

Approaches to Quality Measurement

1. When using formal studies, providers focus on specific illnesses and use formal academic research to make decisions, oriented around a very specific set of clinical decisions and adherence to evidence based medicine
2. Treatment may/may not be clear or sensitive to preferences of patients.
3. Slow dissemination of information leads to confusion and disagreement about the best treatment
4. Buyers of health care have traditionally relied on macro measures of cost, efficiency, use and resource use by place of service.

Basic Sales Compensation for Individual Health

1. Typically commissions which vary by
 - duration
 - product
 - agent's persistency and volume
2. Heaped (high first year commissions) more common in the brokerage market and with life insurers
3. Level commissions less likely to instigate replacement activity and generate better returns on investment

What Managed Care Organizations Deliver

1. Consumer service – employer – service trends, reports, funding vehicles
2. Consumer service - employee- accessing care, one call resolution of questions/problems
3. Product mix - ability to meet needs for choice, quality and financing i.e., full spectrum of plans
4. Provider networks - consistent quality and adequate size
5. Network capabilities - for some employers, national
6. Preventative programs
7. Case management for chronic disease
8. Use management
9. Value added products and services
10. Integrate service
11. Quality - credentialing, use and outcomes data

Distribution Channels for Managed Care Organizations

1. Work directly with small employers
2. Brokers and consultants represent employer's interests. They facilitate design and implementation. Monitor costs carefully
3. Brokers - contract with MCO
 - < 1000 lives
 - paid commission plus incentives for growth, retention or profitability
 - look for efficient sales process
4. Consultants - fee for service from group
 - > 1000 lives, group self-funded
 - want MCO to help add value to employer's benefit program – means broad range of flexible solutions
5. Direct to large employers - requires specially trained people
6. Financial institutions - Gramm - Leach - Bliley Act of 1999 allows affiliations of banks, securities firms and insurers

Effect of Regression to the Mean in Disease Management

1. A problem in studies which follow a patient over time
2. A high percentage of patients who are high cost in one period are not high cost in the next
3. In normal progression of the disease is cost rising to a peak and then dropping. Depending on where the patient is at the start date, costs may show a decline, even if not affected by disease management
4. For a population study, the regression present at the individual level may or may not occur
5. A table is given categorizing members by low, moderate and high cost in two consecutive years
6. In the first year 15 of members have costs of over \$25,000 but only 28% of these are high cost in year 2
7. The moderate cost group is largely chronic patients. The year 1 moderate group's costs drop but year 2 group has higher costs

Common Problems in Claims Databases

1. Incurral dates not recorded correctly
2. Splitting or merging claims
3. Dates of services do not correspond to payment and incurral dates
4. Payments incorrectly assigned to the wrong claim
5. More than one claim open on a policy - often hold larger of two reserves
6. Maximum benefit exceeded
7. Data changes from month to month
8. Inflation benefit not calculated correctly
9. Open claim register is not up to date

Different Definitions of Incurral Date for Medical Expense Coverages

1. **Medical reimbursement plans (5)**

- date service rendered
- admission date for hospital claims
- if hospital discharge date used, must hold an additional liability
- code re-admissions as original hospitalization
- sometimes claims batched and earliest date used
- Beginning of the deductible accumulation period
- Usually determined by convenience in claim adjudication and by system constraints

2. **Medical stop loss coverage**

- benefits on a paid or incurred basis

3. **Extension of benefits** under medical plans

- for disabled, use date of disablement.
- can be based on individuals or related to aggregate claims

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The Affordable Health Care Act's Medical Loss Ratio and Premium Rate Reviews

1. Insurers must report spending on clinical services, quality, other
2. Insurers must rebate any amount by which clinical services and quality is less than 85% of the premium for large groups (80% for small groups and individual coverage) starting 1/1/11
3. Establish a process for reviewing premium increases and require plans to justify increases
4. States to report on trends in premium increases
5. States to recommend if certain plans should be excluded from the Exchanges based on their premium increases
6. Grants to states for costs