Time Is of the Essence: Preparing to Meet the MLR Requirement

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Health care reform is intended to make health care more affordable, hold insurers more accountable, and expand coverage to all Americans. Passed by Congress and signed into law by President Obama in March 2010, The Patient Protection and Affordable Care Act (P.L. 111-148 - called PPACA), will introduce ongoing regulatory changes, many of which go into effect in 2011. One such change, a provision of the act known as medical loss ratio, requires health insurers to spend 80 to 85 percent of consumers' premiums on medical care and health care quality improvement, rather than on administrative costs, starting in 2011.[1] While the law is currently being challenged, carriers still need to abide by it, making time of the essence.

On November 22, 2010, the Department of Health and Human Services (HHS) released its interim final rule implementing the requirements of the new section 2718 of the Public Health Services Act (added by section 10101 of the Affordable Care Act), entitled, "Bringing Down the Cost of Health Care Coverage."

Meeting the new requirement may be difficult for most carriers, and especially smaller plans that provide individual coverage. Insurers with a small population in a particular state may experience health care costs well below 80 percent one year and well above the next. That is because of the presence or absence of a few large claims can impact costs, making it increasingly challenging to meet MLR requirements. Additionally, insurers cannot combine product lines across state lines to come up with one MLR for their company.

As access to health care increases, an influx of new members will require additional claims administration, both during the enrollment phase and beyond. For smaller plans — those having annual receipts of $5 million or less — unable to amortize costs across a larger population, this may prove cost prohibitive and prevent them from remaining in compliance with the new regulation. Plus, smaller carriers typically spend more on marketing as a percentage of their budgets in order to compete with large providers, further raising their administrative costs.

Many insurance companies spend a significant portion of the premium dollar on administrative costs, including executive salaries, overhead, and marketing. While 87 cents out of every premium dollar goes directly towards paying for medical services, out of the remaining premium dollar, four cents goes to consumer services such as prevention, disease management, care coordination, investments in health information technologies and health support; provider support; and marketing.[2] Six cents goes to costs associated with government payments, regulation and claims processing and other administration. Health insurance plan profits comprise three cents of the premium dollar.

Meeting the new requirement will require managed care organizations to put processes in place to reduce expenses — or risk reducing profit or business viability — and it is not optional; insurance companies that fail to meet the MLR requirement will be obliged to provide a rebate to their customers starting in 2012. Rebates must be paid to individuals who paid the premium, although insurers may pay the rebate to employers if the employer agrees to distribute to employees their share of the rebate. Insurers must also report to their enrollees how the rebate was calculated. Insurers who fail to comply with the law are subject to civil fines to be assessed by HHS up to $100 per day per individual affected by the violation.[3]

[1] U.S. Department of Health & Human Services, 45 CFR Part 158, Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule, http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf

[2] America's Health Insurance Plans, press release, "New Report Shows Slower Premium Growth, But Increasing Pressure to Address Waste in Health Care System", December 2008

[3] U.S. Department of Health & Human Services, Section 2718 "Bringing Down the Cost of Health Care Coverage", http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf

In 2011, the new rules will protect up to 74.8 million insured Americans and estimates indicate that up to 9 million Americans could be eligible for rebates starting in 2012 worth up to $1.4 billion.[4]

Source: U.S. Department of Health & Human Services

How can providers effectively reduce administrative costs, deliver more value to consumers for their premium dollar and meet the medical loss ratio (MLR) requirement? This paper explores the strategies that enable organizations to respond quickly to change and options for lowering expenses, improving processes and delivering quality service to members while achieving MLR compliance.

Regulatory Challenges

The medical loss ratio is designed to limit supposedly wasteful spending on administration and limit profits to 20 percent in the individual and small-group markets and 15 percent in the large-group market, giving consumers greater value for their money. However, the insurance industry is a low-profit industry with current research estimating profits at about 2.2 percent.[5] With profits already low, there is not a lot of profit-related excess to be removed from each insurance dollar.

Where the opportunity exists is in lowering those expenses classified as administrative and then improving processes to reduce spending on administrative or non-core functions. However, regulators are still working to determine which costs should be classified as medical expenses and which are administrative. For example, nurse hotlines are currently considered administrative because they are typically used to diagnose whether a patient needs to be seen by an emergency room physician, but if they start providing nutrition counseling, they may fall under medical expenses. Congress asked the National Association of Insurance Commissioners, a nonprofit organization representing the nation's state and territorial insurance commissioners, to establish uniform definitions of MLR activities and standardized methodologies for calculating measures for such activities. Section 2718 requires HHS to "certify" the NAIC recommendations.

In other words, if an insurance company wants to expand the pool of potential profit dollars, they need to increase spending on medical services to meet MLR ratios and decrease administrative costs.

According to the U.S. Healthcare Efficiency Index®, the U.S. health care system throws away an estimated $30 billion every year due to inefficient paper and manual processes.[6]

Opportunities for Trimming Administration Costs

Organizations able to lower administrative costs will have a competitive edge versus those who cannot. That's because they'll be able to meet MLR requirements and increase profitability. Smaller plans providing individual coverage will likely be driven out of the market because they will be unable to meet the MLR requirements. Larger organizations need to have a strategy for increasing medical spending, streamlining processes and reducing administrative expenses.

Reclassification of expenses is one option insurers may pursue; however, manipulating the data could prove dangerous. In addition to being a complex undertaking, the definition of activities that improve health care quality are still open to regulatory interpretation. Wellpoint, one of the country's largest health care companies, has outlined a procedure to move expenses that were previously classified as administrative into categories

[4] U.S. Department of Health & Human Services, press release, "New Affordable Care Act Rules Give Consumers Better Value for Insurance Premiums," November 22, 2010, http://www.hhs.gov/news/press/2010pres/11/20101122a.html

[5] *Fortune Magazine*, "Fortune 500", 2009, http://money.cnn.com/magazines/fortune/fortune500/2009/performers/industries/profits/

[6] The U.S. Healthcare Efficiency Index, "National Progress Report", 2010

that are now considered medical. As a result, they have been able to move half a billion dollars from administrative to medical costs and meet the MLR requirements.

Reducing or restructuring commissions is another area insurers are exploring, yet most organizations will find it difficult to renegotiate existing distribution contracts, and doing so may encourage brokers to leave and take clients with them. Broker and agent commissions can account for five percent or more of premiums and many fear reduced income as insurers are pressed to become more efficient. Plus, commissions have to be higher in the individual market to compensate agents for selling a policy to only one family at a time. Some plans are requiring brokers to bill commission directly to the end user to ensure commissions are excluded from premium revenue and from administrative costs. Others are modifying commissions from a recurring model to a one-time fixed cost.

Improving claims management and reducing the cost of the operational function can help managed care organizations achieve efficiencies, streamline processes and meet MLR requirements. A business process outsourcing (BPO) provider assists managed care organizations with MLR requirements through processing automation and reducing complexities associated with complicated manual process. As a result, insurance organizations can manage claims more efficiently, lower their overhead and achieve the government mandate.

Efficient Claims Management Paves the Way for MLR Compliance

Business Process Outsourcing provides rapid access to industry-compliant technology solutions and electronic workflow tools that automatically route claims for review, action or approval. When delivered via Software-as-a-Service, organizations alleviate the need for additional capital expense and gain access to a secure Web-based data repository and data protection via online backup and recovery. Administrative expenses and claims processing time is reduced and customer service improves as a result of smooth and accurate transactional activity. BPO ensures timely response to claims management so organizations can meet changing compliance goals and other mandates associated with MLR, HIPAA and ICD-10. Other benefits include:

Alleviate administrative burden – BPO provides cost-effective and efficient support and resources for low margin or non-core activities. Automated workflow provides visibility into claims operations and improves turnaround times to less than 24 hours.

Improve first pass rate – Manual adjudication increases claims processing costs and results in decreased quality. It also requires more time to service a claim. A BPO provider with automated workflow improves first pass rate through streamlined processing and defined and repeatable processes, reducing administrative costs and supporting compliance with MLR requirements. Organizations that outsource claims processing increase first pass rate by an average of 10 to 12 percent in less than 30 days, saving managed care organizations millions of dollars each year.

Scale up or down to meet business needs – By 2013, insurers will be flooded with new enrollments as access to care increases. This will translate to a substantial rise in claims processing and more members requiring customer service assistance. It will also increase the cost of processing a claim due to rising labor costs, overhead costs and more. By working with an experienced outsource partner, organizations can reduce administrative costs, provide quality service to new enrollees and plan subscribers and achieve MLR compliance.

Documented audit trail – Managed care organizations offering either group or individual coverage must submit to the Secretary reports regarding the percentage of total premium spent. This cost includes expenditures on reimbursement for clinical claims, for spending to improve the quality of care, and on all other non-claim costs with an explanation of the nature of these costs. Because the rebate issue will create additional compliance challenges, working with a BPO provider can provide a complete and documented audit trail to facilitate compliance.

Fraud detection – MLR regulations limit how much health plans can invest in programs and services that are considered administrative, without considering that they may be vital to improving the quality, safety and cost of the health care system. For example, MLR provides a credit for money that was paid out for fraudulent billing and recovered, but it doesn't include the cost of developing and administering anti-fraud programs. Partnering with the right BPO provider can decrease fraud and abuse while reducing administrative costs through electronic workflow and reporting tools that automatically route claims for review, action or approval, resulting in greater efficiency and accuracy.

Define Your Strategy

With providers needing to comply with MLR requirements this year, organizations must have a strategy that will enable them to meet ongoing regulatory changes and increase profitability. Regardless of what the final ruling looks like, managed care organizations need to be nimble and able to respond to current and future compliance challenges. Those that can't — or are slow to respond — may be unable to survive.

As new changes come to bear, and organizations seek to improve processes, it is imperative to continually reevaluate the level of service required to identify new opportunities for outsourcing to deliver cost savings and greater efficiencies. By partnering with the right BPO provider, managed care organizations can gain a competitive edge by effectively reducing administrative overhead, improving processes and achieving MLR compliance.

About the Author – Larry Metcalf is the Director of Business Development, Healthcare Payer Solutions for SOURCECORP. With more than 30 years of experience in business process outsourcing (BPO), Metcalf has developed domestic, near-shore and off-shore solutions for the manufacturing, financial, health care and government markets. He has shared his expertise in Personal Health Records (PHR) and Electronic Medical Records (EMR) as a panelist at RSA and HIMSS conferences. For more information, email LarryMetcalf@srcp.com or visit www.sourcecorp.com.