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REFORM Update

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The Centers for Medicare and Medicaid Services (CMS) recently released final regulations addressing Medical Loss Ratios, or MLRs. The health care reform legislation established a requirement that group and individual insurance carriers allot a specified amount of premium dollars to claim payments. A carrier that fails to meet these MLR requirements is required to refund policyholders a portion of the premiums paid. These requirements do not apply to self-funded plans.

Initial guidance on MLRs was issued in December 2010. The initial rules specified reporting requirements for carriers and details on calculating and distributing rebates. We addressed this guidance in our *Reform Update* at http://www.mcwent.com/Reform_Update/2011/Reform_Update_23.pdf. Now comes additional guidance that provides further clarification on MLRs, including:

- Mini-medical plan calculations
- Expatriate plan calculations
- Additional information on categorizing expenditures
- Details on distribution of rebates

Insurance carriers are responsible for complying with the MLR requirements, but employers should understand how to distribute rebates properly.

Mini-Medical Plan Calculations

The initial guidance provided special rules for calculating the MLR with mini-medical plans. A mini-medical plan is defined as a policy with total annual benefit limits of $250,000 or less. Because these plans tend to have much higher administrative costs, carriers argued that they would not be able to pass the standard MLR calculation.

To take into account these special circumstances, the government allowed these plans to multiply by two their claims experience and health quality improvement activities before calculating the MLR. These plans were also required to submit claim and administrative costs quarterly to CMS. The quarterly reports were used to determine if the doubling of claims was a reasonable measure to use when calculating the MLR.

After reviewing two quarters of data, CMS determined that it was necessary to continue to allow special consideration for mini-medical plans. The appropriate multiplier for mini-medical claims experience and funds used for activities to improve health quality will vary by year:

Year	Multiplier
2012	1.75
2013	1.50
2014	1.25

The graduated adjustment is allowed to encourage insurers to reduce administrative expenses and to operate more efficiently. Unless the health care reform regulations are amended, mini-medical plans will not be available beyond 2014.

Expatriate Plan Calculations

Expatriate plans also tend to have higher administrative costs, and argued the need for special consideration with regard to the MLR calculation.

The new regulations modified the definition of an expatriate plan, which is a group policy providing coverage to employees, substantially all of whom are:

- Working outside their country of citizenship.
- Working outside their country of citizenship and working outside the employer's country of domicile.
- Non-U.S. citizens working in their home county.

In the initial guidance, CMS allowed a special circumstances adjustment for expatriate plans. Like mini-med plans, these plans could multiply by two their claims experience and costs for health quality improvement activities before calculating the MLR.

These plans were also required to submit data on a quarterly basis. Based on the results of the first two quarters, CMS determined the special circumstances adjustment should continue. Expatriate plans can continue to multiply by two the claims and costs associated with quality improvement. This multiplier will apply to expatriate plans indefinitely.

Additional Information on Categorizing Expenditures

The initial MLR rules spelled out what expenses should be counted in claims and quality improvement and what expenses should be considered administrative. Carriers are responsible for categorizing their expenses when calculating the MLR, so it is critical that they know how to do this.

Clarifications made by the recent guidance include:

- CMS confirmed fraud reduction expenses are not to be treated as quality improvement activities. Payments recovered through fraud reduction efforts can be used as adjustments to incurred claims.
- CMS confirmed a percentage of ICD-10 conversion cost can be counted as a quality improvement activity. Current systems are designed to pay claims using an ICD-9 diagnostic code. HIPPA requires carriers to convert claim systems to use ICD-10 codes.

Details on Distribution of Rebates

Health care reform requires insurance carriers that have not met the applicable MLR standard to provide a rebate to each policyholder in an amount proportionate to the amount of premium paid.

The government received many comments on the process for distributing rebates, resulting in the following key clarifications:

- Employers will be responsible for distributing rebates.
- Plan participants and employers will not have to pay taxes on rebates.
- Insurers will be required to distribute a notice with the rebates. The notice provides transparency on how carriers use premium dollars. Feedback is requested on this notice requirement:
  - Should the notice include both current and prior year information on the MLR?
  - Should a notice requirement apply to all insured plans, not just those issuing rebates?
- The minimum threshold for a payable rebate was increased to $20 per subscriber, which includes the employer and employee portions combined.
- The carrier is responsible for distributing rebates to plan participants if an employer cannot. For example, if the employer goes out of business.

These new regulations confirm that insurers should provide rebates to the policyholder, which means the employer or entity that paid the premiums. More guidance has been provided on how employers should handle rebate monies and the distribution process. Interestingly, the details differ depending on your plan:

- ERISA group health plan
- Non-federal government plans

Insurance carriers can require a written assurance from employers that the rebate will be used for the benefit of current subscribers. Different rules govern how different employers handle rebates.

ERISA Group Health Plans

The Department of Labor (DOL) provided separate guidance on the payment of rebates to ERISA plans. To the extent that premium rebates are considered plan assets, they are subject to Title I of ERISA. Title I includes:

- Exclusive benefit requirements, meaning plan assets need to be used for the exclusive benefit of plan members
- Trust and reporting requirements
- General standards of fiduciary conduct requirements

The requirements of Title I are complex, so determining if the rebates are considered plan assets is crucial.

The definition of plan assets is somewhat vague. Based upon the definition, distributions from health insurance carriers can be considered plan assets. Much will depend on the plan language and funding arrangements.

If a trust is the policyholder and in the absence of specific plan language to the contrary, the employer would have no right to the rebate. The trust is the policyholder, and will thus be the recipient of the rebates. These rebates would be considered plan assets.

However, it is more common for the employer to be the policyholder. If the plan document supports the employer as the policyholder, then the employer will be the recipient of the rebates. However, even if the employer receives the rebates, it may not be able to keep them. If employees pay a percentage of the premiums, that specific percentage of the rebate is considered plan assets.

ERISA requires that plan assets be held in trust until the point when they are needed to fund eligible claims. That said, very few ERISA plans maintain a trust to fund the benefit plan. This is because the Department of Labor issued Technical Release 92-01 in May 1992, granting a non-enforcement stance on this trust requirement. To qualify for the non-enforcement stance, the plan has to collect employee contributions via a Section 125 plan and then pay for benefits out of general assets. The trust non-enforcement stance will apply to premium rebates if they are used within three months of receipt. The employer can use them to pay premiums or to issue rebates to plan participants.

Under ERISA, the general standards of fiduciary conduct will apply to the distribution of rebates considered plan assets. This means fiduciaries must act prudently and solely in the interest of plan members, in accordance with the terms of the plan. Employers may want to amend their plans to include the allocation method for the distribution of rebates.

An employer who pays 100% of the premiums is entitled to keep the rebate and use it to offset premiums. In this case, rebates are not considered plan assets. If employers and employees split the cost of coverage, the employer must use a reasonably objective allocation method. Plans may be able to allocate rebates to offset reasonable administrative expenses. However, employers taking this approach should amend plan documents to specify that plan assets generated from rebates will be used in this manner. If distributing the rebates is not cost-effective, the employer can use the rebate for other plan purposes, such as applying the rebate to reduce future employee contributions or to fund benefit enhancements.

The determination of plan assets is complex. Because fiduciary standards apply to your behavior, it is best to seek counsel from your benefits attorney when determining the best course of action for rebate distribution.

Non-Federal Government Plans

Separate guidance was issued to address rebates for non-federal government plans. This guidance was fairly general. The policyholder is required to use the portion of a rebate that is attributable to employee contributions to benefit plan subscribers. The policyholder can use rebate funds either to reduce employee premium contributions or to provide cash refunds. The rebates are to be distributed to employees covered by the group health plan during the plan year in which the rebate is issued.

DHHS has requested comments on this separate guidance.

Concluding Thoughts

The MLR rules applied to insured plans in 2011, so employers who insure their health plans need to consider how rebates will be handled. The government allows time for carriers to provide the required data to calculate the MLR. Rebates related to the 2011 plan year will be payable by August 1, 2012.

It may make sense to consider how your organization will allocate rebates. Plan documents may have to be amended to address this issue.