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REFORM Update

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The Medical Loss Ratio or MLR requirements of the ACA are seen as a mechanism to help control costs and bring greater transparency to the health insurance market. These requirements, effective on January 1, 2011, are designed to make sure that eighty-five cents on the dollar is spent on claims costs, while the remaining fifteen cents are allocated to administrative expenses in the large group market. In the small group and individual markets, eighty cents on the dollar are spent on claims cost, while the remaining twenty cents are allocated to administrative expenses. If a carrier fails to meet this benchmark, a portion of the premium must be refunded to subscribers.

The reporting and calculations required by the recently issued interim regulations are complex. In this *Reform Update* we will merely summarize the process. It is important to understand that these MLR requirements apply only to insurance carriers. Self-funded medical plans **are not** required to meet any specific MLR, **nor** will they be required to participate in the reporting process.

Key Definitions

These regulations establish specific definitions that health carriers can use in determining their MLR. Key terms include:

- **MLR Reporting Year**: Refers to the timeframe for reporting data. MLR data is reported on a calendar-year basis.
- **Enrollees**: Individuals enrolled in individual coverage or enrolled for group health insurance coverage, including the dependents of a subscriber.
- **Small Group Market and Large Group Market**: Insurers must report data by market. Small group market includes small employers (1-100 employees). Large group market includes large employers (101+ employees). For MLR reporting until 2016, ACA allows states to define small employers as those with up to 50 employees.

Disclosure and Reporting Requirements

For each MLR reporting year, insurers are required to submit a report to the Secretary of Health and Human Services with information specific to earned premiums and expenditures in various categories, including:

- Reimbursement for clinical services (claim cost)
- Activities that improve health care quality with respect to coverage benefits and health care provider reimbursement structures, including activities that:
  - Improve health outcomes
  - Prevent hospital readmissions

- Improve safety and reduce medical errors
- Encourage health promotion and any general wellness focused endeavors

- Non-claim costs include sales expenses, broker fees and commissions, state and federal taxes, licensing and regulatory fees, community benefit expenditures and general administrative expenses

This report must be submitted by June 1st of the year following the end of the MLR reporting year. This allows insurers to include claims for services provided during the MLR reporting year that are processed and paid in the three months following the end of the MLR reporting year.

In general, insurance carriers will report this data on an aggregate basis by state, segregated by market (individual, small group and large group). Insurers are permitted to combine the data from the individual and small group markets only if the state requires that the two markets be combined for rating purposes. A few exceptions are noted:

- **New Insurers**: When a carrier enters a new market, the claims experience will be immature, which can significantly affect the calculation of the MLR. The government will thus allow experience and premium calculations to be deferred to the following MLR reporting year.
- **Expatriate plans:** These plans cover employees working outside their country of citizenship, outside the employer's country of domicile, or citizens working in their home country outside the employer's country of domicile. Insurers can choose to report the data for these plans separately and multiply their claims experience and quality improvement activities by a factor of two. The doubled experience should be used to calculate the MLR. This adjustment applies only for 2011 and carriers are required to report their data quarterly if they wish to use the adjustment.
- **Mini-medical plans:** These plans will struggle with meeting the statutory MLR requirements. The government is allowing mini-medical plans the same special circumstances adjustments for 2011 as expatriate plans, provided they report data on a quarterly basis. For the purposes of MLR, a mini-med plan is defined as a plan that has an annual dollar benefit limit of $250,000 or less.

If a carrier insures a group with employees located in multiple states, then the information for the entire group will be reported in the state that regulates the contract.

Calculating and Providing Rebates

The data received is used to calculate the MLR. Simply put, the MLR will be:

$$\frac{\text{Incurred Claims and Expenditures for Quality Improvement}}{\text{Insurers Premium Revenue Less Federal and State Taxes and Licensing and Regulatory Fees}}$$

When claims are divided by the premiums, the result must be at least:

- 85 percent in the large group market
- 80 percent in the small group and individual markets

If an insurer fails to achieve the minimum MLR required, then the insurer must rebate a portion of the premiums. The rebate is calculated by determining by how much the carrier's MLR falls below the minimum required, and then multiplying that amount by the premium revenue less federal/state taxes, licensing and regulatory fees. The rebate is provided on a pro-rata basis to each enrollee and must be proportional to the amount of premium the enrollee paid. A notice is required to accompany the rebate, explaining what the rebate is and how it was calculated.

Rebates must be provided no later than August 1st in the year following the applicable MLR reporting year. They can be provided as a premium credit, in a check or as a credit to the enrollee's credit card.

For group-insured plans, the rebate will be provided to the employer, who is required to determine the share that should be allocated to employees. The employer will distribute the refund.

Enforcement and Potential Penalties

Insurers have a number of responsibilities for complying with the MLR requirements. The Federal Government has the right to audit the data and rebate calculations of insurers. Audit findings will be made public.

The government can impose civil monetary penalties for any failures relating to the reporting and rebate requirements. The penalty can be up to $100 per day per individual affected by the failure.

Concluding Thoughts

The MLR requirements apply to insurance carriers only. Employers will be affected if they fully insure their health plan and the carrier is required to distribute a rebate. Carriers will also become more careful about rate setting as it relates to administrative expenses.