Thomas D. Bixby
Law Office LLC
Legal Advice for Health Plans

HEALTH LAW ALERT
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HHS Publishes Medical Loss Ratio Rule
Employers May Administer and Receive Portion of Rebates

Today, the Department of Health and Human Services' Office of Consumer Information and Insurance Oversight ("OCIIO") formally published an interim final rule (the "MLR Rule") that dictates how insurers are to calculate loss ratios and administer the rebates required by the Patient Protection and Affordable Care Act (the "Affordable Care Act"). The MLR Rule "adopts and certifies in full all of the recommendations . . . of the National Association of Insurance Commissioners (NAIC) regarding [medical loss ratios]."

The MLR Rule will require insurers that fail to meet the medical loss ratio standard established by the Affordable Care Act to pay rebates to employers (and others that sponsor insured groups) as well as to "enrollees," as required by the statute. Rebates are to be based on the proportion of premium employers and subscribers paid during the course of the year. Insurers will be allowed to contract with employers (or other plan sponsors) to distribute the portion of rebates that must be paid to individual subscribers.

The MLR Rule is codified at 45 C.F.R. Part 158. The Rule is incorporated into my compilation of Selected Federal Health Insurance Provisions, which is available here (or go to the "Resources" page of tbixbylaw.com). See the first line under "Compiled Rules."

1. Premium Rebates

The MLR Rule requires an insurer that does not meet a minimum "medical loss ratio" standard during a calendar year to provide a rebate to its customers no later than the next August 1st. Generally, the Act defines an insurer's loss ratio as the percentage of premiums spent on the sum of (a) claims and (b) "activities that improve health care quality." The minimum medical loss ratio for the individual and small group (100 or fewer employees) markets is 80%, whereas the minimum for the large group market (101 or more employees) is 85%.[1]

Relevant Dates

The MLR Rule goes into effect on **January 1, 2011**. Comments on the Rule must be submitted no later than **January 31, 2011**. Insurers that fail to meet the minimum medical loss ratio for calendar year 2011 must provide rebates by **August 1, 2012**. The rule is published at 75 *Federal Register* 74863 (Dec. 1, 2010) (click here).

[1] States may elect to impose a more stringent—higher—loss-ratio standard on insurers. Until 2016, States may also elect to define the small group market as groups of 50 or fewer employees and the large group market as groups of 51 or more employees.

How the Rebate is Paid

Form of Payment. Rebates may be made in the form of a lump sum check. With respect to an enrollee who originally paid premium with a credit card or debits directly from a bank account, the insurer may pay the rebate by crediting the appropriate credit card or bank account with the lump sum. Insurers may pay current enrollees with a credit on future premium payments, provided that the entire rebate is credited to the first premiums due on or after August 1.

Notice with Payment. The rebate must be accompanied by a notice that briefly explains the medical loss ratio requirement and why the subscriber is receiving a rebate. The notice must also provide (among other things) the insurer's medical loss ratio, the total amount being paid to enrollees, and the total amount being paid to employers.

De Minimis Payments. OCIIO acknowledges that very small rebates are "largely of symbolic value" and that the "cost of processing and distributing the rebate might be greater than the amount of the rebate." Nevertheless, insurers "should not be allowed to retain these unpaid rebate funds." The MLR Rule therefore permits insurers to refrain from paying enrollees rebates of less than $5, but requires them to distribute the aggregate amount of the de minimis rebates equally to other enrollees entitled to a rebate.

Unclaimed Rebates. When rebates are not claimed after an insurer makes good faith efforts to locate an eligible enrollee, the insurer must comply with applicable State law, such as State unclaimed property and escheat laws.

Who Gets the Rebate. Read literally, the Affordable Care Act would require insurers to rebate a portion of the premium to "each enrollee." But, because the term "enrollee" includes a subscriber's family members, who may not pay premium, paying the rebate to each individual enrollee would "provide a windfall to those who did not pay premiums." Moreover, in the group insurance context, employers (or other plan sponsors) often pay a significant portion of an enrollee's premium. Paying a rebate to "each enrollee" would, therefore, "frustrate the purpose of [this provision of the Affordable Care Act by depriving] those who actually paid premiums of the rebate."

The OCIIO has therefore elected to "requir[e] any rebate be provided on a pro rata basis to the person or entity that paid the premium on behalf of the enrollee." Thus, an insurer that fails to meet the minimum medical loss ratio threshold must provide the employer (or other plan sponsor) and the employee (or other subscriber) a rebate proportional to the amount of premium that each paid.

Accordingly, in order to determine the proportion of the rebate to which each subscriber and employer is entitled for the 2011 calendar year beginning January 1, 2011, an insurer must track the portion of premium each pays during the calendar year. The amount of premium each subscriber pays varies by a number of factors, such as the number of months the subscriber is enrolled, whether s/he has family, individual, or other coverage, the specific product in which s/he is enrolled (*e.g.*, HMO, PPO, or HDHP), and the portion of premium the employer pays. In addition, insurers will need to collect or maintain addresses for former subscribers who may become eligible for a rebate.

Hence, insurers will need to implement systems to collect and maintain information on subscribers' addresses, the amount of premium each subscriber pays, and the amount an employer (or other plan sponsor) pays overall. The systems need to be designed to reflect the complex set of circumstances that affect the amount of premium different parties may pay. Group policyholders, which will usually be the source of the information, may be reluctant to take on the administrative burden of collecting and providing this information for the insurer.

> ***Action Item:*** *An insurer should ensure that it has processes in place (or should establish processes) to reliably collect from each group policyholder (1) up-to-date addresses for current and former subscribers, (2) the amount of premium each subscriber pays, and (3) the premium the group policyholder pays. These processes should be in place no later than January 1, 2011.*

2. Group Administration of Rebates

Because "it is the group policyholders [*i.e.*, employers] and not the [insurers] who know the extent to which [subscribers] made the original premium payments," the OCIIO recognizes that "group policyholders may be in a better position to determine the rebate amount each individual [subscriber] should receive." To reflect this "practical reality," the MLR Rule permits insurers to contract with group policyholders, such as employers, to distribute rebates to subscribers. The insurer, however, remains "liable for complying with all of its obligations under [the MLR Rule]" and must obtain records and documentation necessary to demonstrate that rebates have been accurately calculated and distributed. The information the insurer must collect includes the following amounts:

- Premium paid by each subscriber;
- Premium paid by the group policyholder;
- Rebate provided to each subscriber;
- Rebate retained by the group policyholder; and
- Unclaimed rebates.

Group policyholders that perform administrative tasks, such as calculating and distributing rebates, may seek remuneration for performing these functions.

> ***Action Item:*** *Insurers should consider contracting with group policyholders (such as employers) to administer rebates and determine the amount (if any) of compensation the group policyholders should receive for performing the administrative tasks. Insurers that elect to have group policyholders administer rebates should draft agreements to ensure the group policyholder meets applicable requirements and all appropriate information is provided to the insurer.*

3. Calculation of Medical Loss Ratio and Rebates

In general terms, an insurer calculates its loss ratio for the Affordable Care Act by adding reimbursement for clinical services (or incurred claims) to expenses for activities that improve health care quality. The insurer then divides that amount by earned premium (after deducting State and Federal taxes). The result is the percentage of premium dollars spent on claims and health improvement activities. An insurer must report this loss ratio for each market—individual, small group, and large group—in which it does business, with separate calculations for each State in which the insurer is licensed. Insurers must report this information to the OCIIO for each calendar year by June 1 of the subsequent year. Rebates must be paid by August 1.

An insurer must grant OCIIO "access and entry to its premises, facilities and records, including computer and other electronic systems . . . to evaluate, through inspection, audit, or other means, [the insurer's] compliance with the requirements for reporting and calculation of data submitted to [OCIIO], and the timeliness and accuracy of rebate payments made under [the MLR Rule]." To the extent that vendors, subsidiaries, or parent organizations have information "that pertain[s] to any aspect of the data reported to [OCIIO] or to rebate payments calculated under [the MLR Rule]," the insurer must "contractually obligate any such . . . third parties to grant" access to their premises, facilities and records, including computer and other electronic systems.

> ***Action Item:*** *Insurers should evaluate whether third parties—vendors, affiliates (including parent companies), or others—may have information relevant to medical loss ratio calculations and rebate distributions. To the extent third parties have such information, insurers should contractually obligate them to provide OCIIO the requisite access.*

Insurers must pay rebates to subscribers and group policyholders when the insurers' medical loss ratio fails to meet the minimum standards established by the Affordable Care Act: 80% for the individual and small group markets and 85% for the large group market. A loss ratio that falls below these thresholds indicates administrative and other expenses that are too high "to provide value to policyholders," triggering a rebate of premiums constituting the difference between the minimum medical loss ratio and an insurer's actual medical loss ratio. Thus, insurers have a significant incentive to avoid administrative and other expenses that cannot be included in the loss ratio calculation, whereas expenses that may be included in the loss ratio calculation—actual claims paid to providers and expenses for

Enforcement

OCIIO believes that State Departments of Insurance should continue to play a significant "oversight role with respect to [enforcing] the reporting provisions of [the MLR Rule]." Accordingly, OCIIO will "accept the findings of audits conducted by State regulators, so long as certain specified conditions are met." Those conditions include State laws that permit public release of the audit findings and timely reporting of the findings to OCIIO. OCIIO will, of course, retain the right to conduct its own audits and investigations.

activities that improve health care quality—do not increase the insurer's risk of paying out a rebate.

Activities that Improve Health Care Quality. An activity that improves health care quality must be designed to improve health quality and increase the likelihood of desired health outcomes in ways that may be "objectively measured." The activity must 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."

Thus, case management, care coordination, chronic disease management, and medication compliance initiatives qualify as activities that improve health care quality. The MLR Rule explicitly lists wellness assessments, wellness/lifestyle coaching programs designed to achieve specific and measureable results, coaching programs designed for specific chronic diseases or conditions, and coaching or educational programs designed to change behavior, such as smoking and obesity programs, as activities that improve health care quality.

On the other hand, activities "designed primarily to control or contain costs" are treated as administrative expenses. Expenses related to improving or replacing claims systems, specifically including "costs of implementing new administrative simplification standards and [ICD-10] code sets adopted pursuant to . . . HIPAA," are administrative expenses. Similarly, administrative expenses include expenses associated with retrospective and concurrent review, provider credentialing, marketing, and fraud prevention activities (to the extent expenses exceed the amount actually recovered to reduce incurred claims).

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For more information, please contact Tom Bixby at (608) 661-4310 or TBixby@tbixbylaw.com

Thomas D. Bixby Law Office LLC
(608) 661-4310 | www.tbixbylaw.com