

# Health Care Reform Update

## Medical Loss Ratio Regulations Issued

As reported earlier, insurance carriers are required to satisfy certain medical loss ratio (“MLR”) thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan, it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to enrollees.

This does not apply to self-funded plans.

Last week, the Department of Health & Human Services (HHS) issued interim final regulations, effective January 1, 2011, implementing this requirement. They generally establish that:

- Carriers determine MLR on a state basis by market segment (individual, small group, or large group). Carriers do not disaggregate by type of plan within these markets (e.g., PPO v. HMO v. HDHP) or by policyholder.
- Carriers can deduct federal and state taxes that apply to health insurance coverage from a carrier’s premium revenue when calculating its medical loss ratio. Carriers cannot deduct agent and broker fees and commissions.
- There are some special exceptions for newer plans, smaller plans, mini-meds, and expatriate plans.

Additional information follows.

### REBATE AMOUNT

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For each calendar year (“MLR reporting year”), a carrier must rebate the difference between the required MLR and the carrier’s actual MLR.

The required MLR is .85 in the large group market,<sup>1</sup> and .80 in the small group market.<sup>2</sup> These ratios may be higher for coverage offered in a state whose law provides that carriers in the state must meet a higher MLR.

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<sup>1</sup> Coverage sold to an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. However, a state may substitute “51” employees for “101” employees.

<sup>2</sup> Coverage sold to an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. However, a state may substitute “50” employees for “100” employees.

The carrier's MLR is determined by doing the following calculation for each market in each state<sup>3</sup>:

the carrier's incurred claims plus expenditures for activities that improve health care quality <sup>4</sup>
divided by
premium revenue minus the carrier's federal and state taxes and licensing and regulatory fees

For example, a carrier must rebate a pro rata portion of premium revenue if it does not meet a .85 MLR for the large group market, assuming the state does not impose a higher MLR. If a carrier has a .80 MLR for the coverage it offers in the large group market, the carrier must rebate 5% of the premium paid by or on behalf of the enrollee for the MLR reporting year after subtracting premium and subtracting taxes and fees. In this example, an enrollee may have paid \$2,000 in premiums for the MLR reporting year. If the federal and state taxes and licensing and regulatory fees that may be excluded from premium revenue are \$150 for a premium of \$2,000, then the carrier would subtract \$150 from premium revenue, for a base of \$1,850 in premium. The enrollee would be entitled to a rebate of 5% of \$1,850, or \$92.50.

However, a carrier is not required to provide a rebate to an enrollee if the total rebate owed to the policyholder and the subscribers is less than \$5 per subscriber covered by the policy for a given MLR reporting year.

## EXCEPTIONS

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- **Smaller Plans.** Carriers may add to their medical loss ratio a "credibility adjustment" when the carrier's medical loss ratio for a market within a state is based on less than 75,000 people enrolled for an entire calendar year.
- **Newer Plans.** Certain carriers that have newly joined the insurance market may be able to delay reporting their medical loss ratio until the next year. When 50% or more of a carrier's premium income accounts for policies that have not been effective for an entire calendar year, they are eligible to delay reporting until the following year.
- **Mini-Med and Expatriate Plans.** HHS will apply a methodological adjustment to the way the medical loss ratio is calculated for mini-med and expatriate plans. This adjustment will address the unusual expense and premium structures of mini-med and expatriate plans and enable their carriers to apply for an adjustment to reported medical claims and quality improvement expenses.

## TIMING OF PAYMENTS AND INTEREST

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Rebates must be paid by August 1st each year. Carriers will be required to make the first round of rebates to consumers in 2012. A carrier that fails to timely pay any rebate must additionally pay the enrollee interest at the current Federal Reserve Board lending rate or 10% annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due.

## FORM OF PAYMENT AND RECIPIENTS

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Enrollees owed a rebate will see a reduction in their premiums, receive a rebate check, or, if the enrollee paid by credit card or debit card, a lump-sum reimbursement to the same account that the enrollee used to pay the premium. In some cases, the rebate may go to the employer that paid the premium on the enrollee's behalf. Regardless of whether the rebate is provided to enrollees directly or indirectly through their employer, each enrollee (here, each employee with respect to premiums paid for himself and any

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<sup>3</sup> With respect to each contract situated (issued or delivered as stated in the contract) in a state.

<sup>4</sup> The numerator does not include administrative services such as workforce salaries and benefits, agent and broker fees and commissions, and general and administrative expenses.

spouse or dependent) must receive a rebate that is proportional to the premium amount paid by that enrollee. The employer would keep the remainder. A carrier and employer can agree, via contract, that the employer will administer rebates to plan participants on behalf of the carrier.

## **NOTICE OF REBATES**

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For each MLR reporting year, at the time any rebate of premium is provided, a carrier must provide each enrollee who receives a rebate the following information in a form prescribed by HHS:

- A general description of the concept of an MLR;
- The purpose of setting a MLR standard;
- The applicable MLR standard;
- The carrier's MLR;
- The carrier's aggregate premium revenue minus any federal and state taxes and licensing and regulatory fees; and
- The rebate percentage and amount owed to enrollees based upon the difference between the carrier's MLR and the applicable MLR standard.

## **REPORTING**

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Beginning in 2011, insurance companies will have to report the following information to HHS annually in each state it does business for each market:

- Total earned premiums;
- Total reimbursement for clinical services;
- Total spending on activities to improve quality; and
- Total spending on all other non-claims costs excluding federal and state taxes and fees.

These reports will be posted publicly by HHS.

The report for each MLR reporting year must be submitted by June 1 of the year following the end of an MLR reporting year on a form and in the manner prescribed by HHS.

## **ENFORCEMENT**

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HHS enforces the reporting and rebate requirements.

Insurance carriers may face a civil monetary penalty for each violation that may not exceed \$100 for each day for each individual affected by the violation. The amount is subject to mitigating and aggravating circumstances. This is in addition to any other penalties prescribed or allowed by law.

## **EFFECT ON COMMISSIONS**

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The regulations include agent and broker commissions as part of the non-claims costs in the MLR calculation and do not allow for any portion of the agent and broker commissions to be considered a passed-through expense and excluded from the MLR calculation. However, in the individual market the regulation does permit states to seek waivers from the MLR requirements, including the possibility of seeking a waiver to have agent and broker commissions taken out of the denominator of the MLR calculation for policies sold in that state. The regulation specifically states that the impact of the MLR standard on agents and brokers will be a factor in considering whether a particular individual market would be destabilized. Furthermore, the regulation establishes a process by which stakeholders will have input on the waiver decision-making process and specifically included agents and brokers among the

stakeholder groups that must be included. It does not appear that similar waivers are available in the group market.

The interim rule is effective on January 1, 2011, but HHS is actively seeking comments on the regulation and will issue further guidance and a final rule later this year. HHS specifically requested comments on how this interim rule will impact agent and broker compensation and how that may lead to marketplace disruption.

The regulations delay the timeframe that MLR rebate payments must be made to policyholders until August 2012, providing an opportunity for a legislative solution to be enacted.

## EMPLOYER ACTION

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Employers do not need to take any action with respect to the new MLR rules, but should be aware of potential available rebates. As explained above, rebates are not determined on an employer-by-employer basis, but on a carrier's entire book of business in a state, segmented by the small or large group market. Rebates are only available with respect to fully insured plans. Employers may be asked to administer rebates to health plan participants on behalf of an insurance carrier. Carriers will be required to secure written agreements from employer before implementing this type of arrangement. Employers should be aware that carriers may decide to no longer automatically deduct commissions and remit them to brokers, but might instead bill employers a service fee.

## RESOURCES

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For the regulations, visit: [http://www.ofr.gov/OFRUpload/OFRData/2010-29596\\_PL.pdf](http://www.ofr.gov/OFRUpload/OFRData/2010-29596_PL.pdf).

For the fact sheet, visit: [http://www.healthcare.gov/news/factsheets/medical\\_loss\\_ratio.html](http://www.healthcare.gov/news/factsheets/medical_loss_ratio.html).



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