Brought to you by Seubert & Associates

Medical Loss Ratio Rules

The Patient Protection and Affordable Care Act (PPACA) established the **medical loss ratio (MLR) rules** to help control health care coverage costs and ensure that enrollees receive value for their premium dollars. The MLR rules became effective on **Jan. 1, 2011**.

These rules require health insurance issuers to spend **80 to 85 percent** of their premium dollars on medical care and health care quality improvement, rather than administrative costs. Issuers that do not meet these requirements must provide rebates to consumers beginning in 2012.

The Department of Health and Human Services (HHS) is the federal agency in charge of implementing the MLR rules. HHS issued interim final regulations on the MLR requirements in December 2010, which became effective on Jan. 1, 2011. Additional final regulations on the MLR requirements were released by HHS on Dec. 7, 2011. These final regulations do not change the basic components of the MLR rules; rather, they address technical issues involved in how issuers calculate their MLR and distribute rebates. The final regulations become applicable on **Jan. 1, 2012**.

This Seubert & Associates Legislative Brief summarizes the MLR rules, including the technical issues addressed by the final regulations. Please read below for more information.

MLR REQUIREMENTS

The MLR requirements apply to health insurance issuers offering group or individual health coverage. The rules apply to both non-grandfathered and grandfathered plans. The rules do not, however, apply to self-insured plans.

Health insurance issuers in the large group market must spend at least **85 percent** of premiums on medical care and health care quality improvement activities. Issuers in the small group and individual markets must spend at least **80 percent** of premiums on those items.

In each state where an issuer does business, it is required to report to HHS on how it spent its premium dollars for the year. HHS will publicly post these reports starting in 2012 to help educate consumers on the value of insurance coverage offered in their state.

Issuers that do not meet the applicable MLR standard (that is, 80 or 85 percent) must provide rebates to consumers. Rebates must be paid by **August 1** of each year. The first round of rebates is due by **Aug. 1, 2012**. The rebates are based upon aggregated market data in each state, and not upon a particular group health plan's experience.

CALCULATING THE MLR

An issuer's MLR is calculated as a fraction. The numerator of the fraction is the amount of incurred claims paid, plus expenses for health care quality improvement activities. The denominator is the premium revenue, minus federal or state taxes and licensing and regulatory fees.

In addition, the final regulations provide that an issuer may deduct from earned premiums the higher of either the amount paid in state premium tax or actual community benefit expenditures up to the highest premium tax rate in the state. Community benefit expenditures are expenditures for activities or programs that aim to improve access to health services, enhance public health and relieve government burden.

In general, the MLR for a particular year (the MLR reporting year) is based on data for that year, plus data from the prior two years. However, special rules apply for 2011 and 2012.

In determining whether the issuer meets the MLR requirements, amounts paid toward medical care include direct claims paid to providers (including incentive and bonus payments made to providers) and activities to improve health care quality.

Health Care Quality Improvement Activities

Expenses for health care quality improvement activities are included with an issuer's claims payments when calculating its MLR. To be considered a health care quality improvement activity, the activity must be designed to improve health quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

Qualifying Activities

Health care quality improvement activities include:

- Case management;
- Care coordination;
- Chronic disease management;
- Wellness programs;
- Supporting health information technology;
- Hospital discharge programs; and
- Measures to improve patient safety and reduce medical errors.

The final regulations state that a portion of ICD-10 conversion costs can be classified as health care quality improvement activities for the 2012 and 2013 reporting years. The ICD-10 conversion involves updating medical code sets to comply with HIPAA's transaction standards for electronic health claims.

Non-Qualifying Activities

Items that are *not* considered health care quality improvement activities include:

- Activities primarily to control or contain costs;
- Establishing or maintaining a claims adjudication system;
- Retrospective and concurrent utilization review;
- Fraud prevention activities (Note: The amount of claims payments recovered through fraud reduction efforts, up to the amount of fraud reduction expenses, can be included in incurred claims when calculating the MLR);
- Costs of executing provider contracts or developing a provider network;
- Provider credentialing; and
- Marketing.

Administrative Expenses

An issuer's administrative expenses do not count toward medical care spending. Examples of administrative expenses that cannot be taken into account when calculating the MLR include:

- Amounts paid to third party vendors for secondary network savings, network development, administrative fees, claims processing and utilization management;
- Amounts paid (including amounts paid to a provider) for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee (such as medical records copying costs, attorneys' fees and compensation to administrative personnel);
- Cost containment and loss adjustment expenses;
- Workforce salaries and benefits (including sales personnel);
- Agents' and brokers' fees and commissions;
- General administrative expenses; and
- Community benefit expenditures.

Although there was a significant push to have HHS reclassify agents' and brokers' fees and commissions, the final regulations left these costs as administrative expenses that do not count toward medical spending.

Mini-Med and Expatriate Policies

Special MLR calculation rules apply to mini-med policies with total annual benefit limits of $250,000 or less and expatriate policies. The special calculation rules were created by HHS to take into account the increased administrative expenses associated with these policies so as to minimize market withdrawal. To help determine whether the special reporting rules should apply beyond the 2011 MLR reporting year, issuers of mini-med and expatriate plans were directed to submit reports to HHS for each of the first three quarters of the 2011 reporting year.

DISCLOSURE AND REPORTING

Under the MLR rules, issuers must submit a report to HHS concerning premium revenue and expenses related to the group and individual health insurance coverage that it issued for each MLR reporting year.

In general, the report must be submitted to HHS by **June 1** of the following year, in the form and manner required by HHS. Under this guidance, the first reports would be due by **June 1, 2012**.

REBATES

For each MLR reporting year, the issuer must provide a proportionate rebate if the MLR does not meet the minimum requirements. The amount of the rebate is based on the premium received (less appropriate taxes and fees), which is then multiplied by the difference between the required MLR and the issuer's actual MLR for the year.

Payment of Rebates

Under the previous rule, issuers would have been required to apportion rebates for individual enrollees based on the amount of premium paid, and then pay the rebates either directly to the enrollees or to the group policyholder with assurance from the policyholder that it would distribute the rebates to enrollees. According to HHS, this payment scheme had unintended administrative consequences for issuers and tax implications for individuals receiving the rebates.

Under the final regulations, issuers are generally required to provide rebates directly to policyholders. Policyholders must use the rebates for the benefit of enrollees. Policyholders are permitted to use the rebates for the benefit of enrollees in ways that are not taxable, such as through lower premiums. This process varies according to the type of plan. For plans subject to ERISA, for instance, the rebates may be considered plan assets that are subject to ERISA's fiduciary responsibility requirements.

Exception for Small Rebate Amounts

No rebate is required to be paid to a group policyholder if the total amount owed to the policyholder and enrollees combined is less than **$20** for an MLR reporting year. For rebates distributed directly to enrollees, such as when an issuer does not receive assurance that the policyholder will use the rebate for the benefit of enrollees, no rebate is required if it would be less than **$5** per subscriber covered by the policy.

Timing of Rebates

An issuer must provide any rebate owed no later than **August 1** following the end of the MLR reporting year. If the rebate payment is late, interest on the rebate amount must be paid as well.

Also, if an issuer's solvency would be affected beyond certain levels, HHS may defer all or a portion of the required rebates. However, the issuer will be required to pay the rebates, with interest, in a future year.

NOTICES

When providing a rebate to a group policyholder, the issuer must provide the policyholder and the subscribers with a notice describing the MLR requirements. The notice must include the following information:

- A general description of the concept of an MLR;
- The purpose of setting a MLR standard;
- The applicable MLR standard;
- The issuer's MLR;
- The issuer's aggregate premium revenue, minus any federal and state taxes, and licensing and regulatory fees that may be excluded;
- The rebate percentage and amount owed to enrollees based upon the difference between the issuer's MLR and the applicable MLR standard; and
- The fact that the total aggregated rebate for the group health plan is being provided to the policyholder and a description of how the rebate will be handled.

For each MLR reporting year, issuers must submit a report to HHS regarding their rebates.

In addition, HHS issued a final rule on May 11, 2012 that requires issuers that meet or exceed the MLR standards to provide a basic notice of the MLR rules to policyholders and subscribers. This notice requirement only applies for the 2011 MLR reporting year. HHS has issued required language for this notice. The notice must be provided with the first plan document (for example, open enrollment materials) provided to enrollees on or after **July 1, 2012**.

ADJUSTING THE MLR FOR THE INDIVIDUAL MARKET

In situations where enforcement of the 80 percent MLR requirement would destabilize the individual market in a particular state, HHS may adjust the MLR standard for individual insurers in that state. A request for adjustment must be made by the state's insurance commissioner (or equivalent state official). The adjustment can be applied for up to three years.

In determining whether to adjust the standard, HHS will consider factors such as the number of issuers that would be likely to leave the state's individual market, the number of individuals that would be affected and the impact on premiums in the state.

ENFORCEMENT

HHS is responsible for enforcing the reporting and rebating requirements of the MLR rules. In order to enforce these rules, HHS can audit issuers for compliance. Issuers must provide HHS with access to records and must maintain records to demonstrate compliance for **six years**.

Issuers that do not comply with the MLR requirements may be subject to civil penalties **up to $100 per day** for each individual affected by the violation. HHS can also order an issuer to pay rebates if it has failed to do so.

Penalties will not be assessed for periods where the issuer did not know of the failure, or would not have known about it if it had exercised reasonable diligence. HHS may not issue a penalty for the period after the issuer discovered the failure (or would have discovered it if it had exercised reasonable diligence), if the failure was due to reasonable cause and not due to willful neglect and the failure was corrected within 30 days.

MORE INFORMATION

The final regulations are available at: www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31289.pdf

More information on the MLR rules is available on the HHS's website at:
http://cciio.cms.gov/programs/marketreforms/mlr/index.html

This Seubert & Associates Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

© 2011-2012 Zywave, Inc. All rights reserved.

EEM 5/12