

# HEALTH REFORM **IMPACT**

## What you need to know NOW

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### The Devil is in the Details: Interim Final Rules Provide Medical Loss Ratio Definitions and Process

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One of the most publicized features of the recent Health Reform Legislation<sup>1</sup> is new limits on non-medical expenses by insurers, as calculated under medical loss ratios ("MLR"). If such expenses (e.g., administrative costs and profits) exceed certain statutory caps, insurers must pay rebates to insureds. On December 1, 2010, the Department of Health and Human Services ("HHS") published in the Federal Register final interim regulations (the "Regulations") setting forth what health plans must do to report and satisfy the MLR standard. The Regulations contain disclosure and reporting requirements; methodology for MLR calculation and rebates; processes for MLR adjustments, if necessary, to prevent market destabilization; and enforcement mechanisms.

**Background.** The Health Reform Legislation stipulated that for plan years beginning after September 23, 2010 (note that, for plans that run with calendar year, these changes will be mandatory on January 1, 2011), health plans offering coverage in the group or individual markets, including grandfathered plans (but excluding self-insured plans), must report to the HHS the proportion of premium dollars spent on clinical services as compared to the percentage spent on administrative services. Each health plan must keep its annual non-medical costs lower than 15% of premium revenue for the large group market and 20% for the small group and individual market.<sup>2</sup> The statute set this percentage as a floor; and individual states are allowed to adopt MLRs that are higher than the federal standard.

The Health Reform Legislation also required the National Association of Insurance Commissioners ("NAIC") to establish uniform definitions of elements contributing to the MLR, as well as standardized methods for calculating the MLR.<sup>3</sup> Following months of open forums, deliberation and receipt of input from a broad range of stakeholders, the NAIC on October 27, 2010, submitted its model regulation to HHS for review and certification. The Regulations then followed on November 22, 2010. The remaining sections of this issue of *Health Reform IMPACT* will summarize key provisions of the Regulations.

<sup>1</sup> References to "Health Reform Legislation" or "Health Reform" mean The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

<sup>2</sup> Under the Health Reform Legislation (at §1304(b)), a small group employer is defined as 1-100 employees and a large group employer is more than 100 employees. However, since this is a change from the previous statutory definitions, states may continue to classify an employer with up to 50 employees as a small employer until 2016.

<sup>3</sup> The Patient Protection and Affordable Care Act, at § 10101.

**Disclosure and Reporting Requirements.** Beginning in 2011, every health insurer will have to report the following information for each state in which coverage is offered: 1) total earned premiums; 2) total reimbursement for clinical services; 3) total spending on quality improvement activities; and 4) total spending on non-claims costs excluding federal and state taxes and fees.<sup>4</sup> For each state submission, the elements must be delineated for individual plans, small group plans and large group plans.<sup>5</sup> Reporting must be made at the health insurance company level rather than the holding company. These elements will be reported on an annual basis, with data aggregated for the calendar year and submitted no later than June 1 of the following year (the first such report is due June 1, 2012). The details regarding format and process for submission have yet to be released. Temporary allowances exist for expatriate plans and mini-med plans (policies with total coverage of \$250,000 or less annually), and a permanent system for reporting MLR is established for new health plans so long as the new plans' policies issued represent more than 50% of the issuer's premium revenue in the state market.<sup>6</sup>

While all of the definitions are important to the reporting, perhaps the most controversial of the definitions involves the distinctions among clinical services, quality improvement activities and non-claims costs. Clinical services include all direct medical claims paid in the year, unpaid claim reserves associated with claims incurred during the year, the change in contract reserves, reserves for contingent benefits, the claim portion of lawsuits and any experience rating refunds paid or received. Claims do not include rebates given due to the previous year's MLR or claims recovered as a result of fraud and abuse investigations.<sup>7</sup> Quality improvement activities are narrowly defined. Under the Health Reform Legislation, quality improvement activities include reimbursement structures improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors, and implementing preventative and wellness activities. In the Regulations, an expense that would otherwise be a non-claims expense must satisfy one of the foregoing categories and must be all of the following to be counted as a quality improvement activity:

1. designed to improve health quality;
2. designed to increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;
3. directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or designed to provide health improvements to a population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees; AND
4. grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other national recognized healthcare quality organizations.<sup>8</sup>

In response to whether plans must provide specific data illustrating the effectiveness of quality activities, HHS states that although "an issuer does not have to present initial evidence proving the effectiveness of a quality improvement activity, the issuer will have to show measurable results stemming from the executed quality improvement activity."<sup>9</sup> While many within the insurance industry were hoping that cost savings measures related to quality would qualify as a quality

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<sup>4</sup> 75 Fed. Reg. 74864, 74866 (Dec. 1, 2010).

<sup>5</sup> Id. HHS will allow large group plan and small group plan reporting to be aggregated in those states where the two markets are combined for state ratings purposes. 75 Fed. Reg. at 74871.

<sup>6</sup> 75 Fed. Reg. 74864, 74872 (Dec. 1, 2010).

<sup>7</sup> 75 Fed. Reg. 74864, 74874 (Dec. 1, 2010), as corrected by 75 Fed. Reg. 82277, 82279 (Dec. 30, 2010).

<sup>8</sup> Id. at 74875.

<sup>9</sup> Id. at 74876.

improvement activity, the Regulations expressly emphasize that the only cost saving measures capable of qualifying must meet all of the quality improvement activity criteria.<sup>10</sup> HHS also lists activities that may not be reported as quality improvement and instead are non-claims costs, including concurrent and retrospective utilization review, fraud prevention, development and management of the provider network, and provider credentialing.<sup>11</sup> Even though these measures provide value to the member, they fall outside the definition of quality improvement for MLR calculation purposes.<sup>12</sup>

**MLR Calculations and Rebates.** While the determination of which expenses fall into each category might be complex, the calculation of the MLR is conceptually straightforward. The numerator consists of the total reimbursement for clinical services and the total spending on quality improvement activities.<sup>13</sup> The denominator equals the total earned premiums minus the plan's federal and state taxes, licensing and regulatory fees.<sup>14</sup> Once the numerator is divided by the denominator, the results shall be rounded to the nearest one-tenth of 1%. The Regulations also provide for "credibility adjustment" to the MLR to address the greater claims variability experienced by smaller plans and also the impact of high deductible plans.<sup>15</sup>

Should the MLR be lower than 85% for large group plans or 80% for individual and small group plans, rebates will be due to plan enrollees. To calculate the rebate owed each member, the plan must look at the amount of premium paid by the individual enrollee (minus taxes and fees) and multiply that by the percentage amount by which the plan missed the MLR threshold.<sup>16</sup> MLR reporting is due June 1, and the rebates must be paid by August 1. The rebate, and an accompanying notification, may be paid by issuing premium credit (for current enrollees) or a lump sum check or reimbursement to the same account used to pay the premium. For group plans, health plans may delegate the distribution of the rebate to the group employer; however, the health plan maintains ultimate responsibility for compliance.<sup>17</sup> Where rebates are calculated to be less than five dollars per enrollee, the administrative costs of identifying and notifying enrollees likely outweigh the value to enrollees, so no individual rebate is required; however, these funds must be aggregated and distributed to all then-current enrollees who receive a premium credit.<sup>18</sup> The rebate process also requires annual reporting to HHS.

**Adjustments to MLR Requirements.** The Health Reform Legislation allows for HHS to adjust the MLR requirements for individual markets should the Secretary of HHS determine that the MLR application "may destabilize the individual market in such State."<sup>19</sup> The Regulations clarify the process required for states applying for such adjustment and sets forth the following assessment criteria for HHS to use in determining the likelihood of destabilization:

1. the number of issuers reasonably likely to leave the market or to cease offering individual products and the impact of such losses on competition in the market;
2. the number of individual enrollees covered by plans likely to leave the market;

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<sup>10</sup> Id. at 74875.

<sup>11</sup> Id. at 74875-74876.

<sup>12</sup> Id. at 74876.

<sup>13</sup> Id. at 74880.

<sup>14</sup> Id.

<sup>15</sup> Id.

<sup>16</sup> Id. at 74883.

<sup>17</sup> Id. at 74884.

<sup>18</sup> Id.

<sup>19</sup> The Patient Protection and Affordable Care Act, at § 10101.

3. whether the MLR requirement will cause individuals to be unable to access insurance brokers or agents;
4. if alternative coverage options are available for enrollees should their plans leave the market; and
5. the impact on premiums charged, benefits offered and cost-sharing for consumers by plans remaining in the market should other plans withdraw from the market.<sup>20</sup>

**Enforcement Mechanisms.** HHS retains authority to receive all reports related to MLR as well as enforcement rights. HHS will conduct audits regarding the data reported but alternatively can choose to accept audits performed by state regulators subject to certain conditions.<sup>21</sup> Health insurers remain responsible for all documentation related to MLR calculation, reporting and rebates.<sup>22</sup> The Regulations allow for civil monetary penalties for failure to comply with reporting or rebate requirements. While HHS is requesting additional comment regarding the proper amount or range of penalties, the Regulations currently set the penalty for each violation of the reporting or rebate requirements at \$100 per entity, per day, per individual affected by the violation,<sup>23</sup> so the aggregate fines could be significant. HHS indicates that penalty amounts may be altered for certain factors such as compliance history and gravity of violation, as well as other mitigating and aggravating circumstances.<sup>24</sup>

If you have questions regarding the information in this issue, or with respect to other provisions of the Health Reform Legislation as it relates to your insurance industry and operations, please contact any of the attorneys in our Insurance and Managed Care Practice Group listed below.

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<sup>20</sup> 75 Fed. Reg. 74864, 74887 (Dec. 1, 2010).

<sup>21</sup> Id. at 74889.

<sup>22</sup> Id. at 74890.

<sup>23</sup> Id. HHS notes that these civil monetary penalties are the same in structure and amount as those used by HHS in the Health Insurance Portability and Accountability Act (HIPAA) regulations.

<sup>24</sup> Id.