Update Regarding Medical Loss Ratio Reporting Under Federal and State Law
By Fred E. Karlinsky, Esq., Richard J. Fidei, Esq., and Erin T. Siska, Esq.

Introduction

With the June 1, 2012, deadline for filing medical loss ratio ("MLR") data reports under federal law fast approaching, health insurers need to be up to date with the federal MLR reporting requirements and new guidance issued by federal and state regulators regarding compliance with these mandates.

I. Overview of the Act

President Obama signed the Patient Protection and Affordable Care Act[1] into law on March 23, 2010, and the Health Care and Education Reconciliation Act[2] into law on March 30, 2010 (collectively, the "Affordable Care Act" or the "Act"). Section 2718 of the Act[3] requires health insurers to spend at least 80% of every premium dollar on health care for patients with individual policies and small group plans. For large groups, the minimum to be spent on care is 85%.[4] Recently promulgated federal regulations address the healthcare reimbursement and expense components permitted in the calculation of the applicable medical loss ratios.[5] The MLR rules limit administrative costs, including certain taxes and agent commissions, to 15% or 20% of premium, depending on the type of policy or plan involved. If insurers do not meet these MLR thresholds, they must provide rebates to their policyholders, in the form of a premium credit, cash refund or benefit enhancement.[6]

MLR data reports are due to the Center for Consumer Information and Insurance Oversight ("CCIIO") within the Centers for Medicare & Medicaid Services ("CMS") by June 1 of each year; CCIIO's data report submission window opened May 1.[7] If applicable, rebates must be paid by August 1 of each year.[8] A study published by the Kaiser Family Foundation on April 26, 2012, estimates that health insurers will pay $1.3 billion in rebates this August, with the amounts varying widely from state to state and from insurer to insurer, but the largest total amounts being refunded in Texas and Florida.[9] The study is based on preliminary data provided by health insurers to their state Departments of Insurance in their 2011 Supplemental Health Care Exhibits.[10]

Certain issues have arisen in connection with the implementation of these new requirements. For example, the Act allows each state to apply for a downward adjustment to the federal MLR requirements and certain states have applied for, and received, MLR adjustments. Additionally, the inclusion of agent commissions within the non-claims costs required to be part of the MLR calculation has led to a reduction or restructuring of agent commissions for many individual and group programs, particularly small group plans. This has resulted in some alternative approaches for the payment of agent compensation, which have implicated possible state law compliance issues.

II. HHS Rulemaking and State-by-State Adjustments to MLR Requirements

The Act delegated implementation of its MLR requirements to the Department of Health and Human Services ("HHS") and its rulemaking process. Most of the relevant guidance is set forth in the HHS's Interim Final Rule.[11] One of its more notable provisions is its formula for calculating MLR.

As a starting point, the numerator of the MLR calculation is the sum of the insurer's incurred claims plus expenditures for activities that improve health quality. The denominator is the insurer's premium revenue minus the insurer's federal and state taxes and licensing and regulatory fees.[12] For the 2012 reporting year, the numerator may also include any rebates paid for the 2011 MLR reporting year if the 2012 MLR reporting year experience is not fully credible.[13] For the 2013 reporting year, the numerator of the insurer's MLR calculation may include any rebates paid for the 2011 MLR reporting year or the 2012 MLR reporting year.[14] In the denominator, earned premium includes "all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan." [15] Of course, this would include agent commissions that are typically a component of, and paid from, earned premium. Credibility adjustments are allowed, if applicable.[16]

The Interim Final Rule allows an insurer to include in the numerator its expenses for "quality improvement activities" but not other "non-claims costs," such as agent and broker fees and commissions, which remain part of the denominator in the MLR calculation.[17] It also requires insurer reports to include an explanation of how premium dollars are used for all non-claims costs, including agent and broker fees and commissions.[18]

The Interim Final Rule allows for a temporary downward adjustment to the MLR for a state's individual market, if appropriate.[19] To date, eighteen (18) applications have been filed with CCIIO. Seven (7) applications were granted, in whole or in part, ten (10) were denied and one (1) was not acted upon.[20] In reviewing the applications, the CCIIO considered whether it was reasonably likely that enforcement of an 80% minimum standard would destabilize the applicable state's market.[21]

The two most recent applications were filed by Wisconsin and North Carolina. Wisconsin's application was denied and North Carolina's application was granted, but only in part. The discussion in both determinations focused on the number of insurers reasonably likely to exit the state if the 80% federal minimum standard was to be implemented immediately.

In reviewing the Wisconsin application, which requested adjustments to the individual MLR thresholds to 71%, 74% and 77%, for the years 2011, 2012 and 2013, respectively, CCIIO noted that: (i) the four insurers that had expressed an intent to leave the state were basing their decisions on reasons other than the risk of having to pay rebates under the Act; (ii) most of the remaining insurers already meet or nearly meet the 80% minimum standard; and, (iii) the other remaining insurers not meeting the 80% standard appeared to be in the process of adapting their business models to meet the 80% standard and were likely to remain in the Wisconsin market. Accordingly, the CCIIO could not conclude that it would be "reasonably likely" that the

Wisconsin market would be destabilized if the 80% standard were to be implemented in accordance with the Act. CCIIO also responded to some of the public comments it received and indicated that Wisconsin has a "highly competitive individual market, characterized by a large number of well-performing HMOs whose experience shows that efficient issuers are able to meet the statutory MLR standard while remaining solvent and profitable." It further observed that the data submitted to CCIIO indicated that in 2010 the aggregate MLR for health insurers in the Wisconsin market was, in fact, approximately 82%.

North Carolina's application requested MLR adjustments to 72%, 74% and 76% for its individual market for the years 2011, 2012 and 2013, respectively. CCIIO deemed the North Carolina market to be a highly concentrated one, with one dominant insurer accounting for more than 81% of the market share and with no other insurer having more than a 4.5% market share. Moreover, recent decisions by one-third of North Carolina's other insurers to leave the state, while unrelated to the new federal MLR requirements, resulted in reduced consumer options. The CCIIO found that immediate implementation of the Act's 80% minimum MLR requirements could lead to the destabilization of the North Carolina market. Therefore, CCIIO allowed North Carolina an adjustment to a 75% threshold in 2011, but did not permit any adjustments for 2012 or 2013.

In total, the states whose adjustment requests were granted for 2011 are Maine, Nevada, New Hampshire, Kentucky, Iowa, Georgia and North Carolina. Many of these applications were approved only in part, or conditionally, as CCIIO has expressed its intent to create a "glide path" for each state's compliance with the new federal 80% standard.

Applications for temporary downward adjustments from the 80% standard submitted by North Dakota, Delaware, Louisiana, Indiana, Michigan, Kansas, Oklahoma, Florida, Texas and Wisconsin were all denied. For the most part, denials were founded upon a determination that if any insurers were to exit these jurisdictions, there would still be a sufficient number of carriers to sustain a robust market providing different options for consumers.

It is interesting to note that the Interim Final Rule established requirements regarding the distribution of rebates, and initially provided that they should be sent to group plan enrollees. It was later determined that this would have resulted in an unintended taxable event for each enrollee.[22] After receiving input from the Departments of Labor and Treasury on this issue, HHS issued clarification in a Final Rule [23] that the rebates should be distributed in a tax-free manner.[24] Thus, for most employer-sponsored plans, the group policyholder / employer will receive the rebate and will have to distribute the rebate to the group plan enrollees / employees.[25]

Notably, the Final Rule did not contain any changes to the way agent and broker compensation is treated under the MLR requirements set forth in the Interim Final Rule.[26]

III. State Law Issues

There are two main issues that have arisen in view of the new federal MLR requirements: (i) alternative approaches to the payment of agent and broker commissions; and, (ii) the reservation of a state's right to establish its MLR threshold under the Act.

A. Agent & Broker Compensation

An important state compliance issue that has developed relates to changes in agent and broker compensation approaches to accommodate the restrictions in the calculation of the MLR under the Act. The NAIC predicted, during the HHS rulemaking process, that the inclusion of agent and broker commissions as part of the non-claims component of the federal MLR calculation would result in the dramatic change in the structure of agent compensation from a commission-based model to a flat fee or fee per employee model.[27] Agencies and producers have since claimed that their income has dramatically dropped and that they may be forced out of business at a critical time when insureds are in need of additional service and advice as to plan options.

Meanwhile, the Kentucky Department of Insurance, in an Advisory Opinion issued this year, has acknowledged that insurers in Kentucky have started having their agents collect a separate commission from the insured for group health plans, in an effort to avoid paying rebates under the new federal MLR requirements.[28] This Advisory Opinion prohibits agents from doing so, unless they are acting as an insurance counselor and licensed as such.[29] Under Kentucky law, insurance counselors owe fiduciary duties to the insured and cannot simultaneously act as an agent of the issuer and the insured.[30] Thus, traditional producers may need to decide whether to remain an agent of the issuer or seek licensure as an insurance counselor providing specialized advice and representation to the insured. It remains to be seen whether there is a market for this type of specialized service in Kentucky, or any other jurisdiction, or an appetite of insureds to separately pay for services that have been traditionally provided at no additional charge above or beyond the premium paid by the insured.

The Advisory Opinion also advises health insurers of the Kentucky Department of Insurance's long-standing position that agent compensation must be included in an insurer's rate filing as part of premium.[31]

Since the promulgation of the HHS's Final Rule, there have been three principal federal bills filed that would change the treatment of agent and broker commissions. First, HR 1206 would exclude producer compensation from federal MLR calculations entirely. Despite having 200 co-sponsors, this bill has languished in the House since March 2011. More recently, S. 2068 and S. 2288, the Access to Independent Health Insurance Advisors Act of 2012, were filed in the Senate in February and April of 2012, respectively. These bills are similar to HR 1206 but would apply to the individual and small group markets only, and would leave producer compensation in the large group market subject to existing federal MLR requirements. Both Senate bills are currently with the Senate Committee on Health, Education, Labor and Pensions.

B. State MLR Thresholds

Some state statutes require a higher minimum MLR for purposes of providing rebates, or reviewing insurer rates, than is required under federal law. Thus, another important issue that has been raised relates to the continuing applicability of these standards in light of the Act.

The CCIIO has indicated that a higher state MLR standard would not automatically apply. While 45 C.F.R. § 158.211(a) provides for a higher state MLR threshold, it is CCIIO's position that states must satisfy certain requirements before enforcing higher thresholds.[32] In support of this position, CCIIO cites 45 C.F.R. § 158.211(b) which requires each state to "seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the state, and value to consumers so that premiums are used for clinical services and quality improvements." Since states could not have considered these factors in formulating a higher MLR threshold prior to passage of the Act, CCIIO has determined that the HHS will only accept a higher state MLR from states that exercised their option under 45 C.F.R. § 158.211 after the Affordable Care Act was signed into law.[33] States that have gone through this exercise include Massachusetts, New Mexico and New York.[34]

Massachusetts recently issued an insurance bulletin indicating that carriers must file "separate and distinct" financial reports and MLR rebate calculation forms to the state and federal governments.[35] Additionally, all Massachusetts carriers subject to federal rebate requirements were requested to submit copies of their federal rebate calculation forms to the Massachusetts Division of Insurance as informational filings, and include materials that describe the carrier's rebate plan.[36] Massachusetts law requires a 90% MLR for the individual and small group markets for reporting year 2011.[37]

New Mexico had passed its own MLR law that became effective May 19, 2010, and required a minimum MLR of 75% for the individual market and 85% for all other markets.[38] It deferred enforcement of the New Mexico law until the federal regulations were published.[39] Ultimately, on April 8, 2011, it decided to adopt the 80% and 85% federal MLR standards, in lieu of different state-mandated ratios.[40]

The New York Department of Financial Services has indicated that it is exercising its right to adopt a higher MLR requirement and is implementing an 82% minimum MLR standard for the small group and individual markets for purposes of calculating rebates.[41] It has also indicated that carriers who follow the federal standards for reporting and rebate distribution, and provide a copy of their federal reports to the New York Superintendent of Financial Services, will have satisfied their state reporting obligations under New York law.[42] However, for rate review purposes, the New York Superintendent of Financial Services has retained discretion to review rates under state law standards that require a minimum MLR of 82%.[43] The Superintendent's stated position is that Section 2718 of the Affordable Care Act and CFR Part 158 do not address rate review issues.[44] Thus, it appears the Superintendent has discretion to require an 82% MLR threshold in rate filings for the individual, small group and large group markets.

As the foregoing examples illustrate, there are many different approaches a state can take with respect to implementation of the new federal MLR requirements. As might be expected, some states have simply indicated that health insurers are responsible for complying with applicable state and federal law.[45]

Conclusion

At this point in time, all states that intended to apply for a temporary downward adjustment to the new federal 80% MLR standard for the individual market should have already done so. A small number of states received a reprieve from the federal MLR standard for 2011, while Maine was the only state that was granted a downward adjustment for 2011, 2012 and (conditionally) 2013. Health insurers and producers should be aware that state Departments of Insurance are monitoring changes to the way agent commissions are structured. Meanwhile, twenty-six (26) states have asked the U.S. Supreme Court to overturn the controversial Act and several pieces of proposed federal legislation regarding agent commissions remain pending. Thus, many significant developments are sure to arise as these complicated issues continue to crystallize and be discussed by our state and federal governments.

---

[1] Pub. L. 111-148.
[2] Pub. L. 111-152.
[3] 42 U.S.C. § 300gg-18.
[4] 45 C.F.R. § 158.50.
[5] 45 C.F.R. § 158.60.
[6] 45 C.F.R. § 158.240; s*ee also* 76 Fed. Reg. 76596-97.
[7] 45 C.F.R. § 158.110; *see also* Technical Guidance dated April 20, 2012, *available at* http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf (last accessed May 2, 2012).
[8] *Id.*
[9] *See* http://www.kff.org/healthreform/upload/8305.pdf (last accessed May 10, 2012).
[10] *Id* at 5.
[11] 75 Fed. Reg. 74864 *et. seq*.
[12] 45 C.F.R. § 158.221.
[13] 45 C.F.R. § 158.221(b)(1).
[14] 45 C.F.R. § 158.221(b)(2).
[15] 45 C.F.R. § 158.130.
[16] 45 C.F.R. §§ 158.230-158.232.
[17] 45 C.F.R. §§ 158.150 and 158.160.
[18] 45 C.F.R. § 158.160 (b)(2)(iv).
[19] 45 C.F.R. §§ 158.301-346.
[20] *See* http://cciio.cms.gov/programs/marketreforms/mlr/index.html for additional information as to each state's application, including copies of each state's application and the HHS determination as to same. Guam's application was not acted upon because its individual market is so small that it is considered "non-credible" and therefore it is presumed to meet or exceed the relevant MLR standard.
[21] 45 C.F.R. § 158.301.
[22] 45 C.F.R. § 158.241(b).
[23] The final federal MLR regulations are codified at 45 C.F.R. Part 158.
[24] 76 Fed. Reg. 76579-76581; *see also* 45 C.F.R. § 158.242.
[25] *Id*. *See also* 76 Fed. Reg. 76596-97.
[26] This remained unchanged by HHS, despite the National Association of Insurance Commissioners' ("NAIC") written resolution urging that agent compensation be exempt from the sum of non-claims costs included in the MLR, *available at* http://www.naic.org/documents/committees_ex_phip_resolution_11_22.pdf last accessed May 8, 2012. Otherwise, the HHS adopted all of the NAIC's recommendations in promulgating its federal regulations regarding MLR.
[27] *See id.* The NAIC's written resolution to HHS refers to an August 2011 Government Accountability Office report finding that "almost all of the insurers we interviewed were reducing brokers' commissions and making adjustments to premiums in response to the [Act's] MLR requirements. These insurers said that they have decreased or plan to decrease commissions to brokers in an effort to increase their MLRs."
[28] Kentucky Advisory Opinion 2012-01 (Jan. 10, 2012).

[29] *Id*.
[30] *Id*.
[31] *Id*. *See also* KY. REV. STAT. § 304.12-190.
[32] Technical Guidance dated April 20, 2012 at 7(*see infra* note 7).
[33] *Id*.
[34] *Id*.
[35] *See* Mass. Bulletin 2012-02 (April 23, 2012).
[36] *Id*.
[37] MASS. GEN. LAWS ch. 176J, § 6(d).; *see also* MASS. REGS. CODE tit 211, § 66.09 (8).
[38] *See* N.M. Ins. Division Bulletin No. 2011-006 (April 8, 2011).
[39] *Id.*
[40] *Id*.
[41] N.Y. Ins. Circular Letter No. 15 (Dec. 22, 2011). An 85% standard will apply to the large group market, which is the same as under federal law. (The New York State Insurance Department was recently combined with the New York State Banking Department to create the New York State Department of Financial Services, in an effort to modernize regulatory oversight of the state's financial services industry.)
[42] *Id*.
[43] *Id*.
[44] *Id*. In addition to the foregoing, the issue of whether an insurer may offer a "premium holiday" in order to avoid having to pay a rebate was raised in the CCIIO's April 20, 2012 Technical Guidance regarding MLR. CCIIO indicates that since neither the Act nor the federal MLR regulations address this issue, it would be up to state regulators to determine whether a "premium holiday" would be permissible. Although there has been no state guidance provided to date on this issue, presumably a "premium holiday" may be improper under most states' Unfair Insurance Trade Practices Acts.
[45] *See, e.g*., Dec. 16, 2010 letter from Maine Bureau of Insurance's General Counsel to Maine Health Insurance Carriers regarding producer compensation (reminding all health carriers that MLR calculations should be made consistent with both Maine Insurance Rule 940 and 45 CFR Part 158 and, additionally, that their agent compensation structure should be consistent with both state and federal law requirements).