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Q&As on Medical Loss Ratio Rules

The Affordable Care Act (ACA) includes medical loss ratio (MLR) rules that require health insurance issuers to report how they spend their premium revenue to the Department of Health and Human Services (HHS). Beginning in 2012, issuers that do not spend at least 80 percent (small group and individual markets) or 85 percent (large group market) of their premium revenue on reimbursement for clinical services and health care quality improvement must provide rebates to consumers.

HHS has issued regulations to implement the MLR rules. HHS has also issued guidance on the MLR rules in the form of questions and answers (Q&As). These Q&As address a number of topics related to the MLR rules, including counting employees for determining market size, offering a "premium holiday," distributing rebates as pre-paid debit cards and providing MLR notices. On April 5, 2013, HHS issued an additional Q&A on the MLR rules to address how issuers should treat ACA fees.

This Legislative Brief contains select Q&As on the MLR rules. More information on the MLR rules is available through the Center for Consumer Information and Insurance Oversight website.

APPLICABILITY OF THE MEDICAL LOSS RATIO RULE TO CERTAIN TYPES OF PLANS (45 CFR §158.102)

Q: Are self-funded plans subject to the MLR reporting and rebate requirements?

A: No. Section 2718(a) of the PHS Act and its implementing regulation, 45 CFR §158.102, provide that the MLR requirements apply to health insurance issuers offering group or individual health insurance coverage. A self-funded plan (sometimes referred to as a self-insured plan) is not a health insurance issuer, as defined by § 2791(b)(2) of the PHS Act, and thus is not subject to the MLR requirements. It does not matter if the self-funded plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA) or if it is a non-ERISA plan.

Q: Is the experience for health insurance benefits provided through a Medicaid managed care organization (MCO) contract with a state Medicaid agency to provide benefits to Medicaid beneficiaries subject to the MLR reporting and rebate requirements?

A: No. Section 2718(a) of the PHS Act applies to health insurance issuers offering employer group or individual health insurance coverage. Medicaid coverage offered under a contract with a state Medicaid agency is governed by Title XIX of the Social Security Act and regulations at 42 CFR Part 438, and not by state insurance law. Under these circumstances, issuers are not offering group health insurance coverage as defined under §2791(b)(4) of the PHS Act because the coverage is not offered in connection with a group health plan, nor are they offering individual health insurance coverage as defined under §2791(b)(5) of the PHS Act, because the coverage is not offered to individuals in the individual market. Congress recognized the inapplicability of Title 27 of the PHSA to MCO contracts when it enacted section 1932(b)(8) of the Social Security Act, which makes some, but not all, Title 27 requirements applicable to Medicaid MCO contracts.

Q: Is the experience for health insurance benefits provided through a contract with CMS that offers health insurance coverage through Medicare, such as Medicare Advantage plans (Medicare Part C) and Medicare prescription drug plans (Medicare Part D), subject to the commercial MLR reporting and rebate requirements?

A: No. Section 2718(a) of the PHSA applies to health insurance issuers offering group or individual health insurance coverage. Medicare Advantage plans and Medicare Part D prescription drug plans are not group health insurance coverage as defined under §2791(b)(4) of the PHSA (because the coverage is primarily provided under a contract with the Medicare program, not an employer group health plan) or individual health insurance coverage as defined under §2791(b)(5) of the PHSA (because the coverage is not offered to individuals in the individual market). Such coverage is instead subject to a comprehensive regulatory scheme under Parts C and D of Title XVIII of the Social Security Act and regulations at 42 CFR Parts 422 and 423. Congress clearly recognized the inapplicability of the MLR requirements in section 2718 to Medicare Advantage plans when it added separate and distinct MLR requirements to the Part C statute. This answer applies even in cases in which the Medicare Part C or Part D plan is designed for members of an employer group under section 1857(i)(1) of the Social Security Act.

Q: Are blanket health insurance policies subject to the MLR reporting and rebate requirements?

A: Some states categorize certain health insurance coverage as blanket health insurance policies distinct from group and individual health insurance coverage. Guidance issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 62 FR 16893, 16896 (April 8, 1997) addressed the interaction of federal regulations with state law, and noted that federal law categorizes health insurance coverage into two markets, group market and individual market. The PHS Act does not include the term blanket coverage. The Affordable Care Act does not modify the types of coverage that fall within the PHS Act, and the 1997 HIPAA guidance remains in effect. Even if a state law defines certain coverage as blanket coverage, an issuer offering such blanket coverage is subject to the MLR requirements if the coverage meets the definition of group or individual health insurance coverage under §2791 of the PHS Act.

EMPLOYER GROUPS OF ONE (45 CFR §158.103)

Q: The MLR regulation, 45 CFR 158.103, defines a small employer as having 1-100 (or at state option, 1-50) employees. When is a health plan a group of one and thus reported with small group market experience and when is it reported with individual market experience?

A: PHS Act §2791 defines the terms “individual market,” “large group market” and “small group market.” We codified those terms in 45 CFR §158.103. To be considered a group health plan, the health plan must have “employees” among its participants. For the purpose of determining whether a group health plan exists, federal law does not classify an individual and his or her spouse as employees when the trade or business is wholly owned by the individual or by the individual and his or her spouse. Thus, where a sole proprietor and/or a spouse-employee are the only enrolled employees, the health plan would not be considered to be a group health plan. Thus its experience would be aggregated with the issuer’s individual market experience and not with the issuer’s small group market experience.

However, if a sole proprietor enrolls a non-spouse employee, the experience of that plan is part of the small group market for MLR purposes. Even if the only enrollee is an employee who is not an owner or spouse, the plan is part of the small group market for MLR purposes.

COUNTING EMPLOYEES FOR DETERMINING MARKET SIZE (45 CFR §158.103, §158.120, §158.210)

Q: When reporting group MLR experience, what method should issuers use for counting “employees” covered by a group policy that does not cover all of the employees of the employer, where the issuer does not have the information to determine the employer’s total number of employees, which it needs in order to determine whether the group policy should be treated as large group or small group, as required by 45 CFR §158.120, and to determine the MLR standard required by 45 CFR §158.210?

A: At the time of sale, issuers should make every attempt to accurately count the number of employees employed by the group policyholder so as to accurately categorize the group as belonging in the small or large group market.

If the policyholder does not make the issuer’s policy available in all of the states in which it has employees, the issuer may not be able to count all of the employees. For example, an employer may be based in New York with 150

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employees in New York and 20 employees in Maryland. The Maryland employees may have health insurance with one issuer while the New York employees are covered by a different and separate (affiliated or unaffiliated) issuer. The issuer of the Maryland policy may not know the total number of the policyholder's employees and may categorize the group in its systems to be in the small group market for purposes of the policy it issues, the rates it charges and so forth. In such a situation, the issuer may determine the group size for MLR reporting purposes and the minimum MLR standard based on the information available to the issuer. Unless the issuer has information which puts the issuer on notice that the total number of employees would cause the plan to be a large group for MLR purposes, the issuer may determine the number of employees solely based on the number of employees in Maryland and it may report the experience of the policy in the small group market or large group market based on the number of the plan's Maryland employees.

This guidance is intended to clarify CMS' prior guidance on Counting Employees for Determining Market Size, which is available at http://cciio.cms.gov/resources/files/20110718_mlr_guidance.pdf, and amends the prior guidance only insofar as the situation presented by the scenario in this guidance is concerned.

INDIVIDUAL ASSOCIATION POLICIES (45 CFR §158.120(D))

Q: In what state should issuers report their MLR data for individual or non-group association policies?

A: Issuers should report their MLR data for individual or non-group association policies in the state where the individual resides at the time the certificate of coverage is issued. Some individual policies are issued through an association, such as the Automobile Association of America, to individual members of the association. In this instance, the association may be located in a different state than the insured resides. The association is the policyholder and the covered individual receives a certificate of coverage. 45 CFR §158.120(d) instructs issuers to include the experience for individual market business sold through an association in the state report for the "issue state of the certificate of coverage." This is the state where the insured individual resides at the time the certificate of coverage is issued, not the state where the association or policyholder is located, or the state in which the issuer is located.

This guidance is intended to clarify CMS' prior guidance on the Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations, which is available at http://cciio.cms.gov/resources/files/association_coverage_9_1_2011.pdf.pdf.

OFFERING POLICYHOLDERS A "PREMIUM HOLIDAY" (45 CFR §158.130)

Q: If, during a MLR reporting year, an issuer finds that its MLR is lower than the standard required by 45 CFR §§158.210 and 158.211, may the issuer institute a "premium holiday" in order to avoid having to pay rebates?

A: Neither the MLR regulation nor the PHS Act address whether an issuer may offer its policyholders a "holiday" from owing premiums. Premiums are established and collected in accordance with state law and the terms of the policy or contract that, where required, is filed with the applicable state regulatory agency. Thus, whether a premium "holiday" is permissible is a matter of state law.

An issuer seeking to temporarily suspend or reduce premiums in a state's individual, small and/or large group market should check with its state regulatory agency as to whether it may do so. However, if an issuer chooses to provide a premium holiday and its state regulator allows it to do so, HHS expects that the premium holiday would be provided in a non-discriminatory manner, meaning that it is offered to every policyholder in a state's market and not based on product type or the experience of a particular policy. An issuer that offers a premium holiday is responsible for refunding any overpayment of premium by a policyholder who is offered a premium holiday but fails to accept or receive such premium holiday for any reason.

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REINSURANCE AND REPORTING (45 CFR §158.130(A)(3))

Q: If an issuer reinsures 100 percent of a block of business by entering into reinsurance and administrative services agreements after March 23, 2010, even if the effective date of the agreement(s) is prior to March 23, 2010, is the ceding issuer or the assuming issuer responsible for filing the annual MLR Reporting Form?

A: The assuming issuer is responsible for filing the annual MLR Reporting Form only in the following circumstance. 45 CFR §158.130 (a)(3), states: "Reinsured earned premium for a block of business that was subject to indemnity reinsurance *and* administrative agreements *effective prior to March 23, 2010*, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on *all* of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer."

However, the ceding issuer is responsible for filing the annual MLR Reporting Form and issuing any rebates if either of the agreements were entered into after March 23, 2010, even if they have an effective date prior to March 23, 2010.

Q: 45 CFR §158.130(a)(3) states "Reinsured earned premium for a block of business that was subject to indemnity reinsurance and administrative agreements effective prior to March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer." If the ceding entity performs any administrative functions after the effective date of the reinsurance agreement, is the ceding issuer or the assuming issuer responsible for filing the annual MLR Reporting Form?

A: If the ceding issuer retains responsibility for *any* administrative functions, related to the reinsured block of business, after the effective date of the reinsurance agreement and administrative agreement, then for MLR reporting and rebate purposes, the ceding issuer remains responsible for filing the MLR Reporting Form and reporting the experience of the block of business that is the subject of the agreement.

Q: If an issuer enters into a 100% indemnity reinsurance agreement and the ceding issuer is responsible for reporting the experience for MLR purposes, may the ceding issuer adjust premiums for taxes paid by the reinsurer on the ceding issuer's MLR report?

A: No. General accounting principles require alignment between revenue and expenses. If the reinsurer receives the premium revenue for reinsured business and has the legal obligation to pay any tax due on it, and pays such tax, the ceding issuer may not report the tax amount and may not apply it as an adjustment to premiums when completing its MLR Annual Reporting Form and calculating its MLR. This is the case regardless of whether the reinsurer is an affiliate of the ceding issuer. The MLR regulation only permits issuers to deduct those taxes related to a reinsured block of business that were owed and paid by the reporting issuer. Therefore, if the ceding issuer did not owe or pay the related taxes or was reimbursed for premium taxes through any portion of commissions or allowance on reinsurance (see 45 CFR §158.162(b) (2)(ii) and (iii)), the issuer is not allowed to deduct such taxes from premium when reporting its experience.

EXCHANGE USER FEES (45 CFR §158.161(A), §158.221, §158.240)

Q: May an issuer include user fees paid to a state Exchange or a federal Exchange in the federal and state licensing and regulatory fees, as defined in 45 CFR §158.161(a), that must be subtracted from premium in calculating an issuer's MLR and rebate pursuant to 45 CFR §158.221(c) and 45 CFR §158.240(c)?

A: Yes. Exchange user fees should be included in the licensing and regulatory fees that are subtracted from premium in the MLR calculations. 45 CFR §158.161(a) - Reporting of federal and state licensing and regulatory fees - requires issuers to report as an adjustment to premium "statutory assessments to defray operating expenses of any state or federal department…". The Affordable Care Act §1311(d)(5)(A) requires states to ensure that the Exchanges are self-

sustaining beginning with 2015 and allows the Exchanges to charge assessments or user fees to participating health insurance issuers. HHS' implementing regulation, at 45 CFR §155.160, provides that as of Jan. 1, 2015, states must ensure that the Exchanges have sufficient funds to support ongoing operations and they may generate funding, such as through user fees on participating issuers, for Exchange operations. 45 CFR §156.50 requires participating issuers to remit user fees and other assessments to the Exchange, whether state- or federally operated.

Since the Exchanges are established as part of a state or federal department and the user fees are intended to support operating expenses, user fees constitute statutory assessments that defray the operating expenses of such department and qualify for inclusion in the licensing and regulatory fees described in 45 CFR §158.161(a).

STATES WITH A HIGHER MEDICAL LOSS RATIO STANDARD (45 CFR §158.211)

Q: If a state requires a higher minimum MLR for state rebate or rate filing purposes than that required by federal law, does the state standard automatically apply to issuers in that state for purposes of the applicable federal MLR?

A: No. 45 CFR §158.211 states that "[f]or coverage offered in a state whose law provides that issuers in the state must meet a higher MLR than that set forth in §158.210, the state's higher percentage must be substituted for the percentage stated in §158.210 of this subpart." However, 45 CFR §158.211(b) requires that before a state sets a higher minimum MLR to apply for purposes of the federal MLR, it "must seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the state and value for consumers so that premiums are used for clinical services and quality improvements."

Since it would not have been possible for a state to have considered whether its MLR standard should be higher than the federal MLR standard prior to the passage of the Affordable Care Act, HHS will only apply a higher MLR to issuers in states that have taken affirmative action since March 23, 2010 indicating that they have exercised their option pursuant to 45 CFR §158.211 to require issuers to meet a higher MLR standard for federal MLR purposes. Examples of states that have taken such affirmative action are Massachusetts, New Mexico and New York.

MINI-MED EXPERIENCE – APPLICATION OF THE ADJUSTMENT (45 CFR §158.220, §158.221)

Q: Beginning with the 2013 experience, when issuers of mini-med policies calculate their MLR according to the formula in 45 CFR §158.221, should they apply the applicable adjustment (multiplier) for each year to the reported experience from each year and then add each of those adjusted numerators together, or, should the reported experience for each MLR year be added together and then apply the adjustment (multiplier) for the current MLR reporting year to the aggregated experience?

A: 45 CFR §158.220(b) provides that, beginning with the 2013 MLR Reporting year, an issuer's MLR is calculated according to the formula in §158.221, aggregating the data reported for three years. On Dec. 7, 2011, the Department issued an MLR Final Rule amending §158.221 and providing mini-med issuers with an adjustment (or multiplier) to the numerator of the MLR (i.e., the total of claims and quality improving activities) as follows: a factor of 1.75 for 2012; 1.50 for 2013; and 1.25 for 2014. The multiplier is applied to the numerator of the issuer's MLR formula.

For non-mini-med experience, each year's experience is added together to obtain the numerator for purposes of calculating the federal MLR. Similarly, issuers of mini-med policies should add the reported experience for each MLR year together to obtain the numerator and then apply the multiplier for the current MLR reporting year to the aggregated experience. This is consistent with how other experience is aggregated for purposes of calculating the federal MLR.

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FORM OF REBATE (45 CFR §158.241)

Q: When providing MLR rebates to current or former enrollees in the individual, small group or large group markets pursuant to 45 CFR §158.241, may issuers use a pre-paid debit card as a means of rebate distribution?

A: Generally, yes. 45 CFR §158.241 states that an issuer may provide rebates in the form of a premium credit, lump-sum check or, if the enrollee paid the premium using a credit or debit card, by returning the entire rebate to the account used to pay the premium. CMS believes that an alternative, such as a debit or credit card, is a reasonable alternative as long as it is as convenient to use as a check and meets all of the conditions described below.

An issuer may provide rebates in the form of a pre-paid debit card (presumably by arrangement with a bank or other financial institution) provided all of the following conditions are met:

- The applicable policyholder's or subscriber's name must be on the card in order to ensure that the rebate reaches the intended policyholder or subscriber and is not stolen or diverted to a creditor or other third party;
- The card must not have an expiration date;
- The policyholder or subscriber must not incur any fees in association with the use or non-use of the card. If the institution that issues the card does not have any locations within a reasonable distance to the policyholder's or subscriber's mailing address and the policyholder or subscriber incurs a fee from another financial institution in order to cash the card, any such fees imposed by the other financial institution must be reimbursed by the issuing institution;
- At the policyholder's or subscriber's request, the entire balance on the card must be convertible to cash;
- The policyholder or subscriber must be able to contact the issuer or the issuing institution in order to opt out of receiving the rebate in the form of a pre-paid debit card and request a paper check. Such check must be mailed within ten (10) calendar days of the request;
- The policyholder or subscriber must be able to contact the issuing institution during normal business hours to obtain the cash value, or balance, on the card; and
- The policyholder or subscriber must be provided with an easy-to-understand notice of their rights and an explanation of the terms of the card at the time the cards are mailed.

RECIPIENTS OF NOTICE OF REBATE IN THE GROUP MARKETS (45 CFR §158.250)

Q: For an issuer that must provide the rebate directly to the group policyholder, must the notice of rebate to the policyholder's subscribers be provided to those enrolled during the MLR reporting year, or to those who are current subscribers at the time of the rebate?

A: In accordance with the rules in 45 CFR §158.242 describing who is entitled to the rebate under a group health plan, an issuer must provide notice of rebate to all subscribers enrolled in the group. This means that all subscribers enrolled in the group during the MLR reporting year except those who are no longer enrolled at the time the issuer provides the notice of rebate will receive a notice of rebate. For notice of rebates that must be provided by August 1, 2012, this means that the notice must be sent to all subscribers enrolled in the group at the time in 2012 that the notice is sent.

In addition to providing notice of rebate to all subscribers enrolled in a group plan at the time the issuer provides the notice of rebate, issuers may choose to include subscribers enrolled in the group plan during the MLR reporting year even if the subscribers are no longer enrolled at the time the issuer provides the notice of rebate, based on the instructions for the notice of rebate, but is not required.

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NOTICE OF MLR INFORMATION AND DEFINTION OF PLAN DOCUMENT (45 CFR §158.251)

Q: For an issuer whose MLR meets or exceeds the applicable MLR standard, may the notice under 45 CFR §158.251 be provided separately from the first plan document that the issuer provides to enrollees on or after July 1, 2012?

A: Yes. The regulation does not prohibit issuers who prefer to provide the one-time notice of MLR separately from any other plan documents provided that they do so prior to or concurrent with the first plan documents that are provided to enrollees on or after July 1, 2012.

Q: 45 CFR §158.251 directs an issuer whose MLR meets or exceeds the applicable MLR standard to provide policyholders and group subscribers a notice of MLR information with the first "plan document" that the issuer provides to enrollees on or after July 1, 2012. What is a "plan document" for purposes of 45 CFR §158.251?

A: For the purposes of 45 CFR §158.251, a plan document can be considered a document pertaining to the plan or policy that is distributed to all policyholders in individual and group markets and all subscribers in group markets. Examples of plan documents include policies, summary plan descriptions, benefits summaries, and group contracts.

ACA FEES

Q: May an issuer exclude from premium in its MLR and rebate calculation the fees it must pay under ACA, such as those required by the risk adjustment program (ACA §§1321(c)(1) and 1343, along with the Independent Offices Appropriations Act (IOAA) authority found at 31 U.S. C. 9701), for funding the Patient Centered Outcomes Research Institute (ACA §6301), and on an issuer's net premium (ACA §9010)?

A: Yes. For MLR purposes, issuers may exclude from premium all "Federal taxes and assessments allocated to health insurance coverage reported under section 2718 of the PHS Act," as well as State taxes and assessments, which include "[a]ny industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly…". 45 CFR §§158.162(a)(1) and 158.162(b)(1). ACA assessments or fees are a state or federal assessment and therefore may be excluded from premium under the MLR reporting and rebate requirements. 45 CFR §§158.221(c) and 158.240(c). This MLR treatment is similar to the MLR treatment of Exchange user fees, which is addressed in CCIIO's Technical Guidance Bulletin 2012-02, dated April 20, 2012, Question and Answer #34 (http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf).

However, an issuer's operating costs or any administrative costs associated with taxes or fees, such as those related to implementing and operating data submission and validation systems for the risk adjustment program, are not part of a state or federal assessment and therefore may not be deducted from premium for purposes of the MLR calculation.

Q: When may an issuer exclude ACA fees, such as those required by ACA §9010, from premium in its MLR and rebate calculations?

A: Issuers may exclude ACA assessments or fees from MLR calculations for a reporting year only if such assessments or fees were incurred in that reporting year. Issuers may not exclude ACA assessments or fees they expect to incur in future MLR reporting years. Specifically, an issuer may not report such amounts as assessments and fees described in 45 CFR §158.161(a) and §158.162(a)(1) and (b)(1), or as unearned premium described in 45 CFR §158.130(b)(4). As discussed in the HHS Notice of Benefit and Payment Parameters for 2014, published on March 11, 2013, "PHS Act section 2718 does not provide for estimated regulatory fees for future years to be deducted from premium used in MLR and rebate calculations for the reporting year." 78 FR 15410 at 15505-15506.

Source: Department of Health and Human Services

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