APTA Private Practice
A Section of the American Physical Therapy Association
1421 Prince Street
Suite 300
Alexandria, VA 22314
(800) 517-1167
www.ppsapta.org
APTA American Physical Therapy Association

Reasons Why UM Is Prevalent Now in Rehab

There are many reasons, both internal to payers and external within the larger health system, for increasing scrutiny of rehabilitation benefits. While there may be justifiable reasons for increased overall health care spending on physical therapist services, from the perspective of a health care purchaser these services become a target for cost containment. These reasons include:

- Aging population
- Increased consumer awareness of physical therapy
- Expansion of coverage for rehabilitation services under the ACA
- Increased covered lives as a result of coverage expansions (ACA Exchanges and Medicaid)
- Proven value of the physical therapy benefit compared with high-risk or invasive alternatives, such as opioid use, knee surgery for meniscal tears, and low back surgery.

Physical Therapist Responsibility For Compliance

Some providers have contributed to the perceived need for increased oversight. APTA and PPS support appropriately identifying and educating clinicians or facilities with atypical billing or treatment patterns. APTA and PPS, however, *do not* support applying blanket administrative hurdles to reduce utilization when outliers can be addressed through targeted management.

Impact of the ACA's Medical Loss Ratio Provision

The medical loss ratio (MLR) accounts in part for the rise in use of third-party administrators in private health insurance administration. The MLR is a provision of the ACA that changed the way private health insurers are regulated. The MLR is defined most simply as the portion of premium income insurers must pay out for health services. Depending on the size of the company, the MLR requires insurers to spend between 80% and 85% of premium dollars on medical care, with no more than 15% to 20% on administration, marketing, and profits. If targets are not met, insurers must issue rebates to consumers. Elements in the medical portion of the ratio include quality activities that lead to measurable improvement in patient outcomes or patient safety, promotion of wellness, and enhancement of health information technology in a way that improves quality, transparency, or outcomes.

In August 2010, the National Association of Insurance Commissioners (NAIC) recommended to the US Department of Health and Human Services (HHS) that effective case management and related activities be included in the MLR. As part of the effort to meet the triple aim of health care reform, NAIC went on to advise inclusion of care coordination and other services that promote quality and comprehensive care. It was recognized that if case management and other activities were not included in the MLR, there would be no reason for insurers to pay for such services. HHS's decision to accept the recommendation had far-reaching impacts, mostly on providers and consumers.

Traditionally, UM provided by the payer fell under the administrative portion of the MLR, as the functions were primarily retrospective (after the fact) and concurrent (during the course of care). Now, if the payer outsources UM to a third-party vendor that has a program intended to improve quality and that provides prospective review (before care is rendered) as well as concurrent review, the payer can shift dollars spent on UM to the medical portion of the ratio, thereby reducing its exposure to penalty rebates. Outsourcing allows payers to fix their cost of care.

Self-funded plans are not considered insurers and therefore are not subject to the MLR provision. This is true even if an insurer administers a self-funded plan for the employer or plan sponsor.