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Medical Loss Ratio Requirements for Health Insurers

The Department of Health and Human Services (HHS) has released an interim final rule to implement medical loss ratio (MLR) requirements for health insurers under the Affordable Care Act. Under this "medical loss ratio" provision of the Affordable Care Act, health insurers are required to spend a certain percentage of premiums on direct medical care for patients and health care quality improvements, rather than on administrative costs. The final rule outlines disclosure and reporting requirements, how insurance companies will calculate their medical loss ratio and provide rebates, and how adjustments could be made to the MLR standard to guard against market destabilization. See the HHS press release and MLR Fact Sheet for more information.

Currently, there is no uniform requirement that health insurers spend a minimum share of premiums on medical care. Beginning in 2011, insurers of large group plans must spend at least 85% for direct care and quality improvements (80% for small group plans and for individual policies). In addition, under the MLR rules, mini-med plans will be allowed minimum health care ratios as low as 40%, as opposed to the 85% level of the standard employee insurance (mini-med plans are often characterized by a relatively high expense structure relative to the lower premiums charged). If the MLR is less than these set percentages, the insurer is required to provide an annual rebate to each enrollee on a pro rata basis. Beginning on January 1, 2014, the calculation to determine rebate amounts will be based on the average ratio over the previous three years.

Highlights of the MLR regulations include:

- Small group is defined as 2 to 50 employees, unless a state defines it differently, until at least 2016.
- MLR rebates will be sent to policyholders, which include employers or employee organizations as well as individual plan policyholders. Insurers may distribute rebates to employers; in turn, employers would need to issue rebates to employees, based on employee contributions.
- Policyholders are potentially eligible for a rebate determined on a "block" basis. The "block" is defined by organization size (individual, small or large employer group), legal entity issuing coverage, and state of issuance (limited medical and expatriate international plans handled separately).
- For the 2011 reporting year, issuers of limited medical ("mini-med") and expatriate international plans are subject to separate calculation rules.
- Broker commissions will be included in the MLR calculation.
- States may apply to have the requirement adjusted if meeting the 80% spending

requirement would destabilize their individual markets. Four states - Maine, Iowa, South Carolina and Georgia - already have said they'll seek adjustments. Some small plans won't have to provide rebates, at least for the first year.

- The MLR standards rule does not apply to self-insured group health plans.
- The calculation and payment of MLR rebates applies to any health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan).
- Insurance companies that issue policies to individuals, small employers, and large employers must report information in each state it does business, such as total earned premiums, 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.

HHS has direct enforcement authority for the MLR requirements. Insurers are required to retain documentation that relates to the data that the insurers reported, and to provide access to those data and their facilities to HHS. Civil monetary penalties can be imposed if an insurer fails to comply with the reporting and rebate requirements. The penalty for each violation is $100 per entity, per day, per individual affected by the violation.

Employers are advised to continue to monitor health reform developments. Should you have questions about this or any aspect of federal health insurance reform, contact your Conner Strong account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong, visit our online Resource Center.

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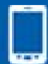
connerstrong.com  877-861-3220 news@connerstrong.com Change My Preferences

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