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Federal Government Issues Final Medical Loss Ratio Regulations

On November 22, 2010, the U.S. Department of Health and Human Services (HHS) issued final regulations on the medical loss ratio requirements provided for in the Patient Protection and Affordable Care Act (PPACA).

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The medical loss ratio (MLR) represents the percentage of premium dollars that health insurers "lose" through spending on their insureds' health care, as opposed to amounts that can be spent on administrative expenses or retained as net profits. The final regulations are basically unchanged from those recommended by the National Association of Insurance Commissioners (NAIC) in October.

Beginning in 2011, insurers will be required to adhere to the MLR standards, which proponents believe will improve the quality of health care coverage and keep rising insurance costs at bay. The MLR regulations stipulate targets of 80% for small-business plans and 85% for large-company plans (i.e., 80 or 85 cents of the premium dollar). If these targets are not met, insurers will be required to pay rebates to their insureds beginning in 2012. Specifically, for plans covering 50 or fewer people, PPACA requires insurers to spend at least 80 cents of the premium dollar on health care and certain activities to improve quality. For employer plans covering more than 50 people, the MLR requirement is 85 cents on the dollar.

According to HHS, over 20% of consumers are covered by plans that spend less than 70 cents of every premium dollar on the provision of care, and in extreme cases less than half of every premium dollar is spent on care. HHS officials believe that the new requirements will prevent insurers from spending excessive amounts on such expenses as administrative overhead, marketing, and executive bonuses. The regulations set forth reporting and disclosure requirements and the methodologies for calculation of the medical loss ratio and consumer rebates, and provide for adjustments to prevent market destabilization.

Consumer Rebates

Estimates indicate that in 2012, as many as 9 million people could be eligible for the first round of rebates totaling $1.4 billion, and rebates in the individual market could average $164 per person. Rebates are to be paid by August 1 of each year in the form of reductions in premiums, rebate checks, or lump-sum reimbursements to the credit or debit card accounts used to pay the premiums. Each consumer owed a rebate will receive an amount that is proportional to the premium amount paid; therefore, in instances where an employer pays a portion (or all) of the premium, the employer would receive a portion (or all) of the rebate.

Disclosure Requirements

Beginning in 2012,[1] each insurer that issues policies to individuals and employers will be required to report the following information in each state in which it conducts business:

- Total earned premiums
- Total reimbursement for clinical services
- Total spending on activities to improve quality of care
- Total spending on all other non-claims costs excluding federal and state taxes and fees

[1] The first report, containing information for calendar year 2011, will be due by June 1, 2012.

The regulations require insurers to retain documentation that relates to the data they report and to provide access to data and their facilities to HHS, if requested. Insurers will also need to report aggregate premium and expenditure data for each market, except for expatriate plans and "mini-med" plans. Insurers will be permitted to report information for these plans separately.

Mini-Med Plans

Limited medical benefit plans, or "mini-med" plans, are insurance products with low annual benefits and low premiums. They often have higher cost structures than other plans and the insurers that sell them may have difficulty complying with the MLR requirements. In recognition of this, for calendar year 2011 HHS will change the way MLR is calculated for mini-med plans and allow their issuers to apply for an adjustment to their reported medical claims and quality improvement expenses. Plans that claim the adjustment will be required to provide early reporting to HHS to allow HHS to review data on their expense structures and profitability.

Quality-Improving Activities

The regulations provide a comprehensive list of "quality improving activities" that will count toward the 80% or 85% standard. Insurers will be required to demonstrate that they have achieved measurable results from their quality-improving activities in order to justify their inclusion in the MLR calculation. As suggested by the NAIC, each quality-improving activity must meet the following criteria:

- "It must be designed to improve health quality;
- It must be 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;
- It must be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees; and
- It must 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."

Tax Adjustments

The regulations will allow insurers to deduct federal and state taxes that apply to health insurance premiums when calculating MLR. However, taxes on investment income and capital gains will not be deducted from premium revenue. For not-for-profit plans, assessments they are required to pay in lieu of taxes may be deducted.

Accommodations to Prevent Market Disruption

PPACA authorizes HHS to make adjustments to the MLR requirements on a state-by-state basis until 2014 to prevent market destabilization in the individual health insurance market. To qualify for an adjustment, a state must demonstrate that requiring insureds to meet the 80% MLR will likely destabilize the individual insurance market and possibly result in fewer choices for consumers. A standard adopted in the regulations will also allow HHS to consider the effect of the MLR on consumer access to agents and brokers.

Enforcement

PPACA gives HHS direct enforcement authority for the MLR standards. However, HHS will also accept the findings of a state audit of MLR compliance if they are based on MLR requirements set forth in the federal law and regulations. The regulations impose civil monetary penalties if an insurer fails to comply with the reporting and rebate requirements. The penalty for each violation is $100 per day for each responsible entity, per individual affected by the violation.

Next Steps

We continue to monitor HHS and other agencies as the implementation of PPACA moves forward and as other related matters arise. We will provide timely updates as such developments occur.

In addition to providing sophisticated legal services to a broad array of clients in the healthcare and insurance industries, Edwards Angell Palmer & Dodge LLP attorneys monitor and analyze federal and state legislative and regulatory processes to ensure that our clients are informed of government actions and initiatives.

This advisory is for guidance only and is not intended to be a substitute for specific legal advice. If you would like further information, please contact the Edwards Angell Palmer & Dodge attorney responsible for your matters or one of the attorneys listed below:

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