as remote users within clients' own UM platforms and have proven their effectiveness at significantly reducing UM costs while improving quality, consistency and productivity. MediCall's US-licensed registered nurses transparently provide services in a variety of UM aspects, such as UM intake; inpatient precertification or predetermination; concurrent, outpatient or retrospective utilization review; and network direction.

In summary, this approach to UM can help a plan manage the impacts of MLR in several ways:

- ▶ Realize a significant reduction in administrative costs by utilizing MediCall nurses to perform concurrent and retrospective reviews
- ▶ Clinically redeploy costly US-based clinical resources to prospective reviews
- ▶ Reclassify costs related to prospective UM reviews to the medical cost component (numerator) of MLR

2. Reassess the classification of administrative cost

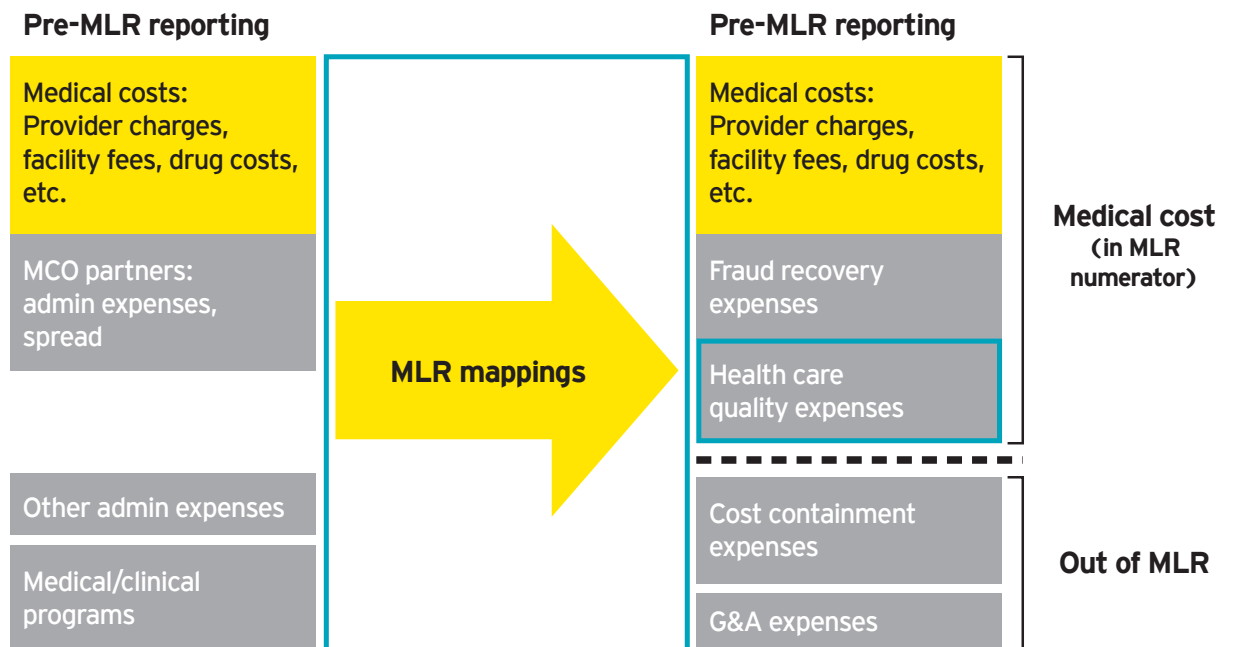
Your MLR position can be adversely affected by inaccurately classifying health care costs as administrative. It is critical that you scrutinize all costs currently classified as administrative to identify any that can legitimately be reported as health care or quality improvement costs instead. Doing so will have a double advantage, reducing the administrative component of MLR while increasing the health care component, thus making it easier for your plan to meet or exceed its MLR requirement.

MLR reporting regulations provide guidance, but you do have some flexibility in classifying costs. Bear in mind that the ultimate goal is accurate reporting.

Common questions to address during a reassessment of MLR mappings include:

- ▶ How do the expenses improve health care quality according to HHS and NAIC definitions?
- ▶ Is the quality improvement activity grounded in evidence-based medicine, widely accepted best clinical practice or criteria issued by recognized medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations?
- ▶ How will you measure the level of engagement of the quality improvement activities with enrollees?
- ▶ In addition, how will you track and report the effects of these activities on health outcomes in this population?
- ▶ How can you approximate shared expenses?
- ▶ Are there pitfalls to changing your POV after initial reporting?

Figure 4. Reassessing the classification of MLR mappings



Taking the time to reassess your MLR mappings can create a direct positive advantage for your MLR.

3. Reinvest savings into your membership's wellness

By reinvesting administrative and medical savings into your membership's wellness, you can further decrease your plan's costs over time and thus continue to enhance your plan's MLR position.

By using advanced analytics to segment populations within your membership, you can create new types of programs with defined metrics. Employing a robust and integrated data set analytics solution will allow your plan to create relevant, health-related messaging and interventions targeted at high-risk members and to invest in innovative delivery channels.

One of the most critical and overlooked aspects to any wellness program is member engagement. Currently, many wellness programs do little more than add more "noise" to the cacophony of members' everyday lives – sending out letters that get tossed away, emails that get deleted and prerecorded messages that get hung up on. Program content and delivery must be tailored to the individual, taking into consideration how best to engage the person and motivate him or her to respond.

Advanced analytics and integrated data (for example, member, clinical and outcomes data) will drive new care management programs, plan design, reimbursement models and everything in between. The challenge with analytics is to go beyond data based on historic or retrospective information gathered through past claims. You also need to be able to collect the most current information available on each member.

By freeing up finances and clinical resources from the UM process, investments can be made to pursue a prospective approach to robust analytics. For example, nursing staff could be clinically redeployed to conduct comprehensive health risk assessment activities to collect and summarize member data, which could then be utilized to optimize analytics in the form of HCC, HEDIS and STARS compliance. Also, it is important to approach disease management (DM) and case management (CM) with a data-driven hypothesis model and determine what the levers truly are.

All plans should be looking at innovative new ways to execute "traditional" programs (for example, programs for treating diabetes, cardiac problems or COPD, among other conditions). Many plans are already looking at extending DM and CM programs onto mobile devices and providing more personalized support programs.

Every plan should evaluate its population prior to executing any new or revised programs. While all programs have similarities across the population, the distributions across various disease states may vary significantly.

Expenditures that enhance your membership's wellness should be categorized as ongoing wellness programs and studies. The programs will evolve over time and become more effective as lessons are learned. The marriage of member data with outcomes and program data will become a strategic asset. A portfolio management approach should be used when you're managing multiple programs, allowing for real-time reporting on program status.

To prioritize your wellness programs based on your population, you should evaluate your population using a data- and fact-driven approach. It's time for health care organizations to think and act with a marketing hat on. Available data can be used to segment your population beyond a disease state. Integrating basic demographic information with clinical data can allow you to customize delivery channels and content.

Figure 5. Reinvestment program characteristics

Selection criteria	Common programs
<ul style="list-style-type: none"> ▶ Improve population wellness ▶ Can leverage one year's worth of data and analytics for development and evaluation ▶ Increase health care quality ▶ Lower industry costs ▶ Provide a timely payback – one year, preferably. 	<ul style="list-style-type: none"> ▶ Asthma ▶ Diabetes ▶ COPD ▶ Cancer ▶ Osteoarthritis ▶ Obesity ▶ Smoking cessation

In summary, by following the Reduce, Reassess, Reinvest approach we've laid out, you can potentially avoid the fourth "R" – the rebate you must make to members if your plan fails to meet its MLR requirement. What's more, you can position your plan for lasting success in the post-health care reform era.

MLR forecasting tool

Using legal entity premium and membership data as a base, Ernst & Young can provide an MLR forecasting tool that allows assumptions and rules to be input, modified and saved to assist health plans in exploring potential MLR scenarios and estimating MLR impacts of:

- ▶ Reassessing the classification of administrative costs
- ▶ Reinvesting savings into membership's wellness
- ▶ Reducing premiums

The output results are summarized annually by segment, in "heat map" format. Detailed supporting worksheets are also available for more detailed analysis.

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