

January 18, 2012

## New Rules Issued on Medical Loss Ratio Requirements

### RESOURCE LINKS

Department of Health and Human Services  
<http://www.hhs.gov/>

Center for Consumer Information & Insurance Oversight (CCIIO)  
<http://cciio.cms.gov/>

CCIIO Medical Loss Ratio Information Page  
<http://cciio.cms.gov/programs/marketreforms/mlr/index.html>

CCIIO Resources and Guidance  
<http://cciio.cms.gov/resources/regulations/index.html#mlr>

United States Department of Labor  
<http://www.dol.gov/ebsa/newsroom/tr11-04.html>

Kaiser Family Foundation  
<http://healthreform.kff.org/Scan.aspx?tag=Medical+Loss+Ratio>

On December 7, 2011, the U.S. Department of Health and Human Services (“HHS”) and the Centers for Medicare & Medicaid Services (“CMS”) issued a [final rule](#)<sup>1</sup> (the “Final Rule”) revising medical loss ratio (“MLR”) requirements under the Patient Protection and Affordable Care Act (“PPACA”), as well as an [interim final rule](#)<sup>2</sup> (the “Interim Final Rule”) specifically addressing the rebate requirements for non-federal governmental plans (the Final Rule and the Interim Final Rule are collectively the “Rules”).

The MLR requirements, which took effect on January 1, 2012, apply to insured group health plans and individual health plans, including health plans that are grandfathered under PPACA. They do not apply to self-insured plans. Insurers are required to provide rebates to policyholders when their spending for covered plan benefits and quality improving activities in relation to the premiums received falls below the applicable MLR standard for the MLR reporting year. The rebates are determined based on the premium costs of insured coverage, as distinguished from pharmaceutical or manufacturer

rebates common to the health care industry. The purpose of the Rules is to reduce the cost of health care coverage by limiting the amount of premium available to insurers to spend on administrative costs and purposes other than the provision of health care services.

The MLR standards are 85 percent for the large-group insurance market and 80 percent for the small-group or individual insurance market. The definition of “small group” under the Rules is an employer group with 1-100 employees; however, states may elect to use a 50-employee threshold through 2016. Compliance with the MLR is determined by means of a fraction, the numerator of which consists of the issuer’s expenditures for incurred claims and activities that improve health care quality, and the denominator of which equals the issuer’s premium revenue. In circumstances

<sup>1</sup> 76 Fed. Reg. 76574 (Dec. 7, 2011).

<sup>2</sup> 76 Fed. Reg. 76596 (Dec. 7, 2011).

**IMPORTANT DATES**

**MLR Statute Effective**

January 1, 2012

**Final Rule and Interim Final Rule Effective**

January 3, 2012

**Comment Period for Final Rule**

February 6, 2012

**Rebates Due for 2011 MLR Reporting Year**

August 1, 2012

permitted by the Rules, a deficient MLR can be improved by: (i) increasing the numerator of the MLR through the use of a permitted multiplier (as provided for by regulation) to the claims paid or increasing expenditures on health care quality activities, or (ii) decreasing the denominator by deducting certain permitted expenditures. These provisions of the Rules address public comments that had been received concerning the administration of rebates and the appropriate standards for certain types of health plans.

**Who Gets the Rebate?**

When the applicable MLR requirement is not satisfied and there is a rebate due, a number of issues arise concerning who should receive the rebate and how the rebate should be paid. The Rules address these issues as follows:

**Policyholders.** The interim final rule required the issuer to make direct rebate payments to enrollees who had paid any portion of the premium during the MLR reporting year. This requirement generated public comments concerning its applicability to group health coverage. It was noted that issuers may not have access to the identity of the enrollees and are not equipped to address the tax consequences of the rebates, which are taxable to the enrollees if paid to them directly. In response to those public comments, the Rules now require issuers to pay the rebates to the group policyholder that paid the premium for group health care coverage. However, the benefit of the rebate must still be passed on to the enrollees. An “enrollee” is defined as a subscriber, policyholder, or government entity that paid the premium. Though there is no requirement that the rebate be passed on to enrollees in a manner that does not give rise to tax liability on their part, many group policyholders will want to provide the benefit on a tax-favored basis to avoid the administrative complications of reporting and withholding taxable income. (Examples of how to provide the benefit of the rebate to enrollees to avoid taxable income include the payment of premiums by the policyholder, premium “holidays,” or credit for future premiums.)

To satisfy the statutory obligation to convey the benefit of the rebate to enrollees, the Rules establish separate criteria for the manner in which rebates are to be passed on to enrollees for group health plans covered by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), group health plans that are not ERISA-covered, or governmental plans (e.g., church plans) and non-federal governmental health plans. The distinctions are the following:

- **ERISA Group Health Plans.** Public comments highlighted the legal reality that rebates to group health plans subject to ERISA might constitute “plan assets” within the meaning of the statute. As such, the disposition of rebates by the policyholder would be fiduciary conduct subject to the fiduciary and prohibited transaction requirements of ERISA. In the preamble to the Rules, CMS and HHS acknowledge that ERISA group health plans are not directly subject to CMS regulation and, therefore, would defer to the criteria and procedures standards applicable under ERISA to determine compliance with the statutory obligation to pass on the rebate benefit to enrollees.

The U.S. Department of Labor (“DOL”) issued Technical Release 2011-04 on December 2, 2011 (the “DOL Release”), to address the treatment of rebates with respect to ERISA plans. The DOL Release makes clear that if the ERISA group health plan or the group health trust is the policyholder, the entire rebate is a plan asset unless the governing plan instruments provide otherwise. If a plan sponsor (e.g., an employer or a Taft-Hartley trust) is the policyholder, the allocation of rebates will depend on the terms of the governing plan instruments and, if those are unclear, allocation may depend on how the participants and the sponsor have shared the cost of the expenditures that resulted in the rebate. This is a complex area as, in addition to the preceding considerations, there are provisions of ERISA, some of which are in the Internal Revenue Code, that generally prohibit employers from obtaining a refund of contributions that they have made to ERISA benefit plans. Plan fiduciaries and plan sponsors may consider looking at DOL guidance in other areas, such as the treatment of demutualization proceeds that constitute plan assets under ERISA.

- **Church Plans.** The Rules provide that when church plans (these group health plans are not subject to ERISA) are entitled to a rebate, the issuer may pay the group policyholder if it has written assurance that the rebate will be used to benefit subscribers. Without that assurance, the issuer must distribute the rebate in equal amounts to each subscriber covered by the policy during the calendar year without regard to the subscriber’s contributions to or costs of coverage.
- **Non-Federal Governmental Plans.** A separate set of final regulations on the MLR requirements applicable to non-federal governmental plans were issued. These regulations allow group policyholders to distribute the benefits obtained from rebates to subscribers by choosing one of the following options: (i) reducing the annual premium for the subsequent policy year for all subscribers covered under any group health plan option at the time the rebate is received; (ii) reducing the annual premium for the subsequent policy year for only those subscribers who were covered under the group health plan option on which the rebate was based; or (iii) providing a cash refund to subscribers covered under the policy on which the rebate is based. The portion of the rebate attributable to former subscribers’ contributions for the MLR reporting year must be used for the benefit of current subscribers.

### **MLR Notifications**

If a rebate is payable, the issuer is required to provide a rebate notification to each policyholder who receives a rebate, each subscriber whose policyholder receives a rebate, and each subscriber who receives a rebate directly. The Rules expand issuer notification requirements for group health plans by requiring the issuer to include in the rebate notification, among other things, a description of the concept of a MLR standard, the issuer’s MLR, the issuer’s aggregate premium revenue, the rebate percentage, and the amount owed to enrollees. Additionally, the Rules further require notification of the total aggregated rebate for the group health plan and statements of the special rebate rules for ERISA plans, church plans, and non-federal governmental plans. The Rules also solicit public comments on whether enrollees should receive notification of MLR standards even when no rebate is required.

## Exceptions and Adjustments to MLR

**Mini-Med Policies.** Mini-med policies are health policies that impose annual dollar limits on benefits paid. For MLR purposes, these are policies with annual dollar limits of \$250,000 or less. Under PPACA, annual dollar limits on benefit coverage no longer will be permitted after 2014 and present only short-term issues. Mini-med policies are more likely to fail the MLR test because, frequently, their health expenditures are materially lower than the premiums paid.<sup>3</sup> The interim final rule had provided a multiplier for mini-med plans that would allow issuers to multiply the MLR numerator by 2.0. A diminishing multiplier, however, will be in effect under the Rules – *i.e.*, 1.75 for 2012, 1.5 for 2013, and 1.25 for 2014. This allows for mini-med plans to be phased out over a three-year period and offers some relief to issuers from the MLR requirements.

**Expatriate Policies.** The Rules retain the relief provided under the interim final rule for expatriate policies, including permitting the use of a multiplier of 2.0 for calculating the MLR numerator, to account for the unique characteristics of these policies.

**Fraud Reduction Expenditures.** In response to public comments, the regulators decided that expenditures by issuers to reduce fraud would not qualify as a quality improvement activity. The regulators concluded that the interim final rule allowed payments recovered through fraud reduction efforts to be treated as incurred claims up to, but not in excess of, their fraud reduction expenses, and this is a sufficient incentive for issuers.

**Data-Coding Conversion Expenses.** Some relief is provided under the Rules for conversion expenses required by the Health Insurance Portability and Accountability Act (“HIPAA”) to update systems to the new data-coding standards endorsed by the World Health Organization (known as “ICD-10”). In recognition of the dual effects of ICD-10 conversion expenses as important for health care quality improvement and care coordination, and to the increased efficiency of administrative functions, the Rules treat these expenses as quality improvement activities. In 2012 and 2013, up to 0.3 percent of an issuer’s earned premium in the relevant state market may qualify as quality improvement activities.

**Community Benefit Expenditures.** Community benefit expenditures are expenditures that may be deducted from the earned premium of not-for-profit, tax-exempt issuers. The Rules provide that the amount deducted for community benefit expenditures may be the higher of either the amounts of any state premium tax paid by the issuer or the actual amount of the issuer’s community benefit expenditures up to the amount that would be generated by the highest premium tax rate in the state.

## Agents’ and Brokers’ Fees and Commissions

Issuers did not receive the relief under the Rules that they had sought through the treatment of licensed brokers’ and insurance agents’ fees and commissions as “losses” for MLR purposes. (There was intensive lobbying activity by the industry seeking to obtain such relief, which was strongly supported by the National Association of Insurance Commissioners (“NAIC”).) This means that those

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<sup>3</sup> See article entitled “The What, Why and How of Medical Loss Ratio,” *National Health Reform Magazine* (Jan. 11, 2011), available at [www.healthcarereformmagazine.com/article/the-what-why-and-how-of-medical.html](http://www.healthcarereformmagazine.com/article/the-what-why-and-how-of-medical.html).

fees and commissions will continue to be an administrative expense that issuers are motivated to control by virtue of the penalties that can flow from the failure to meet MLR standards.

### **Adjustment by State of the Individual MLR**

In passing PPACA, Congress recognized that the application of an 80 percent MLR to individual health plans in certain states could have a significant detrimental impact on the availability of coverage in those jurisdictions. Therefore, Congress permitted exceptions when the Secretary of HHS determined that the 80 percent MLR might “destabilize the individual market” of a state. States must apply to obtain an adjustment to the MLR in their individual market.

As of January 6, 2012, seventeen states have requested adjustments. Six states have received relief from application of the 80 percent MLR (Georgia, Iowa, Kentucky, Maine, Nevada, and New Hampshire).<sup>4</sup> The relief allows each of these states to implement an MLR that is lower than 80 percent. The revised target MLR percentage varies by state and, in some cases, by year. Eight states have been denied adjustment relief (Delaware, Florida, Indiana, Louisiana, Michigan, North Dakota, and, by letters dated January 4, 2012, Kansas and Oklahoma). Three states are still in process: Texas has completed the application process and is awaiting a decision, and North Carolina and Wisconsin have submitted applications that are under review for completeness.

### **What Can We Expect to See Under the Rules?**

- Most issuers in the group and individual markets will make a considerable effort to satisfy the MLR standards. A study by the U.S. Government Accountability Office (“GAO”), dated October 31, 2011, has found that most issuers will satisfy the MLR standards and will not be required to pay a rebate.<sup>5</sup> In those instances where a rebate will be payable for the 2011 MLR reporting year, it must be paid by August 1, 2012. The year 2012 will be critical in assessing the impact of the MLR standards. Particular attention may be useful with respect to the markets in those states that were denied MLR adjustment relief.
- A GAO study issued in the summer of 2011 states that there is some preliminary evidence that the MLR requirements are helping to reduce the costs of health insurance, not health care services.<sup>6</sup>

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<sup>4</sup> The approved changes to the MLR standard are as follows:

Georgia: 2011 – 70%, 2012 – 75%, and 2013 – 80%.

Iowa: 2011 – 67%, 2012 – 75%, and 2013 – 80%.

Kentucky: 2011 – 75%, 2012 – 80%, and 2013 – 80%.

Maine: 2011 – 65%, 2012 – 65%, and 2013 – 65% (subject to verification of additional data).

Nevada: 2011 – 75%, 2012 – 80%, and 2013 – 80%.

New Hampshire: 2011 – 72%, 2012 – 75%, and 2013 – 80%.

[www.cciio.cms.gov/programs/marketreforms/mlr/index.html](http://www.cciio.cms.gov/programs/marketreforms/mlr/index.html).

<sup>5</sup> U.S. Gov’t Accountability Office, “Private Health Insurance: Early Indicators Show That Most Insurers Would Have Met or Exceeded New Medical Loss Ratio Standards,” GAO-12-90R (Oct. 31, 2011), *available at* <http://www.gao.gov/products/GAO-12-90R>.

<sup>6</sup> U.S. Gov’t Accountability Office, “Early Experiences Implementing New Medical Loss Ratio Requirements,” GAO-11-711 (Aug. 29, 2011), *available at* [www.gao.gov/products/GAO-11-711](http://www.gao.gov/products/GAO-11-711).

- Whether MLR standards will have an impact on the cost of medical care itself remains to be determined. It is, at least, an open question as to whether they can be expected to have that effect, as insurers are not penalized under the Rules for failing to control medical costs. Issuers are penalized only for failing to control administrative costs in relation to medical costs. Under the current MLR structure, as medical costs continue to rise and require increases in premium, issuers will also have more money to spend on administration, while still complying with MLR requirements.
- Issuers did not receive the relief that they sought with respect to agents' and brokers' fees and commissions. It is reasonable to anticipate that there may be some evolutionary developments in the relationships between agents and brokers on the one hand and issuers on the other as they seek to adapt to the new environment created by the MLR standard. For example, if brokers' and agents' fees and commissions were paid by policyholders, or perhaps by some as yet to be identified third parties, it would be easier for issuers to satisfy their MLR obligations. This development, however, would likely cause substantive relationship changes between these entities.
- As just noted, only premium income matters for MLR purposes. It is reasonable to anticipate that insurance companies may focus much more attention on products and relationships that deal only with administrative functions in settings for which the compensation received is not deemed a premium, such as, for example, "administrative services only" agreements. Risk could be dealt with separately in distinct arrangements. It is reasonable to speculate that the Rules may accelerate the currently observable trend towards various self-funded arrangements.
- Last, it is possible that the enforcement of the Rules may accelerate the time when it must be concluded by relevant governmental and private institutions that nothing more can be squeezed out of the administrative component of health care coverage. At that time, all that will be left to look at is the cost of health care itself.

For more information about this issue of *IMPLEMENTING HEALTH AND INSURANCE REFORM*, please contact one of the authors below or the member of the firm who normally handles your legal matters.

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