Healthcare BUSINESS STRATEGY™

Health Plan Quality Improvement Expenditures Rising

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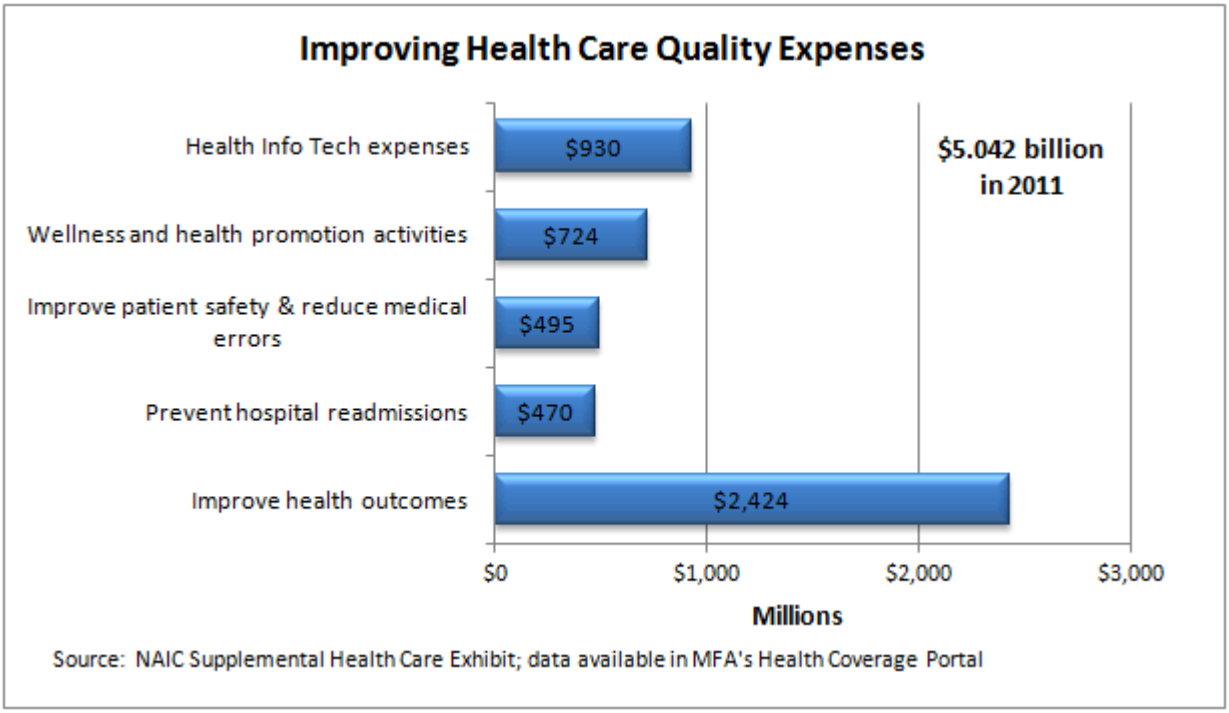
Health insurers spent $5.042 billion on health care quality improvement expenses in 2011, up from $4.936 billion in 2010. This figure is expected to increase over the next several years. Health plans are required to disclose expenses by major types of activity that improve health care quality in the Supplemental Health Care Exhibit (SHCE) filed with the National Association of Insurance Commissioners (NAIC) and state regulators. These activities are split into four categories: improving health outcomes, wellness and health promotion activities, improving patient safety, and preventing hospital readmissions. A fifth category aggregates the health information technology expenditures on these programs. While the primary purpose of the SHCE is for calculating mandated medical loss ratio (MLR) rebates, the data can also be used to benchmark expenditures on various activities by product segment. With analysis, the data can also be used to determine which health plans may benefit from third party vendor services. Quality improvement activities are deductible from MLR rebates so these activities are a win for all stakeholders. This brief provides a look at the total dollars spent on quality improvement programs in 2011 and the activities and segments where the money was spent.

Unlike automobile or life insurance carriers, most health insurers do much more than pay claims. Just as WalMart uses its' size to negotiate better prices on products for their customers, health insurance carriers use enrollment size as bargaining clout with medical and service providers to negotiate discounts that are passed on to their customers. Health insurers are similar to property insurers in that by protecting the covered entity from harm, claim costs are lower and the business is more profitable. Health insurers spent more than $5.042 billion in 2011 to improve health care quality, in essence keeping members free from harm, according to data submitted in the Supplemental Health Care Exhibit (SHCE) filed with the National Association of Insurance Commissioners (NAIC) and state regulators. Health plans are expected to increase expenditures on quality improvement activities, those that can be objectively measured with verifiable results, now that they can deduct these costs from medical loss rebate calculations.

Quality Improvement Expenditures

Health insurance quality improvement costs are expenses (other than those billed by a provider for care delivery) for health plan activities designed to improve health care quality and increase the likelihood of desired health outcomes. Plans must be able to objectively measure activities and produce verifiable results. Qualifying quality improvement activities are defined in Section 1311 of the PPACA and include: improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors, wellness and health promotion activities and activities that enhance the use of health care data (Health Information Technology or HIT) to improve quality, transparency and outcomes.



The largest portion of the $5.042 billion in 2011 was spent on improvement of health outcomes. This includes expenses for the direct interaction of the insurer (including those health outcome services outsourced by an insurer), providers and the enrollee, or the enrollee's representative, to improve health outcomes. Health insurance carriers spent $2.4 billion for these services which include:

- Case management, care coordination and chronic disease management – such as patient centered interventions, coaching, use of medical homes model, education and participation in self-management programs, medication and care compliance initiatives
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine
- Quality reporting and documentation of care in non-electronic formats

Wellness and health promotion activities include: face-to-face, telephonic or web-based interactions such as wellness assessments, lifestyle coaching programs designed to achieve specific and measurable improvements or to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition, public health education campaigns and some costs associated with incentive programs. These activities represented about 14% of the monies spent on improving health care in 2011. Nearly $495 million was spent by carriers on improving patient safety and reducing medical error programs. These expenses focused on efforts for:

- Appropriate identification and use of best clinical practices to avoid harm
- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors of safety concerns
- Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions
- Activities to lower risk of facility acquired infections

More than $470 million was spent by carriers on activities that prevent hospital readmissions such as comprehensive discharge planning and personalized post discharge counseling.

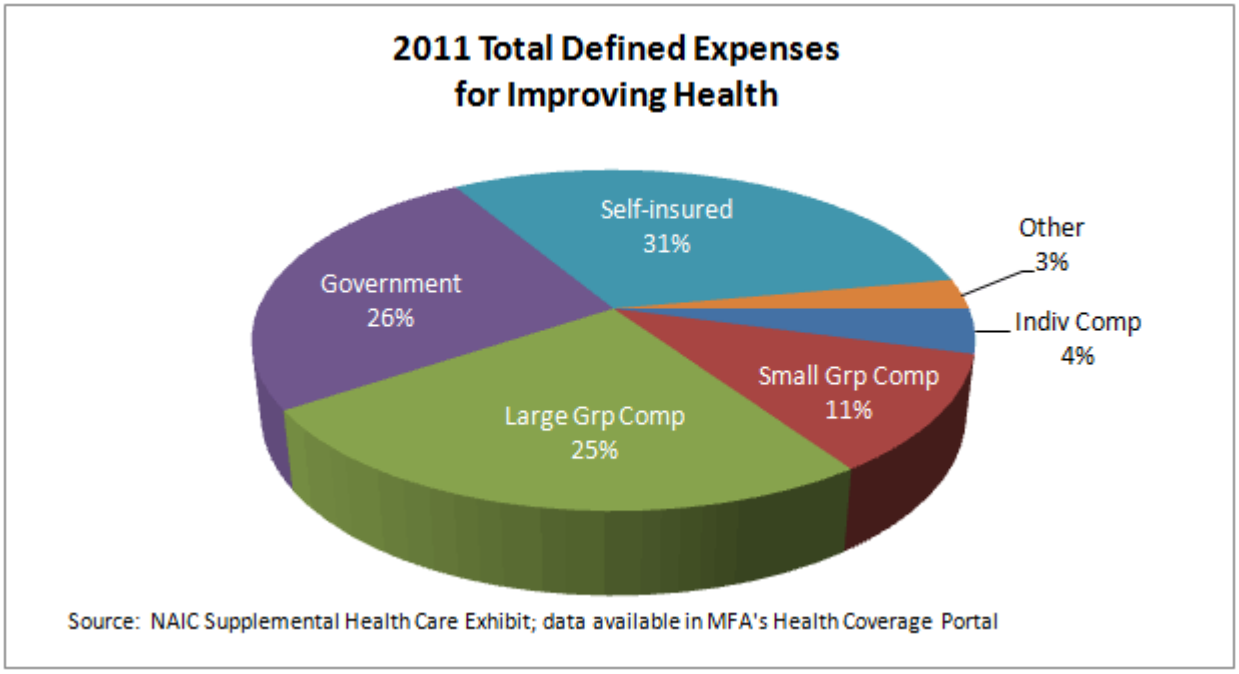
Most of the initiatives above include health information technology expenses to support the activities including data extraction, analysis and transmission of information among various stakeholders. Health information technology or HIT expenses designated for health care quality improvements is the second largest expenditure under the improving health care quality umbrella. Health insurance carriers spent approximately $930 million in 2011 on technology to support quality improvement initiatives. These activities include costs associated with the provision of electronic health records and patient portals. Monitoring, measuring or reporting clinical

effectiveness relating to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care (CAHPS surveys or chart review for HEDIS measures) and public reporting mandated or encouraged by law are tallied here. This category also includes advancing the ability of enrollees, providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care.

Quality Expenditures by Segment

It is not surprising to find that 31% of the dollars spent on improving health, have been spent in the self-insured segment. A third of the insured population is covered by self-funded plans. However, only $1.38 per insured per month is attributed to this segment. This is well below the $4.40 spent in the Government sector on a per insured per month basis.

As the second largest sponsor of health insurance coverage, Government programs, such as Medicaid and Medicare, also cover the sickest populations. So, it also no surprise that 26% of dollars spent on programs that help improve quality of care would go to this segment.



It is somewhat surprising to find that 25% of total quality-improvement dollars - nearly $1.3 billion – is spent on members covered by large group risk-based comprehensive health coverage because only 14% of the insured population is in this segment. Risk-based small group comprehensive coverage accounts for 11% of the money spent on initiatives to improve health and this type of insurance covers 6% of the insured population. The individual segment percent spent on quality improvement mirrors the percentage of people who purchased non-group policies. The larger percentage of quality expenditures in the large group sector may stem from increased competition in this arena. To retain large employers, health plans have long been required to demonstrate the value they provide and quantifiable quality measures have provided that proof.

Quality improvement activities are deductible from medical loss ratio rebates so these activities are a win for everyone concerned. They reduce the cost of health care and more importantly, improve the health and well-being of the populations served by health insurance carriers. Many of these activities are outsourced to third party vendors who also benefit.

By using the data in the Supplemental Health Care Exhibit, health plans can benchmark their own efforts against other health plans. Third party vendors can use the data to identify which plans may benefit from the services they offer. Consultants, government agencies and other concerned organizations can evaluate these data

elements to support policy initiatives. With an aging population, a renewed focus on controlling health care costs, and deductible expenditures related to quality improvement costs from rebate mandates, MFA expects these expenses to increase in the future.

About This Report

This brief is based on an analysis of data filed by Health; Life, Accident and Health; Property and Casualty; and Fraternal companies with the National Association of Insurance Commissioners (NAIC) and state regulators as of December 2011. MFA primarily used data and instructions from the Supplemental Health Care Exhibit of the NAIC Blank. Plans that primarily file with the California Department of Managed Health Care are excluded from this report. The data used in this report is available through Mark Farrah Associates' Health Coverage Portal database.

About Health Coverage Portal™

Market data for health insurance companies can be analyzed in many ways to provide strategic planning insights. The challenge is finding & aggregating the right data. The solution is the Health Coverage Portal™, a database that integrates market measures for all types of health coverage. 50-state Health Coverage Portal™ - and Selective-State Health Coverage Portal™ subscription rates are available. Custom portal designs can also be created upon request.

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