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

HEALTH LAW ALERT
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HHS Simplifies MLR Rebate Requirements for Group Coverage
Also Allows ICD-10 Conversion Costs as Quality Improvement Activities

Yesterday, the Department of Health and Human Services (HHS) published a final rule and an interim final rule that should substantially simplify administration of rebates paid to group policyholders and subscribers under the Affordable Care Act's Medical Loss Ratio (MLR) requirements. The rules will (in most cases) allow insurers to provide rebates directly to the group, but will not hold insurers responsible for collecting information necessary to calculate rebates for subscribers, contracting with the group to provide rebates to subscribers, and ensuring appropriate distribution of the rebates, as would have been required under the original interim final rule. Moreover, insurers (in most cases) will not be responsible to provide rebates to former subscribers of group plans. The rebate process for individual coverage was not affected by the rules.

The final rule will also permit insurers to include certain costs related to conversion of insurers' claims-payment systems to the use of ICD-10 codes as "quality improvement activities" for purposes of calculating an insurer's MLR.

The rules, published at 76 *Federal Register* 76574 and 76596, are effective January 3, 2012. HHS asks for comments on the rules by February 6, 2012. The rules are incorporated into my compilation of Federal Insurance Provisions available here or at tbixbylaw.com (*see* the "Resources" page, under "Compiled Rules").

Rebates for Group Insurance Coverage

Under the Affordable Care Act, an insurer that fails to meet a minimum MLR standard during a calendar year must provide a rebate to its customers. Generally, an insurer's loss ratio is the percentage of premiums spent on the sum of (a) claims and (b) "quality improvement activities." The minimum medical loss ratio for the individual and small group (100 or fewer employees) markets is 80%, whereas the minimum MLR for the large group market (101 or more employees) is 85%. The original MLR Rule, published in December 2010, would have required insurers to provide rebates to group subscribers and the policyholder (*e.g.*, the employer) in proportion to the premium paid by each. In order to implement this requirement, insurers would have been required to collect information about the amount of premium paid by each subscriber and the group policyholder. Insurers had the option of contracting with willing group policyholders to distribute the rebates to subscribers, but remained responsible for the appropriate payments if the group policyholder failed to distribute rebates as required.

HHS recognized that its rebate scheme had "unintended administrative consequences as well as potential tax consequences for [insurers], employers, and consumers."[1] As a result, HHS amended the original MLR Rule to require insurers to provide rebates to the group policyholder (see box below, for exception to this general rule). Under the interim final rule and guidance issued by the Department of Labor in conjunction with the rules, the policyholder will have obligations to see that subscribers' share of the rebate be used "for the benefit of subscribers." These obligations arise from different sources, depending on whether the group policyholder is subject to ERISA or not.

- The Department of Labor explains in Technical Release 2011-4 (click here for a copy) that rebates paid to policyholders subject to ERISA may be "plan assets," which "generally must be held in trust, may not inure to the benefit of any employer, and must be held for the exclusive purpose of providing benefits to participants in the plan." Although the Technical Release provides less-than-definitive guidance on when rebates qualify as plan assets, it does explain that unless "plan documents and other extrinsic evidence [indicate otherwise], the portion of a rebate that is attributable to participant contributions would be considered plan assets."

- The interim final rule (Federal Register citation provided above) imposes explicit requirements on non-Federal governmental plans, which (unlike ERISA group health plans) are subject to regulation by HHS. These plans must use a portion of any rebate for the benefit of subscribers. Non-Federal governmental plans may elect one of four specified options for crediting subscribers with an appropriate portion of a rebate, such as reducing subscribers' portion of premium for the subsequent premium year.

In any event, insurers are no longer responsible for ensuring groups comply with these requirements. Insurers' only duty with respect to group rebates (other than with respect to Church plans, as explained in the box on the right) is to pay rebates to the group policyholder.

Special Rule for Church Plans

Insurers cannot provide a rebate to a group plan that is neither (a) a non-Federal governmental plan nor (b) subject to ERISA (such as a church plan), unless the plan agrees to distribute rebates to subscribers. The affected plan must agree to distribute rebates to subscribers in the same manner as non-Federal governmental plans.

In the absence of such an agreement, the insurer must distribute the entire rebate to subscribers equally—not based on the amount of premium paid. The rebate must go to subscribers covered during the relevant MLR policy year. Thus, a church plan must agree to distribute a rebate to subscribers or lose its share of the rebate. And an insurer must retain addresses for subscribers in such plans for up to 20 months after they disenroll, in case a rebate is owed and the church plan does not agree to distribute the rebate.

[1] Among other concerns, rebates would have to qualify as income for group plan subscribers who paid premium through cafeteria plans.

ICD-10 Conversion Costs

Beginning on October 1, 2013, covered entities subject to the HIPAA Transactions Rule (45 C.F.R. Part 162) are required to replace ICD-9 codes with ICD-10 codes in standard transactions for reporting diseases, injuries, and other health care conditions and to identify hospital inpatient procedures. HHS determined that, since these changes are being required in part to improve quality of care, it would be appropriate to allow insurers to include a portion of ICD-10 conversion costs as "quality improvement activities," rather than administrative expenses, when calculating medical loss ratios in 2012 an 2013. Insurers may include up to 0.3% of earned premium spent on ICD-10 conversion as quality improvement activities.

Other Issues

The rule also phases out favorable treatment of "mini-med" policies with respect to calculation of medical loss ratios, but retains favorable treatment for expatriate policies, which have "significantly different and additional administrative costs than . . . policies that provide primarily domestic coverage." The rule also adjusts how a non-profit insurer's "community benefit expenditures" are addressed in MLR calculations.

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