Technical Guidance on the Medical Loss Ratio Regulation

On April 20, 2012, the Centers for Medicare & Medicaid Services’ Center for Consumer Information and Insurance Oversight (“CCIIO”) issued an informational bulletin to provide guidance on the medical loss ratio provision of the Patient Protection and Affordable Care Act (the “Affordable Care Act” or the “Act”). Under the Act, health insurance issuers offering individual or group coverage must submit annual reports to the Department of Health and Human Services (“HHS”) on the percentages of premiums that the coverage spends on reimbursement for clinical services and activities that improve healthcare quality, and must provide rebates to enrollees if this spending does not meet minimum standards for a given plan year, beginning in 2012.

I. Background

A. The Affordable Care Act

1. Reporting on the Ratio of Incurred Claims to Earned Premiums

Sections 1001 and 10101 of the Affordable Care Act added Section 2718 to the Public Health Service Act (“PHSA”) which, among other provisions, requires health insurance issuers offering individual or group coverage to submit annual reports to the Secretary of HHS on the percentages of premiums that the coverage spends on reimbursement for clinical services to enrollees and activities that improve healthcare quality. These insurers are required to provide rebates to their enrollees if this spending does not meet minimum standards for a given plan year.²

¹ CCIIO Technical Guidance (CCIIO 2012 - 002): Questions and Answers Regarding the Medical Loss Ratio Regulation.

² Section 2718 of the Public Health Service Act (“PHSA”), as added by Section 1001(5) and amended by Section 10101(f) of the Affordable Care Act.
Specifically, the Affordable Care Act requires such health insurance issuers to submit a report to the Secretary of HHS for each plan year describing the ratio of the incurred claims plus the loss adjustment expense to earned premiums, also known as the medical loss ratio. Each report must include the percentage of total premium revenue - after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance - that the coverage spends:

(a) On reimbursement for clinical services provided to enrollees;
(b) For activities that improve healthcare quality; and
(c) On all other non-claims costs, including an explanation of the nature of these costs, and excluding Federal and State taxes and licensing or regulatory fees.

The language also directs HHS to make these reports available to the public on its website.

2. Uniform Definitions Required

The Affordable Care Act directed the National Association of Insurance Commissioners (“NAIC”) to establish (subject to HHS certification) uniform definitions of the activities being reported to HHS, and standardized methodologies for calculating measures of these activities no later than December 31, 2010. The language specified that NAIC’s responsibilities relating to this provision included defining which activities constitute activities that improve healthcare quality. It also required the uniform methodologies to be developed by NAIC to be designed to consider the special circumstances of smaller plans, different types of plans, and newer plans.

3. Rebates if Insurer Spending on Clinical Services and Quality Improvement below Minimum Standards

The Affordable Care Act provides that, beginning no later than January 1, 2011, health insurance issuers offering group or individual health insurance coverage must, for every plan year, provide an annual rebate to each enrollee under such coverage if the ratio of: (i) The amount of premium revenue the issuer spends on reimbursement for clinical services provided to enrollees and activities that improve healthcare quality to (ii) the total amount of
premium revenue for the plan year, excluding Federal and State taxes and licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under the Act, is less than the following percentages, referred to as the medical loss ratio (“MLR”):

(a) 85 percent for coverage offered in the large group market (or a higher percentage that a given State may have determined by regulation); or

(b) 80 percent for coverage offered in the small group market or in the individual market (or a higher percentage that a given State may have determined by regulation), except that HHS may adjust this percentage for a State if it determines that the application of the 80 percent MLR may destabilize the individual market in that State.

The Affordable Care Act requires that in determining these minimum percentages, States shall seek to ensure adequate participation by health insurance issuers, competition in the State’s health insurance market, and value for consumers so that premiums are used for clinical services and quality improvements. Additionally, the Act provides that HHS may adjust the rates if the Secretary determines that it is appropriate to do so, on account of the volatility of the individual market due to the establishment of State Health Insurance Exchanges.

The annual rebate must be paid to each enrollee on a “pro rata basis”. The Act specifies that the total amount of the annual rebate required under this provision shall be equal to the product of:

(a) The amount by which the MLR exceeds the actual ratio of the issuer’s expenditures to its premium revenue as described above; and

(b) The total amount of the premium revenue described above.

Beginning on January 1, 2014, the determination of whether the percentage that the coverage spent on clinical services and quality improvement exceeds the MLR for the year involved must be based on the average of the premiums expended on these costs and total premium revenue for each of the previous three years for the plan.
Lastly, the Affordable Care Act required HHS to promulgate regulations for enforcing these provisions, and specifies that the Secretary may provide for appropriate penalties for non-compliance.

B. Department of Health and Human Services Regulations

1. Interim Final Rule

Through its Centers for Medicare & Medicaid Services (“CMS”), HHS published interim final regulations on the MLR requirements in December of 2010, detailing requirements for satisfying the MLR standards and certifying the NAIC’s definitions and other recommendations. These rules included disclosure and reporting requirements, the methodology for MLR calculation and rebates, processes for MLR waivers, and enforcement mechanisms.3 The interim final rule directed health insurance issuers to provide any necessary rebates directly to enrollees. HHS, through CMS, received numerous comments that such a rebate mechanism would have unintended tax consequences for the individual enrollee. The payment of rebates to enrollees could result in those rebates qualifying as wages and therefore taxable income for such enrollees, but allowing the insurer or group policyholder to use the rebate amounts to reduce future premiums may not be taxable.

2. Final Rule

In December of 2011 HHS issued its final rule on the MLR determination and rebate provisions for 2011 through 2013.4 By June of 2012, health insurance issuers must file reports with HHS and the states detailing premiums received and payments made for clinical care, activities to improve healthcare quality, and other expenses that are not part of the MLR. Health insurers not meeting their MLR must provide rebates to their enrollees beginning in 2012, meaning that if such a rebate is required for 2011, it must be paid by August 1 of 2012. The final rule addresses technical issues concerning the methods used by health insurance issuers to determine the rebates to be paid.

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3 75 Federal Register 74864 (Dec. 1, 2010).

issuers to calculate and report their MLR, as well as how rebates are distributed. After consulting with the Departments of Labor and Treasury, HHS directed insurers to provide rebates to the group policyholder - in all likelihood an employer - in a way that benefits such enrollees in a non-taxable manner (e.g., through lower premiums). Also, ICD-10 conversion costs of up to 0.3 percent of an insurer’s earned premium may be considered quality improvement activities for the 2012 and 2013 MLR reporting years. And, for insurers with community benefit expenditures, the insurer may deduct from earned premiums the higher of 1) the amount paid in state premium tax or 2) actual community benefit expenditures, up to the highest premium tax rate that applies to any issuer in the state. The final rules also addressed the MLR calculation for mini-medical plans.

II. CCIIO Technical Guidance

The bulletin provides MLR guidance through a question and answer format on the applicability of the MLR to certain plans, sole employee employer groups, counting employees for determining market size, individual association policies, offering policyholders a “premium holiday”, reinsurance and reporting, exchange user fees, states with a higher MLR standard, mini-med experience and application of the adjustment, and form of rebate. The guidance provided for several of these topics is summarized below.

A. Applicability to Certain Plans

The bulletin clarifies that self-funded plans are not subject to the MLR reporting and rebate requirements. The MLR requirements apply to health insurance issuers offering group or individual health insurance coverage. Self-funded plans, often referred to as self-insured plans, are not health insurance issuers, as defined by the PHSA, and are therefore not subject to the MLR requirements. The bulletin also indicates that even if a state law defines certain coverage as blanket coverage, an issuer offering such blanket coverage is subject to the MLR requirements if the coverage meets the definition of group or individual health insurance coverage under the PHSA.
B. **Sole Employee Employer Groups**

Where a sole proprietor and/or a spouse-employee are the only enrolled employees, the health plan would not be considered to be a group health plan. Thus its experience would be aggregated with the insurer's individual market experience and not with the insurer's small group market experience. However, if a sole proprietor enrolls a non-spouse employee, the experience of that plan is part of the small group market for MLR purposes. Even if the only enrollee is an employee who is not an owner or spouse, the plan is part of the small group market for MLR purposes.

C. **Number of Employees and Market Size**

At the time of sale, insurance issuers should make every attempt to accurately count the number of employees employed by the group policyholder so as to accurately categorize the group as belonging in the small or large group market. If the policyholder does not make the insurer’s policy available in all of the states in which it has employees, the insurer may not be able to count all of the employees. For example, an employer may be based in New York with 150 employees in New York and 20 employees in Maryland. The Maryland employees may have health insurance with one issuer while the New York employees are covered by a different and separate issuer. The issuer of the Maryland policy may not know the total number of the policyholder’s employees and may categorize the group in its systems to be in the small group market for purposes of the policy it issues, the rates it charges and so forth.

In such a situation, the insurer may determine the group size for MLR reporting purposes and the minimum MLR standard based on the information available to the insurer. Unless the insurer has information which puts it on notice that the total number of employees would cause the plan to be a large group for MLR purposes, the insurer may determine the number of employees solely based on the number of employees in Maryland and it may report the experience of the policy in the small group market or large group market based on the number of the plan’s Maryland employees.
D. **Exchange User Fees**

Exchange user fees should be included in the licensing and regulatory fees that are subtracted from premium in the MLR calculations. The regulation regarding reporting of fees requires insurance issuers to report as an adjustment to premium “statutory assessments to defray operating expenses of any state or federal department.”

E. **Form of Rebate**

An insurance issuer may provide rebates in the form of a premium credit, lump-sum check or, if the enrollee paid the premium using a credit or debit card, by returning the entire rebate to the account used to pay the premium, according to the bulletin. CMS believes that an alternative, such as a debit or credit card, is a reasonable alternative as long as it is as convenient to use as a check and meets all of the conditions described below.

An insurance issuer may provide rebates in the form of a pre-paid debit card provided that all of the following conditions are met:

1. The applicable policyholder’s or subscriber’s name must be on the card in order to ensure that the rebate reaches the intended policyholder or subscriber and is not stolen or diverted to a creditor or other third party;
2. The card must not have an expiration date;
3. The policyholder or subscriber must not incur any fees in association with the use or non-use of the card. If the institution that issues the card does not have any locations within a reasonable distance to the policyholder’s or subscriber’s mailing address and the policyholder or subscriber incurs a fee from another financial institution in order to cash the card, any such fees imposed by the other financial institution must be reimbursed by the issuing institution;
4. At the policyholder’s or subscriber’s request, the entire balance on the card must be convertible to cash;
5. The policyholder or subscriber must be able to contact the insurance issuer or the issuing institution in order to opt out of receiving the rebate in the form of a prepaid
debit card and request a paper check. Such check must be mailed within ten calendar days of the request;

6. The policyholder or subscriber must be able to contact the issuing institution during normal business hours to obtain the cash value, or balance, on the card; and

7. The policyholder or subscriber must be provided with an easy-to-understand notice of their rights and an explanation of the terms of the card at the time the cards are mailed.

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This bulletin is available for download at http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf.

This Committee Update provides general information and not legal advice or opinions on specific facts.