



Highlights of Key Provisions of the Interim Final Rule for the Medical Loss Ratio Provisions of the PPACA

(as of November 23, 2010)

The Department of Health and Human Services (HHS) released the medical loss ratio (MLR) [interim final rule](#) (IFR) on November 22, 2010. According to HHS, the IFR certifies and adopts the recommendations submitted by the NAIC on October 27, 2010. The regulation is effective on January 11, 2011, and comments are due 60 days after publication. The PPACA provision implements standard medical loss ratios of 85 percent in the large group market and 80 percent in the small group and individual markets, beginning on January 1, 2011.

The IFR expands upon the NAIC model regulation and maintains the same three key adjustments to the MLR requirements: the deduction of federal and state taxes and licensing or regulatory fees, the credibility adjustment for health plans with fewer covered lives and products with higher deductibles, and the adjustment for health plan activities that improve health care quality. The IFR also provides flexibility for “mini-med” health plans, allows deferred rebates for health plan issuers at risk of insolvency, and grants states the ability to petition for a waiver should the MLR requirements threaten to destabilize the individual market.

Key provisions in the rules include:

Reporting Requirements

- The reporting requirements include the language from the NAIC model regulation and the Annual Report Supplemental Health Exhibit (Blanks).
- Health plan issuers offering group or individual health insurance coverage, including a grandfathered health plan, must submit a report (“HHS report”) to the Secretary of Health and Human Services (HHS) by the June 1 following the end of an MLR reporting year. An issuer must submit this report for each state in which it is licensed with data that include all policies issued in that state, aggregated separately for the large group market, small group market, and the individual market.
- Small employer (small group) is defined as up to 100 employees, except that as provided under PPACA, until 2016 a state may substitute 50 employees for 100 employees consistent with current law in most states.
- Health plan issuers are required to submit their HHS report by June 1 following the 2011 MLR reporting year, but the MLR IFR outlines an exception for certain issuers who will

also be required to provide quarterly reports by May 1, August 1, November 1 during the 2011 MLR reporting year. Those exceptions include:

- *Mini-Med Policies* – An issuer with policies that have a total annual limit of \$250,000 or less must report the experience from such policies separately from other policies.
 - *Expatriate Policies* – An issuer with group policies that provide coverage for employees working outside their country of citizenship, employees working outside of their country of citizenship and outside the employer’s country of domicile, and citizens working in their home country, must aggregate the experience from these policies but report the experience from such policies separately from other policies.
- For aggregating data, group coverage that covers employees in multiple states must be attributed to a state based on the situs of the contract, defined as the state in which the contract is issued or delivered. For individual market business sold through an association, the experience of the health plan issuer must be on the state report for that state that has jurisdiction over the certificate of coverage. For employer business issued through a group trust or multiple employer welfare association, the experience of the issuer must be included in the state report for the state where the employer or the association has its principal place of business.
 - Issuers with 50 percent or more of total earned premium for an MLR reporting year attributed to new policies with less than 12 months of experience may exclude the new policy experience from the HHS report. If an issuer defers reporting of newer business, then the excluded experience must be added to the experience reported in the following MLR reporting year.
 - Included in the HHS report will be an issuer’s earned premium for the MLR reporting year. Earned premiums issued by one issuer and later assumed by another must be reported by the assuming issuer. Issuers must make adjustments to earned premium to account for:
 - assessments paid to or subsidies received from federal and state high risk pools;
 - portions of premium associated with group conversion charges;
 - any experience rating refunds paid or received (excluding MLR rebates); and
 - unearned premium.
 - The IFR includes details on how a health plan must include *incurred claims*, defined as reimbursements for clinical services, in the HHS report. The total incurred claims amount must be adjusted for group conversion charges, unpaid claims between the prior year’s and current year’s unpaid claims reserves, the change in claims incurred but not reported, other changes in claims-related reserves, and experience rating refunds (excluding any MLR refunds).

Reporting of Activities that Improve Health Care Quality

- The IFR follows the NAIC recommendations for *activities that improve health care quality* that will be counted with incurred claims when calculating the MLR. These activities must:
 - be designed to improve health quality;
 - increase the likelihood of desired health outcomes in ways that can be objectively measured;

- be directed toward enrollees or a specific segment of enrollees or provide health improvements to the population beyond those enrolled; and
 - 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.
- Specified quality initiatives that can count toward claims expenses (incurred claims) are defined as activities that improve health outcomes. They must involve the direct interaction of the health plan, providers and enrollees to improve health outcomes. Examples include case management, care coordination, and chronic disease management; identifying and addressing ethnic, cultural or racial disparities; quality reporting and documenting of care in a non-electronic format; health IT to support these activities; and accreditation fees directly related to quality of care activities.
 - Other acceptable quality initiatives counting toward claims expenses would have the objective of preventing hospital readmissions, improving patient safety and reducing medical errors, promoting wellness and health activities, and enhancing the use of health care data to improve quality and support the meaningful use of health information technology consistent with the American Recovery and Reinvestment Act.
 - The IFR lists those health plan issuer expenses that are explicitly *not* considered activities that improve quality. Examples include those activities that are designed primarily to control or contain costs, upgrades to health IT that are designed primarily to improve claims payment capabilities or to meet regulatory requirements (e.g., costs of implementing new administrative simplification standards), fraud prevention activities (other than fraud detection/recovery expenses up to the amount recovered that reduces incurred claims), the costs of maintaining provider networks, provider credentialing, and retrospective and concurrent utilization review and prospective utilization review that does not meet the definition of activities that improve health outcomes. Other activities are excluded unless the issuer adequately demonstrates and the Secretary agrees that the activity's costs improve quality.
 - The preamble to the IFR also notes that the conversion to ICD-10 will "enhance the provision of quality care through the collection of better and more refined data," but notes the difficulty in designating those ICD-10 transition costs related to maintaining claims adjudication systems and those costs related to the development of data that will improve quality. The Secretary is soliciting further comments on whether ICD-10 expenses should be included as a quality improving activity that can count toward claims expenses rather than administrative expenses.

Reporting of Non-Claims Costs and Taxes and Fees

- Within the HHS report, a health plan must include information about non-claims costs and an explanation of how premium revenue is used other than for incurred claims and expenditures for activities that improve health care quality. A plan must report administrative expenses for cost containment activities, loss adjustment expenses, direct salaries, agent and broker fees and commissions, general and administrative expenses, and community benefit expenditures.

- The health plan must separately report all federal taxes and assessments and taxes not excluded from premium for calculating MLRs (which includes federal income taxes on investment income). The IFR also calls for reporting of state taxes, assessments, licensing and regulatory fees, as well as payments by not-for-profit health plans for community benefit expenditures.

Disclosure of Methodology

- The HHS report must include a detailed description of the methods used to allocate expenses such as incurred claims, quality improvement activities, federal and state taxes, and other non-claims costs to each health insurance market in a state. The health plan must identify the specific basis used to allocate expenses to states, within states, and to lines of business including non-major medical lines and public programs.

Calculating the MLR and Providing the Rebate

- A health plan issuer must aggregate data by state and by the individual, small group, and large group markets. If a state merges the individual and small group markets, the corresponding data may also be merged for purposes of calculating the MLR and any rebates. A state has the option to set a higher MLR than that established under PPACA.
- The MLR is calculated over a three year period including the current MLR reporting year and the previous two reporting years. In 2011, the health plan uses data from the 2011 MLR reporting year only. In 2012, if the health plan's experience is fully credible, the MLR is calculated using the data from the 2012 reporting year only. If the plan's experience is only partially credible, then the MLR is calculated using the data from the 2011 and 2012 reporting years. An MLR is non-credible if it is based on the experience of less than 1,000 life-years, partially credible if the experience is at least 1,000 life-years and fewer than 75,000 life-years, and fully credible with 75,000 or more life-years.¹
- The MLR is the ratio of the numerator (incurred claims plus the issuer's expenditures for activities that improve quality) to the denominator (premium revenue minus federal and state taxes and licensing and regulatory fees). The numerator for the 2012 MLR reporting year may include any rebate for the 2011 reporting year if the 2012 MLR experience is not fully credible. The numerator for the 2013 MLR reporting year may include any rebate for the 2011 or 2012 MLR reporting year.
- For the 2011 MLR reporting year, health plans with a total annual limit of \$250,000 or less ("mini-med" plans) and group policies that provide coverage for employees working outside the country ("expatriate health plans") will be permitted to apply an adjustment to their reported experience such that the calculation of incurred claims and expenditures for quality improving activities is multiplied by a factor of two.
- A health plan issuer may add to the MLR calculation a credibility adjustment based on partially credible experience and health insurance products with higher deductibles. An issuer with MLR experience that is non-credible is presumed to have met the minimum MLR requirements. For the 2013 MLR reporting year, the credibility adjustment based

¹ A *life-year* means the total number of months of coverage for enrollees whose premiums and claims experience is included in the HHS report divided by 12.

on partially credible experience is zero if both 1) the current MLR reporting year and each of the two previous years included experience of at least 1,000 life-years; and 2) without applying the credibility adjustment, the issuer's MLR for all years were below the minimum MLR standard.

- For each MLR reporting year, a health plan must issue a rebate to each enrollee if the issuer's MLR does not meet or exceed the minimum MLR. The amount of the rebate is the premium paid by the enrollee, after subtracting federal and state taxes and fees, multiplied by the difference between the required minimum MLR for a market and the health plan's MLR for that market. The rebate must be paid no later than the August 1 following the end of the MLR reporting year. Late payments must be paid with interest. Rebates must be paid to current and former enrollees in the manner allowed under the IFR. The issuer may choose to provide current enrollees with a rebate in the form of a premium credit (i.e., reduction in a premium owed), lump-sum check, or, if an enrollee paid by credit card or debit card, by lump-sum reimbursement to the same account that the enrollee used to pay the premium.
- A health plan issuer must pay the rebate directly to the enrollee in an individual market policy or the enrollees in a small or large group plan. An issuer may meet its obligation to provide rebates to enrollees if the plan enters into an agreement with the group policyholder to distribute the rebate on behalf of the issuer. The issuer remains liable for complying with the MLR and rebate requirements and must obtain and retain records documenting the accurate distribution of the rebates to enrollees by the group policyholder.
- A health plan is not required to individually calculate rebates when the amount of the rebate is less than \$5 per enrollee. Instead, these "de minimis" rebates are to be aggregated and distributed equally to those enrollees eligible for a rebate.
- In addition to the rebate, an issuer must provide a notice of the rebate to the enrollee in a form prescribed by the Secretary. Issuers must submit to the Secretary a report regarding the rebates provided to enrollees and other information as required under the IFR. The majority of the rebate data must be submitted with the HHS report on the June 1 following an MLR reporting year.
- A state insurance commissioner may request that the Secretary defer all or a portion of the rebates required of a health plan issuer should the commissioner determine that the payment of rebates will cause the issuer's risk based capital (RBC) level to fall below the Company Action Level RBC. If the Secretary grants the deferral, the issuer must pay the rebates with interest in a future year.

Potential MLR Adjustment for a State's Individual Market

- A state insurance commissioner may submit to the Secretary a request for an MLR adjustment, lasting from one to three years, should the state demonstrate that a "reasonable likelihood" exists that the 80 percent MLR may destabilize its individual market.

- The state must provide the Secretary with information pertaining to its individual market, including the current MLR, requirements of issuers withdrawing from the market, consumer protections and coverage options available to consumers who lose coverage as a result of market exit, and data on remaining issuers. Should certain information be unavailable or unduly burdensome for the state to collect, the Secretary may waive certain requirements and, instead, request alternative supporting data or move forward with her determination.
- In assessing a request for adjustment to the MLR, the Secretary may consider a number of criteria, including: the number of issuers reasonably likely to exit the state or cease offering coverage absent an adjustment, and the number of enrollees covered by these issuers; alternate coverage options available to consumers within the state should an issuer exit the market; and the impact on premiums charged, and on benefits and cost-sharing provided, to consumers by issuers remaining in the market.
- The Secretary must provide a 10 day public comment period. A state may hold a public hearing and create an evidentiary record with respect to its application. The Secretary will make a determination, taking into consideration the evidentiary record if applicable, within 30 days of receiving the required information from a state, though she may extend the review period by an additional 30 days.
- A state whose request for an MLR adjustment has been denied may request a reconsideration of that determination. The Secretary will issue her determination within 20 days of receipt of the request.

Enforcement

- HHS will enforce the reporting and rebate requirements – including the requirements that such reports are submitted timely, that data reported complies with the applicable definitions and criteria, and that rebates be paid timely and accurately – and may conduct audits of issuers to this end.
- An issuer must allow access and entry to its premises, facilities, and records to HHS, the Comptroller General, or to their designees to evaluate compliance with requirements governing reporting and calculation of data submitted to HHS and the timeliness and accuracy of rebate payments. Issuers must maintain records for the current year and six prior years.
- If an issuer fails to comply with applicable requirements, after notification of the potential violation by HHS and 30 days for response by the issuer, civil monetary penalties may be imposed. Penalties may not exceed \$100 for each day, for each responsible entity, for each individual affected by the violation, and may be adjusted at HHS's discretion, depending on any mitigating or aggravating circumstances.