[buck research]

A Xerox Company

for your information©

Volume 34 | Issue 08 | January 24, 2011

HHS Issues Medical Loss Ratio and Rate Increase Review Regulations

HHS has issued regulations on two important health reform provisions affecting insured plans – medical loss ratios and review and disclosure of insurer rate increases. While the insurer rate regulation will not impact large employer health plans, the medical loss ratio requirements could result in sponsors of some large insured plans receiving rebates from insurance carriers. Plans will have to share rebates with enrollees in contributory plans.

Background

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, (PPACA) tries to make health insurance more affordable to consumers by requiring that issuers of individual and group health insurance policies (1) satisfy medical loss ratio (MLR) requirements and (2) have "unreasonable" premium rate increases subject to disclosure and review (Rate Review). The MLR regulations require issuers to provide rebates to plans and individuals purchasing insurance if the issuer does not spend a minimum amount of the premium on medical claims. The Rate Review regulations subject insurance carrier rate increases to increased review and visibility. These rules apply to insurers and will impact insured plans. They do not apply to self-funded plans.

In December, 2010, the Department of Health and Human Services (HHS) posted interim final regulations on the MLR requirements and proposed regulations on Rate Review.

Medical Loss Ratio (MLR)

The MLR regulations require that, beginning on January 1, 2011, health insurance issuers spend at least 80% of the premium dollars they receive from selling policies and plans in the individual market and at least 80% from policies they sell in the small group market on a combination of medical care claims and activities to improve health care quality. The parallel rule for the large group market (more than 50 employees) requires an 85% expenditure. Effectively, the MLR provision limits the amount that insurers can spend on administrative expense, overhead, profit, commissions, and other non-claim expenses to just 15% or 20% of the premium. Satisfaction of the MLR requirements is determined for the insurer separately in each state where the insurer issues policies and separately for each of three market segments in the state – individual, small group, and large group.

The regulations require insurers to provide rebates to policyholders and enrollees annually if the insurer fails to meet the MLR standards in a market for the prior year. Insurance companies will have to pay rebates for 2011 by

© 2011 Buck Consultants®, LLC. All rights reserved

August 2012. The recently issued regulations provide details on how carriers will measure and report their MLRs and the rules for allocating a portion of the rebate to enrollees.

BUCK COMMENT. *While many large insured health plans individually could have MLRs that exceed the 85% requirement, the determination for an insurer is based on their entire large group book of business in a state. As a result, it is likely that some large plans will receive rebates even if the MLR solely with respect to the plan exceeds 85%. Also, although commissions may be included in the 15% non-claim expense limit, Aetna has announced that it will exclude commissions in its 15% calculation for the large group health insurance premiums starting February 1, 2011. Other insurers are expected to take similar actions. As a result, large employers that pay benefit advisers with commissions may need to revise those arrangements.*

The carrier can provide rebates in cash or as an adjustment to premiums. For group plans, the regulations allow the insurer to contract with the plan sponsor to pay the rebate directly to the sponsor who would then distribute the rebate to enrollees proportionate to the amount of the premium each enrollee and the sponsor paid.

The regulations include a special adjustment for mini-med (limited benefit) plans and expatriate plans, effectively allowing a 40% and 42.5% MLR in 2011. This special adjustment to the MLR was made to allow insurers to continue to offer these plans in 2011.

BUCK COMMENT. *HHS will review data on mini-med plans to determine if this MLR adjustment should be continued in 2012 and later years. It is anticipated that HHS will provide adjustments to the MLR requirements to allow mini-med plans to continue to be offered until 2014 when the exchanges will be available.*

Insurer Premium Disclosure and Rate Review (Rate Review)

PPACA includes a requirement that HHS establish a process, in conjunction with the states, for the review of “unreasonable increases in premiums for health insurance coverage.” The statute requires that health insurance issuers submit to HHS and the applicable state a justification for an “unreasonable premium increase.” Importantly, this process does not preempt any existing state laws or processes for review or approval of rates. These rules do not apply to self-funded health plans.

The rate review process generally applies to rates that insurers file in a state on or after July 1, 2011. Proposed rate increases that exceed a defined threshold will be subject to review. For 2011, the regulations set the threshold at 10%. Starting in 2012, HHS will develop state-specific thresholds based on the cost of health coverage insurance in the state. If rate increases exceed the annual threshold, the insurer must provide detailed justification for the rate increase. If the state or HHS determines that the increase is unreasonable and the insurer still implements the increase, HHS will post its final determination and the insurer justification on its website. The insurer must also post the information on its website.

© 2011 Buck Consultants®, LLC. All rights reserved
buckconsultants

The rate review process only applies to issuers in the individual and small group markets. Applicable state law (which currently varies) governs the definition of "small group." Where "small group" is not defined by state law, groups covering 50 or fewer employees are considered "small."

BUCK COMMENT. *While HHS considered applying the rate review process to the large group market, the regulations do not include that market in the process. However, HHS did request comments on whether issuers in the large group market should be subject to a similar rate review process in the future. Most states do not currently have a process in place to review rates in the large group market and employers in the large group market have greater leverage in the rate process than exists in the individual and small group markets.*

Conclusion

While the rate review process does not currently affect large plan sponsors, the MLR requirements are likely to affect some large plans. The process for allocating and distributing the rebates to plan enrollees will pose new administrative burdens for plan sponsors.

Buck's consultants are available to discuss these new requirements and other aspects of health reform with you.

This FYI is intended to provide general information. It does not offer legal advice or purport to treat all the issues surrounding any one topic.

© 2011 Buck Consultants®, LLC. All rights reserved