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Regulations Under The Patient Protection and Affordable Care Act Released by the United States Department of Health and Human Services Implementing The Medical Loss Ratio

On November 23, 2010, the United States Department of Health and Human Services ("DHHS") released regulations under the Patient Protection and Affordable Care Act ("PPACA") to implement the medical loss ratio ("MLR") mandate requiring insurers to pay 85% of insurance premiums for medical claims and rebating the difference to the insureds if they fail to meet that standard. The rules are applicable to insurance companies and will affect employers with insured plans. They do not apply to employers with self-funded plans, even those that use stop loss coverage as such plans are not considered "fully insured." "Mini-med" plans were excluded under the PPACA until 2014 because they would otherwise result in massive losses of coverage for many individuals who are covered under such plans.

Determination of the MLR will occur over the 2011 calendar year, and the rebates, if any, will be issued in August of 2012. The recipients of such rebates are, in most circumstances, policyholders. However, with respect to group plans, rebates will be issued to the employer policyholders and the actual enrollees in proportion to the amount of premium that each paid, respectively.

The definition of "medical expense" is relatively narrow as set forth in the regulations. With respect to insurers providing health coverage in multiple states, what constitutes an expense must be determined on a state-by-state basis rather than being aggregated nationwide. Moreover, "medical expense" likely will be limited to direct claims experience with some adjustment for credibility and accuracy plus inclusion of costs that will "improve healthcare quality."

The DHHS has posted a fact sheet on its website regarding MLR. The fact sheet explains, in understandable terms, how the rules will be beneficial to the consumers as follows:

- Establishing greater transparency and accountability with respect to insurance premium, administrative expenses like marketing, advertising, underwriting, executive salaries and bonuses and the costs of the actual medical care component of a policyholder's premium.
- Ensuring consumers receive value for their premium dollar.
- Insurers must spend at least 85% of the premium dollars on medical care and quality improvement activities or rebate the difference.
- Providing rebates to consumers. The rebate and payment terms are described:

Beginning in 2011, an insurance company that issues policies to individuals, small

employers and large groups will have to report certain information to each state in which it does business:

- total earned premium;
- total reimbursement for clinical services;
- total spending on activities to improve quality; and
- total spending on all other non-claims costs excluding federal and state taxes and fees.

Insurers will be required to report aggregate premium and expenditure data for each market, except for so-called "expatriate" and "mini-med" plans. For such plans, insurers will be allowed to report their experience separately.

The regulations specify a comprehensive set of "quality improving activities" that allow for future innovations and may be counted towards the 80 or 85% threshold. Such quality improving activities must be supported in evidence-based practices, take into account specific needs of patients, and be designed to increase the likelihood of desired health outcomes in manners that can be objectively measured.

Consistent with NAIC recommendations, the regulations permit insurers to deduct federal and state taxes that apply to health insurance coverage from an insurer's premium revenue when calculating its MLR. Taxes assessed on investment income and capital gains will not be deducted from premium revenue. In the case of non-profit health plans, assessments that they are required to pay in lieu of taxes may be deducted.

Consistent with NAIC recommendations, the regulations permit insurers to add to their MLR a "credibility adjustment" when the insurer's MLR for a market within a state is based on less than 75,000 people enrolled for an entire calendar year. The credibility adjustment recommended by the NAIC and implemented in the regulation addresses the statistical unreliability of experience based on a small number of people covered. Also, in response to NAIC commentary, DHHS intends to carefully monitor the effects and suitability of the regulations' initial approach to credibility adjustment over the next three years in light of developing experience.

Newer plans (i.e. those that have newly joined the insurance marketplace) may be able to delay reporting their MLR until the next year. When 50% or more of an insurer's premium income accounts for policies that have not been effective for an entire calendar year, they are eligible to delay reporting until the following year.

In the individual market, PPACA allows the Secretary of the DHHS to adjust the MLR standard for a state if it is determined that meeting the 80% MLR standard may "destabilize the individual market." Consistent with NAIC recommendations, the regulation establishes a process for states to request such adjustment for up to three years. In order to qualify for the

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adjustment, a state must demonstrate that requiring insurers in its individual market to meet the 80% MLR has a likelihood of destabilizing the individual market and could result in fewer choices for consumers.

While the PPACA empowers the Secretary of the DHHS to direct enforcement authority with respect to MLR requirements, DHHS recognizes the state's ability to assist in enforcement and will accept the findings of a state audit of MLR compliance if such findings are based on the MLR requirements set forth in the federal laws and the new regulations.

The regulations require insurers to retain documentation that relates to the data they reported, and to provide access to those data and their facilities to DHHS, so compliance with reporting and rebate requirements can be verified.

Finally, the regulations impose civil monetary penalties if an insurer fails to comply with the reporting and rebate requirements imposed under the regulations. While the law does permit DHHS to develop separate monetary penalties for MLR non-compliance, DHHS has incorporated the HIPAA penalties into the regulations (i.e. a penalty for each violation of $100 per entity, per day, per individual affected by the violation).

For more information about any of the topics covered in this issue of the Insurance Law Alert, please contact:

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