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HHS Releases Guidance on Medical Loss Ratio Requirement under PPACA

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On November 22, 2010, the Secretary of the Department of Health and Human Services ("HHS") released an interim final rule that implements the medical loss ratio ("MLR") requirement for health insurance issuers in accordance with the Affordable Care Act (the "Act").[1] The interim final rule was published in the December 1, 2010 Federal Register and contains a 60-day public comment period that ends January 30, 2011. The rules are effective January 1, 2011, and adopt and certify in full all of the recommendations in the model regulations of the National Association of Insurance Commissioners ("NAIC") regarding MLRs.

The interim final rule implements those provisions of the Act that are intended to bring down the cost of health care and ensure that consumers receive value for their premium payments. To that end, the interim final rule requires health insurance companies in the group or individual market, including grandfathered plans, to provide an annual rebate to enrollees if the insurer's "medical loss ratio" fails to meet minimum requirements: generally, 85 percent in the large group market and 80 percent in the small group or individual market.[2]

What does this mean to employers and their employees? Under the law, starting in 2011, insurers are required to spend at least eighty-five cents of every premium dollar (adjusted for taxes and fees) on either (1) reimbursements for clinical services provided to enrollees or (2) activities that improve health care quality (i.e., quality improvement activities).[3]

Note: These MLR rules **do not** apply to self-funded employer-sponsored plans.

In addition to the rebate requirement, the interim final rule establishes rules for greater transparency and accountability around the expenditures made by insurers. The rule requires insurers to report on the major categories in which enrollees' premium dollars are spent, such as clinical services provided to enrollees, activities that improve health care quality, all other "non-claims" costs and federal and state taxes and licensing or regulatory fees.

Medical Loss Ratio

The interim final rule requires health insurance companies in the group or individual market, including grandfathered plans, to provide an annual rebate to enrollees if the insurer's MLR fails to meet minimum requirements; generally, 85 percent in the large group market and 80 percent in the small group or individual market. The numerator of the MLR equals the insurer's incurred claims and expenditures for activities that improve health care quality, and the denominator equals the insurer's premium revenue minus federal and state taxes and licensing and regulatory fees.

Generally, for a nonclaim expense to qualify as a quality improvement activity, the activity must be designed to:

- improve health quality;
- increase the likelihood of desired health outcomes in ways that are capable of being objectively measured, and producing verifiable results and achievements;
- be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees, or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the nonenrollees; and
- be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations.

Rebates to Enrollees

In the unlikely event that an insurance company fails to meet the MLR standard for a given reporting year, it must provide a rebate to each enrollee. For purposes of determining who is entitled to receive a rebate, the term “enrollee” generally means the subscriber or policyholder that paid the premium for health care coverage received by an individual during the respective MLR reporting year.

For each MLR reporting year, an insurer must rebate to the enrollee the total amount of premium revenue received by the insurer from the enrollee (after subtracting federal and state taxes and licensing and regulatory fees), multiplied by the difference between the required MLR and the insurer’s MLR.

Notably, the interim final rule does not address how the rebates to enrollees apply to employers that permit employees to make premium contributions on a pre-tax basis through a cafeteria plan. Generally, such contributions are considered to be made by the employer because amounts reduced from an employee’s salary on a pre-tax basis are not “constructively received” by the employee and are not includible in gross income. In that case, any rebate made available under the interim final rule will likely be received entirely by the employer.

To the extent enrollees are entitled to a rebate, it is left unanswered whether their share of any such rebate would be considered “plan assets” under ERISA and required to be held in trust until distributed, even if the plan does not typically have “assets” for ERISA purposes. However, we expect that rebates will generally take the form of premium credits rather than cash payments.

Insurance Agents and Brokers

As discussed below, insurers are required to report certain information to HHS on an annual basis. The reports must include information on expenditures for “all other nonclaims costs, including an explanation of the nature of such costs.” “Other nonclaims costs” refers to expenditures that are not used to adjust premiums, or incurred claims or activities that improve quality care. HHS interprets this to mean that insurers must account for the use of all premium revenue, not just claims expenses and expenses to improve quality, which includes sales expenses, agents’ and brokers’ fees and commissions, other taxes, community benefit expenditures, and general administrative expenses.

Therefore, it appears that fees and commissions paid to insurance brokers cannot be included in the determination of whether an insurer has satisfied the applicable MLR standard. In other words, commissions are not considered to be either (1) reimbursement for clinical services provided to enrollees or (2) payment for activities that improve health care quality (i.e., quality improvement activities). Potentially this could impact how insurers structure their commission schedules in the future with respect to their group health plan products. In fact, some insurance companies already have advised brokers that commissions will be reduced or eliminated for group products. Such changes to the commission structure may lead some insurance brokerage firms to move toward either a fee-based or a "per employee per month" ("PEPM") pricing structure for their services.

With respect to plans in the individual (i.e., nongroup market), the NAIC raised some concerns in its correspondence with HHS regarding the potential impact of the interim final rule on agents' and brokers' fees and commissions. Some insurers may be particularly reliant on producers to distribute their products in the individual market. Agents and brokers also perform a range of functions on behalf of consumers and insurers. HHS will consider the impact of the MLR standard on agents and brokers, and such impact will be a factor in considering whether a particular individual (i.e., nongroup) market would be destabilized (and therefore would warrant relief from the MLR standard).

Other Insurance Company Requirements

Reporting

The interim final rule requires insurers to report data to HHS on a calendar year basis and at the state level by market (i.e., small and large group, and individual). The interim final rule defines the contract's state-of-issue based on the "situs" of the contract between the insurer and the policyholder, which is the state in which the contract is issued or delivered as stated in the contract (often the employer's headquarters). Special rules apply to determining the "situs" of a policy marketed to individuals and employers through associations or trusts.

Reports must be submitted to HHS by June 1 of the following year, which provides insurers additional time to process claims that were incurred but not reported by the end of the year. Also, insurers will report on a per-entity basis and not at the holding company level, as aggregation across affiliated insurers might combine the experience of insurers offering dissimilar coverage or that use different pricing policies. However, combined reporting across affiliates for "dual contracts" is permitted.[4] In addition, when affiliated insurers offer blended insurance rates to an employer (i.e., rates based on the combined experience of the affiliates serving the employer), incurred claims and expenses for quality improving activities can be adjusted among affiliates to reflect the experience of the employer as a whole.

To the extent an insurer fails to comply with the requirements of the interim final rule, civil monetary penalties may be assessed in the amount of $100 per entity, per day, per individual affected by the violation.

Treatment of "Mini-Med" and Expatriate Plans

Under the interim final rule, a "mini-med" plan refers to a policy offered by an insurer that has a total of $250,000 or less in annual limits. For 2011, issuers of mini-med plans are permitted to apply a twofold adjustment to the total of incurred claims and expenditures for activities that improve health quality. The adjustment is intended to address the unusual expense and premium structure of mini-med plans. Insurers wishing to take advantage of the adjustment are required to report data on a quarterly basis in order for HHS to determine whether, and to what extent, any such adjustment will be appropriate for 2012.

With respect to expatriate plans, such plans generally cover: employees working outside their country of citizenship; employees working outside of their country of citizenship and outside the employer's country of domicile; and citizens working in their home country. Their unique nature results in a higher percentage of administrative costs in relation to premiums than plans that provide coverage primarily within the United States. While some expatriate policies will be exempt from the MLR rule (e.g., policies issued by non-U.S. insurers for services rendered outside of the U.S., or a policy written on a form that was not filed and approved by any state insurance department), expatriate policies that are issued by U.S. domestic insurance companies on forms approved by a state insurance department are covered by the interim final rule. Therefore, the experience of an insurer's expatriate policies is to be reported separately from other coverage, and the calculation of claims and quality improving activities is to be multiplied by a factor of two. As with mini-med plans, insurance companies that offer expatriate plans will be required to report to HHS on a quarterly basis in 2011.

This client alert is meant to summarize and highlight the regulations regarding the medical loss ratio requirements established under health care reform. We will continue to update our clients on new developments in this rapidly changing area of the law. In the meantime, please feel free to contact your Proskauer attorney, or any member of our Health Care Reform Task Force, should you have questions regarding the medical loss ratio requirements or any other aspect of health care reform.

[1] The "Affordable Care Act" means The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA).

[2] The Act defines "small" and "large" group markets for MLR purposes by reference to insurance coverage sold to small employers or large employers. The Act defines a small employer as one that employs 1-100 employees and a large employer as one that employs 101 or more employees. However, until 2016, the Act permits states to limit the definition of a small employer to one that employs 1-50 employees.

[3] Activities that improve health quality must be grounded in evidence-based practices, take into account the specific needs of patients, and be designed to increase the likelihood of desired health outcomes (an insurer will have to show measurable results stemming from the executed quality improvement activity).

[4] Under a dual contract, a group health plan obtains coverage from two affiliated issuers, one providing in-network coverage, and a second affiliate providing out-of-network benefits. The experience of the two affiliated issuers providing coverage to a single employer can be combined and reported on a consolidated basis as if it were entirely provided by the in-network issuer. This maintains the experience of employees in a single reporting entity.