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Medical Loss Ratio Rules

The Affordable Care Act (ACA) established the **medical loss ratio (MLR) rules** to help control health care coverage costs and ensure that enrollees receive value for their premium dollars. The MLR rules became effective on Jan. 1, 2011. These rules require health insurance issuers to spend **80 to 85 percent** of their premium dollars on medical care and health care quality improvement, rather than administrative costs. Issuers that do not meet these requirements must provide rebates to consumers.

The Department of Health and Human Services (HHS) is the federal agency in charge of implementing the MLR rules. HHS issued interim final regulations on the MLR requirements in December 2010. Additional final regulations on the MLR requirements were released by HHS on Dec. 7, 2011. These final regulations did not change the basic components of the MLR rules; rather, they addressed technical issues involved in how issuers calculate their MLR and distribute rebates.

On March 1, 2013, HHS issued a final rule to amend the MLR program. The changes made by the final rule ensure that, beginning in 2014, issuers include premium stabilization amounts in MLR and rebate calculations. **The final rule also extends the annual MLR reporting deadline from June 1 to July 31 and the rebate disbursement deadline from Aug. 1 to Sept. 30, effective for the 2014 MLR reporting year.**

MLR REQUIREMENTS

The MLR requirements apply to health insurance issuers offering group or individual health coverage. The rules apply to both non-grandfathered and grandfathered plans. The rules do not, however, apply to self-insured plans.

Health insurance issuers in the large group market must spend at least **85 percent** of premiums on medical care and health care quality improvement activities. Issuers in the small group and individual markets must spend at least **80 percent** of premiums on those items.

In each state where an issuer does business, it is required to report to HHS on how it spent its premium dollars for the year. HHS posts MLR data on its website to help educate consumers on the value of insurance coverage offered in their state.

Issuers that do not meet the applicable MLR standard must provide rebates to consumers. Rebates must be paid by **Aug. 1** of each year (Sept. 30, effective for the 2014 MLR reporting year). The rebates are based upon aggregated market data in each state, and not upon a particular group health plan's experience.

CALCULATING THE MLR

An issuer's MLR is calculated as a fraction. The numerator of the fraction is the amount of incurred claims paid, plus expenses for health care quality improvement activities. The denominator is the issuer's premium revenue, excluding federal or state taxes and licensing and regulatory fees, and after accounting for payments or receipts related to the ACA's risk adjustment, risk corridors or reinsurance programs.

Until 2014, the MLR for a particular year (the MLR reporting year) is based on data for that year. However, beginning Jan. 1, 2014, the calculation to determine rebates is based on the average ratio over the previous three years.

An issuer may deduct from earned premiums the higher of either the amount paid in state premium tax or actual community benefit expenditures up to the highest premium tax rate in the state. Community benefit expenditures are expenditures for activities or programs that aim to improve access to health services, enhance public health and relieve government burden. Under the 2013 final rule, HHS allows tax-exempt not-for-profit issuers to deduct community benefit expenditures (subject to caps) and state premium tax from premiums in calculating MLRs and rebates.

Also, HHS confirmed in a series of Q&As that ACA assessments or fees are a state or federal assessment and may be excluded from MLR calculations for the reporting year that they were incurred. For example, these include:

- The fees required by the risk adjustment program;
- The fees for funding the Patient Centered Outcomes Research Institute (PCORI); and
- The annual fee on health insurers.

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) may not be deducted from premium for purposes of the MLR calculation.

HHS also clarified that an issuer may include user fees paid to an Exchange as part of the licensing and regulatory fees that are subtracted from the premium in calculating the MLR.

In determining whether the issuer meets the MLR requirements, amounts paid toward medical care include direct claims paid to providers (including incentive and bonus payments made to providers) and activities to improve health care quality.

Health Care Quality Improvement Activities

Expenses for health care quality improvement activities are included with an issuer's claims payments when calculating its MLR. To be considered a health care quality improvement activity, the activity must be designed to improve health quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

Qualifying Activities	***Non-qualifying Activities***
Health care quality improvement activities include: • Case management; • Care coordination; • Chronic disease management; • Wellness programs; • Supporting health information technology; • Hospital discharge programs; • Measures to improve patient safety and reduce medical errors; and • Fees charged by accrediting entities for	Items that are *not* considered health care quality improvement activities include: • Activities primarily to control or contain costs; • Establishing or maintaining a claims adjudication system; • Retrospective and concurrent utilization review; • Fraud prevention activities (Note: The amount of claims payments recovered through fraud reduction efforts, up to the amount of fraud reduction expenses, can be included in incurred claims when calculating the MLR); • Costs of executing provider contracts or

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certification of qualified health plans (QHPs).	developing a provider network; • Provider credentialing; and • Marketing.

Also, HHS provided that an issuer may count a vendor's expenses as activities that improve health care quality to the extent that the issuer and vendor can show that these expenses were incurred for performing allowable quality improving activities on behalf of the issuer. For example, to the extent that a pharmacy benefits manager (or PBM) performs functions that are designed primarily to identify quality concerns, such as potential adverse drug interactions, those costs may be reported, in aggregate, as expenditures for activities that improve health care quality.

Administrative Expenses

An issuer's administrative expenses do not count toward medical care spending. Examples of administrative expenses that cannot be taken into account when calculating the MLR include:

- Amounts paid to third party vendors for secondary network savings, network development, administrative fees, claims processing and utilization management;
- Amounts paid (including amounts paid to a provider) for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee (such as medical records copying costs, attorneys' fees and compensation to administrative personnel);
- Cost containment and loss adjustment expenses;
- Workforce salaries and benefits (including sales personnel);
- Agents' and brokers' fees and commissions;
- General administrative expenses; and
- Community benefit expenditures.

Although there was a significant push to have HHS reclassify agents' and brokers' fees and commissions, the final regulations left these costs as administrative expenses that do not count toward medical spending.

Mini-med and Expatriate Policies

Special MLR calculation rules apply to mini-med policies with total annual benefit limits of $250,000 or less and expatriate policies. The special calculation rules were created by HHS to take into account the increased administrative expenses associated with these policies so as to minimize market withdrawal.

Deferred Amounts for Non-calendar Year Policies in 2013

On Jan. 2, 2014, the Center for Consumer Information and Insurance Oversight (CCIIO) released a Q&A that provides guidance on when an issuer may defer including premium collected for ACA fees on non-calendar year policies in its MLR and rebate calculations. According to the Q&A, for the 2013 MLR reporting year, issuers may defer including in their MLR and rebate calculations the portion of 2013 premiums collected for 2014 ACA assessments or fees on non-calendar year policies.

If issuers elect to defer this portion of premium in the 2013 MLR and rebate calculations, they must disclose the deferred amount for each respective state and market. In addition, issuers must disclose and reduce the MLR tax

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adjustment to premium by the amount of federal and state taxes and fees associated with the deferred portion of premium.

Special Adjustment for Transitional Policy and Exchange Launch

On May 16, 2014, HHS issued a final rule that adjusts the MLR calculation for the 2014 reporting year to account for the special circumstances of plans affected by the transitional policy or the technical problems during the launch of state and federal Exchanges. Under the transitional policy, HHS will not enforce specified ACA market reforms against certain non-grandfathered health insurance coverage in the individual or small group market renewed between Jan. 1, 2014 and Oct. 1, 2014. (HHS extended this transitional policy for two years—until policy years beginning on or before Oct. 1, 2016.)

Under the final rule, these adjustments only extend to issuers in the individual and small group markets that offered transitional coverage or participated in the state and federal Exchanges, and only for the 2014 reporting year. A transitional policy cost adjustment to the formula for calculating an issuer's MLR does not apply in states that did not implement the transitional policy, or in states that did, to issuers that did not elect to implement it.

DISCLOSURE AND REPORTING

Under the MLR rules, issuers must submit a report to HHS concerning premium revenue and expenses related to the group and individual health insurance coverage that it issued for each MLR reporting year. In general, the report must be submitted to HHS by **June 1** of the following year (July 31, effective for 2014 MLR reporting years), in the form and manner required by HHS.

REBATES

For each MLR reporting year, the issuer must provide a proportionate rebate if the MLR does not meet the minimum requirements. The amount of the rebate is based on the premium received (less appropriate taxes and fees), which is then multiplied by the difference between the required MLR and the issuer's actual MLR for the year.

Payment of Rebates

Under a prior rule, issuers would have been required to apportion rebates for individual enrollees based on the amount of premium paid, and then pay the rebates either directly to the enrollees or to the group policyholder with assurance from the policyholder that it would distribute the rebates to enrollees. According to HHS, this payment scheme had unintended administrative consequences for issuers and tax implications for individuals receiving the rebates.

Under the final regulations, issuers are generally required to provide rebates directly to policyholders. Policyholders must use the rebates for the benefit of enrollees. Policyholders are permitted to use the rebates for the benefit of enrollees in ways that are not taxable, such as through lowered premiums. This process varies according to the type of plan. For plans subject to ERISA, for instance, the rebates may be considered plan assets that are subject to ERISA's fiduciary responsibility requirements.

Exception for Small Rebate Amounts

No rebate is required to be paid to a group policyholder if the total amount owed to the policyholder and enrollees combined is less than **$20** for an MLR reporting year. For rebates distributed directly to enrollees by issuers, such as when an issuer does not receive assurance that the policyholder will use the rebate for the benefit of enrollees, no rebate is required if it would be less than **$5** per subscriber covered by the policy.

This exception for small rebate amounts applies to the rebates an issuer is required to pay. It does not apply to amounts that are received by an employer for its group health plan. Thus, this exception does not apply when a group health plan is determining how to handle a rebate.

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Timing of Rebates

An issuer must provide any rebate owed no later than **Aug. 1** following the end of the MLR reporting year (**Sept. 30**, effective for the 2014 MLR reporting year). If the rebate payment is late, interest on the rebate amount must be paid as well. Also, if an issuer's solvency would be affected beyond certain levels, HHS may defer all or a portion of the required rebates. However, the issuer will be required to pay the rebates, with interest, in a future year.

NOTICES

When providing a rebate to a group policyholder, the issuer must provide the policyholder and subscribers with a notice describing the MLR requirements. The notice must include the following information:

- A general description of the concept of an MLR;
- The purpose of setting a MLR standard;
- The applicable MLR standard;
- The issuer's MLR;
- The issuer's aggregate premium revenue, minus any federal and state taxes, and licensing and regulatory fees that may be excluded;
- The rebate percentage and amount owed to enrollees based upon the difference between the issuer's MLR and the applicable MLR standard; and
- The fact that the total aggregated rebate for the group health plan is being provided to the policyholder and a description of how the rebate will be handled.

For each MLR reporting year, issuers must submit a report to HHS regarding their rebates.

In addition, HHS issued a final rule on May 11, 2012 that required issuers that met or exceeded the MLR standards for 2011 to provide a basic notice of the MLR rules to policyholders and subscribers. This notice requirement only applied for the 2011 MLR reporting year. The notice was required to be provided with the first plan document (for example, open enrollment materials) provided to enrollees on or after July 1, 2012.

ADJUSTING THE MLR

In situations where enforcement of the 80 percent MLR requirement would destabilize the individual market in a particular state, HHS has authority to adjust the MLR standard for individual insurers in that state. A request for adjustment must have been made by the state's insurance commissioner (or equivalent state official). The adjustment can be applied for up to three years. In determining whether to adjust the standard, HHS considered factors such as the number of issuers that would be likely to leave the state's individual market, the number of individuals that would be affected and the impact on premiums in the state.

Also, under ACA, states have the flexibility to set higher MLR standards than the federal 80/85 percent thresholds.

ENFORCEMENT

HHS is responsible for enforcing the reporting and rebating requirements of the MLR rules. In order to enforce these rules, HHS can audit issuers for compliance. Issuers must provide HHS with access to records and must maintain records to demonstrate compliance for **six years**.

Issuers that do not comply with the MLR requirements may be subject to civil penalties **up to $100 per day** for each individual affected by the violation. HHS can also order an issuer to pay rebates if it has failed to do so.

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Penalties will not be assessed for periods where the issuer did not know of the failure, or would not have known about it if it had exercised reasonable diligence. HHS may not issue a penalty for the period after the issuer discovered the failure (or would have discovered it if it had exercised reasonable diligence), if the failure was due to reasonable cause and not due to willful neglect and the failure was corrected within 30 days.

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