

Medical Loss Ratio

*Health and Human Services Adopts
National Association of Insurance (NAIC) Recommendations*

Interim Regulations: November 18, 2010

Sixty-day (60) Public Comment Period

Effective Date: January 1, 2011

Websites: www.HealthCare.gov; www.hhs.gov/ociio/regulations/index/html

The interim final regulation adopts and certifies in full all of the recommendations in the model regulation of the National Association of Insurance Commissioners (NAIC) regarding Medical Loss Ratios (MLR). Subpart B addresses the requirements for health insurance issuers (issuers) in the group or individual market, including grandfathered health plans, to provide an annual rebate to enrollees, if the issuer's MLR fails to meet minimum requirements: generally, 85% in the large group market and 80% in the small group (2-50 employees) or individual market. This interim final regulation is generally applicable for plan years beginning on or after January 1, 2011. Self-insured plans are not a health insurance issuer, as defined by section 2791 (b) (2) of the PHS Act, and thus are not subject to this interim final regulation.

1. The statute requires issuers to submit a report that "concerns" the ratio of the "incurred loss" to "earned premium." The statute does not simply require the issuer to report the numeric ratio of the incurred loss to earned premium. In addition, subsection (a) (3) requires issuers to provide an explanation of the "nature" of the "non-claim costs".
2. As stated above, the NAIC recommends and requires calendar year reporting and we adopt this recommendation and require reporting on a calendar year basis.
3. Issuers will report the following:
 - a. Premium earned and any received fees or other contributions associated with the health plan and accounting for unearned premiums
 - i. Prescription drug rebates are rebates that pharmaceutical companies pay to issuers based upon the drug utilization of the issuer's enrollees at participating pharmacies. Rebates should be accounted for and an adjustment to incurred claims.
 - ii. NAIC model regulation does not specifically address de minimis rebate payments, a range of \$1 to \$20 should be sufficient to avoid requiring largely symbolic rebates to enrollees and HHS agrees with this approach.
 - iii. Covered Individual Rebate Notification must accompany:
 - the rebate check and must include a brief explanation of what an MLR is, why the Affordable Care Act created the policy (increased transparency, incentive to lower premiums)
 - Aggregate amount of premium revenue reported by the issuer during the MLR reporting year
 - The issuer's MLR adjustment
 - The required MLR threshold
 - The percentage of premium being rebated

- Total amount being paid or credited to enrollees
- Notification must explain that rebates to current enrollees are being provided in the form of premium credit
- iv. Reporting requirements regarding the rebates to enrollees
 - The number and percent of enrollees who receive a rebate
 - The amount of rebates provided to enrollees, including a breakdown of how much of the rebates were paid to policyholders and how much of the rebates were paid to subscribers
 - The amount of de minimis rebates that were aggregated and a breakdown of how they were made to locate the applicable enrollees
 - Description of how the unclaimed rebates were disbursed
- b. Claim Utilization
 - i. To minimize reliance on estimates for the amount of the reserve, unpaid claim reserves shall be calculated based on claims that have been processed within three months after the end of the MLR reporting year.
- c. Quality Improvement Expenses
 - i. Evidence-based medicine, widely accepted best clinical practice or criteria for medical services
 - ii. Care Management
 - iii. Chronic Disease Management
 - iv. Medication and Care compliant initiatives through the use of the medical home model
 - v. Health Technology to support these activities
 - vi. Patient – centered education and counseling
 - vii. Personalized post-discharge reinforcement and counseling by an appropriate health care professional
 - viii. Quality reporting
 - ix. Improved patient safety, reduce medical errors and lower infection mortality rate
 - x. Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns
 - xi. Wellness Assessment
 - xii. Coaching Programs
 - xiii. Public Health Education Campaigns
- d. Not reportable Quality Improvement Expenses
 - i. Concurrent and Retrospective review
 - ii. Fraud Prevention
 - iii. Provider Network
 - iv. Provider Credentialing
 - v. Marketing Expenses
 - vi. Employee Incentives
 - vii. Claim Adjudication System

- viii. 24-hour customer services/health care professional hotline addressing non-clinical member questions
- ix. Healthy lifestyle promotional activities
- x. Network Fees (major discussion item)
- e. Non-claim costs: Such expenses reduce either the number of health services provided or the cost of such services. They may include:
 - i. Utilization review
 - ii. Detection and prevention of payment for fraudulent request for reimbursements
 - iii. Expenses for internal and external appeals processes
 - iv. Network Access fee to preferred provider organizations (including prescription drug networks)
- f. Non-claim cost excludes:
 - i. Non-claim costs other than taxes and regulatory fees. Insurers will be able to deduct federal and State taxes that apply health insurance coverage from an insurer's premium revenue when calculating its medical loss ratio. Taxes assessed on investment income and capital gains will not be deducted from premium revenue. In the case of non-profit plans, assessments they are required to pay in lieu of taxes may be deducted.
 - ii. Salaries
 - iii. Agents and Brokers fees and commissions
 - iv. General and administrative expenses
- g. Claim Utilization Adjustment
 - i. Prescription drug rebates
 - ii. Overpayment recoveries
 - iii. State subsidies
 - iv. Incentive and bonus payments made to providers
 - v. Amounts paid to third party vendors for secondary network savings
- 4. Credibility Adjustments for 2013 are based on three years' experience comprised of the current MLR reporting year and the two previous MLR reporting years.
- 5. Mini-Med and Expatriate Plans
 - a. HHS will apply a methodological adjustment to the medical loss ratio for the plans
 - b. The adjustment will address the unusual expense and premium structures for these plans
- 6. Civil monetary penalty for each violation of \$100 per entity, per day, per individual affected by the violation. Any issuer against which HHS has assessed a penalty will have the right to submit an appeal
- 7. Maintenance of Records

The issuer must maintain and make available to the Secretary upon request the data used to allocate expenses reported under this Part together with all supporting information required to determine that the methods identified and reported.

The Department estimates that issuers will incur approximately \$33 million to \$67 million in one-time administrative costs, and \$11 million to \$29 million in annual ongoing administrative costs related to compliance. The incurred cost by issuers is estimated to be \$75,018 to \$151,507 for the one-time cost and approximately \$17,261 to \$32,259 per issuer for the annual costs.