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Medical Loss Ratio

# Navigating MLR Rules Requires Preparation and Planning

There is no question that the health insurance industry will be affected by new medical loss ratio (MLR) standards set forth by the Patient Protection and Affordable Care Act (PPACA). Final MLR regulations—designed to focus premiums toward direct patient care and away from administrative activities—have not yet been enacted by the Department of Health & Human Services (HHS). However, a model regulation was sent to HHS by the National Association of Insurance Commissioners (NAIC) on Oct. 21, 2010. [Note: Interim final regulations were released by HHS on Nov. 22, 2010.]

To remain viable and competitive in the post-MLR marketplace, health plans need to start down the path of MLR strategy today. Examining the NAIC model standards, interpreting how the standards will change business processes and preparing for those changes efficiently and effectively will go a long way toward making the right decisions, according to Ingenix Consulting, which hosted a Nov. 4, 2010, Webinar, "Understanding the Implications of the New MLR Requirements."

"It is so important for health plans to be prepared for what's coming and to truly understand the definitions of blocks of business, which activities will be considered 'medical services' and which expenses will be considered administrative, and, therefore, be excluded," said Greta Redmond, FSA, Vice President, Actuarial Services, Ingenix Consulting. "Even though there still are missing pieces in the MLR puzzle, the industry needs to start putting its MLR strategy together" (see "MLR Basics," at right).

Insurers that have blocks of business of less than 75,000 life years are permitted to make a credibility adjustment to their MLR calculation (see box on page 2). If a plan has a limited amount of experience for one entity, it can make adjustments to the actual loss ratio. Another credibility adjustment is by deductible level of the plan, which provides the insurer with an additional multiplier it can apply to increase the credibility adjustment to reflect the volatility of higher-deductible plans.

**MLR Basics**

Ingenix Consulting speakers explained that as of Jan. 1, 2011, insurers will have to spend between 80 percent (for small group and individual policies) and 85 percent (for large group policies) of collected premiums on medical services and quality improvement (QI) expenses. If insurers do not meet this benchmark, they will have to rebate the difference to their members, as required by Section 2718 of the Public Health Service Act and amended by the Patient Protection and Affordable Care Act (PPACA).

Each licensed entity within a state will be required to report its medical loss ratio (MLR) calculations separately. In other words, a carrier with multiple entities doing business in a state cannot aggregate those entities into a single entity or aggregate across states for MLR reporting purposes. There are three basic groupings of licensed entities within states: (1) individual health plans; (2) small group health plans; and (3) large group health plans. States may decide to combine the first and second groups, and there are some special adjustments for dual contracts.

According to PPACA, the formula for MLR is:

$$\frac{\textbf{Reimbursement for clinical services + Expenditures to improve health care quality}}{\textbf{Total premium revenue — Federal and state taxes and licensing or regulatory fees}}$$

| Base Credibility Additive Adjustment Factors | |
|---|---|
| **Life Years**<br>< 1,000 | **Additive Adjustment**<br>No Credibility |
| 1,000 | 8.3% |
| 2,500 | 5.2% |
| 5,000 | 3.7% |
| 10,000 | 2.6% |
| 25,000 | 1.6% |
| 50,000 | 1.2% |
| 75,000 | 0.0% |

These adjustments are not trivial, according to David Tuomala, FSA, Director, Actuarial Consulting, Ingenix Consulting. "If a plan has a relatively small block of business, it could get up to an additional 8.3 percent added to its MLR and that could be increased by as much as 40 percent to 70 percent if there are high deductibles," he told Nov. 4 Webinar attendees.

Further, new, growing blocks of business can benefit from an additional adjustment where they are allowed to push that business into the subsequent year's calculation. "With a newer policy, the MLR will ramp up over time and plans can wait until that business is more mature in the following plan year," he explained.

The annual MLR statement will include data through Dec. 31 of the current plan year. Restated incurred claims captured subsequent to the filing of the annual statement are due March 31; reporting for the MLR rebate calculation occurs May 31 and rebates must be paid by June 30. Redmond pointed out that although plans will be able to capture claims that are submitted after the end of the normal reporting period in their MLRs, they must have systems in place that track back to those events accurately.

## Defining quality improvement (QI) expenses

One of the most significant pieces of the NAIC model regulation is the definition of expenses that improve health care quality, because plans can designate these QI expenses in the numerator of their MLR calculations. Dollar for dollar, every eligible QI expense is treated like a clinical expense in the numerator of the MLR formula, which helps plans increase their reported MLR, thus making the required minimum MLR levels more achievable.

The NAIC has defined five types of QI activity expenses. Although some details were provided regarding how the NAIC characterizes each of these activities, its philosophy appears to be centered on activities that are directly attributable to patient care and are not general in nature, according to Ingenix Consulting. Each is described below.

*#1 – Improve health outcomes, including increasing the likelihood of desired outcomes compared to baseline and reducing health disparities among specified populations.*

The NAIC recommends that only expenses for the "direct interaction of the insurer, providers and the enrollee" be included in this category. Examples of such interaction include case management, care coordination and chronic disease management, as well as expenses associated with addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine.

*# 2 – Prevent hospital readmissions.*

Expenses related to hospital readmission prevention include, according to the NAIC, comprehensive discharge planning and personalized post-discharge counseling by an appropriate health care professional.

*#3 – Improve safety and reduce medical errors, lower infection and mortality rates.*

Identification and use of best clinical practices, identification and encouragement of evidence-based medicine to independently recognize and document clinical errors or safety concerns, activities that lower risk of facility-acquired infections, and prospective prescription drug utilization review to identify potential adverse drug interactions.

*#4 – Increase wellness and promote health activities.*

Expenses related to the following types of activities are considered valid in this category: wellness assessment; wellness and lifestyle coaching programs designed to achieve specific and measurable improvements; coaching programs designed to educate individuals on clinically effective methods of dealing with specific chronic diseases or conditions; public health education campaigns performed in conjunction with state or local health departments; actual rewards/incentives/bonuses/reductions in co-pays that are not reflected in premiums or claims (for small and large employer groups only); and coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking-cessation or weight-loss programs).

*#5 – Enhance the use of health care data to improve quality, transparency and outcomes.*

Categories 1 through 4 include quality reporting and related documentation in non-electronic form and health information technology (HIT) expenses to support the listed activities and state that these activities are to be reported in Category 5. This category also includes any function that may, in whole or in part, improve the quality of care or provide the technological infrastructure to enhance current QI initiatives or make new QI initiatives possible. Plans need to be aware that certain HIT expenses may be capitalizable or depreciated over a number of years, so these expenses must be appropriately allocated from an accounting standpoint.

Specifically excluded from this category are costs associated with establishing or maintaining a claims adjudication system, even if they improve claim payment or help plans meet regulatory requirements for processing claims. Bottom line, an HIT infrastructure expense that specifically supports or makes quality improvement possible is includable, but general HIT expenses are not.

In general, the following expenses also are excluded because they do not meet the definition of a QI: all retrospective and concurrent utilization reviews; fraud prevention activities; cost of developing and executing provider contracts and fees associated with establishing or managing a provider network; provider credentialing; marketing expenses; accreditation fees; costs associated with calculating and administering individual enrollee or employee incentives; or any function not expressly included in Categories 1 through 5.

## MLR implementation issues

There are likely to be many challenges in the MLR implementation process. A major challenge will be the proper identification of specific activities deemed QI expenses by the NAIC (and potentially by HHS in its forthcoming rule) and the accurate representation of the true costs associated with those activities. "It will take a great deal of effort to determine which expense fits into which category," said David Tuomala, FSA, Director, Actuarial Consulting, Ingenix Consulting. "Plans may have global expenses that would have to be parsed out, where some of the expense would count as QI and some of it would not count."

Because of how the NAIC—and perhaps HHS—is categorizing QI activities, plans are going to have to adapt their operations to make the expense eligibility in each category extremely clear. For example, plans may not be accustomed to determining how much of their HIT expense is attributable to specific types of interactions, nor are they now dedicating staff resources to QI activities on a 100-percent basis. As such, Ingenix Consulting recommends that plans develop processes and procedures that allow them to track their expenses and appropriately allocate them to the above-listed interactions.

"We're working with some of our clients now to make sure that they structure departments with two or three cost centers so they can track who is assigned to individual programs, which will make it easier for them to report activities and qualify as a QI expense," Redmond said. Tuomala concurred, adding that reallocating resources may ensure that work falls into the right categories and can be cleanly identified.

At this juncture, the MLR standards are far from final, but their deadline is approaching, so plans need to prepare for multiple contingencies. Ingenix Consulting recommends that plans evaluate their current operations and consider any opportunities to evaluate services that cover several states, group sizes and product areas. Plans' attempts to minimize administrative costs also may include streamlining the number of vendors they work with and negotiating discounted pricing for increasing vendor accountabilities. Further, outsourcing tasks that are labor-intensive when done in-house or that require technology that the plan does not wish to obtain may result in lower administrative costs, according to Ingenix.

Ingenix Consulting is leveraging its clinical, actuarial, fraud and abuse, and operations teams to help health plans achieve continued success under any MLR scenario.

**Contact us today at 800.765.6834 or email connect@ingenix.com.**



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