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For your information

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HHS Issues New Rules Regarding Medical Loss Ratio Requirements

HHS issued both final regulations and interim final regulations regarding the application of the medical loss ratio (MLR) requirements under health care reform. The MLR provision requires issuers to provide rebates to plans and individuals purchasing insurance if the issuer does not spend a minimum percentage of the premium on medical claims. The regulations provide important relief for providing rebates in the group market, as well as extending special treatment of "mini-med" and expatriate policies. However, employers that receive MLR rebates will still have to make a significant compliance effort.

Background

Section 2718 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act, requires that, beginning on January 1, 2011, health insurance issuers spend at least 80% of the premium dollars they receive from policies in the individual market or 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 medical loss ratio (MLR) provision limits the amount that insurers can spend on administrative expenses, 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.

INSIGHT

Since satisfying the MLR requirements is based on an insurer's entire book of business issued in a state, and not on the MLR of an employer-specific plan, any large employer with an insured plan could receive a rebate and would then have to satisfy the distribution and notice requirements for rebates.

An insurer must provide rebates to policyholders and enrollees if the insurer fails to meet the MLR standards in a state for the prior year. Insurance companies will have to pay rebates for 2011 by August 2012. In December 2010, the Department of Health and Human Services (HHS) issued interim final regulations on the MLR requirements. (See our January 24, 2011 For Your Information.) On

December 7, 2011, HHS issued final regulations on the MLR requirements, as well as interim final regulations on certain issues for non-Federal governmental plans. The final regulations are very similar to the December 2010 interim final regulations, but with several important changes for group plans.

Rebates to Enrollees in the Group Market

Under the December 2010 interim final regulations for the large and small group markets, the insurer had to provide the rebate directly to the policyholder and the subscribers (enrollees) "in amounts proportionate to the amount of premium each paid." The guidance allowed the insurer to enter into an agreement with the group policyholder to distribute the rebates on behalf of the insurer, but the insurer still retained responsibility. Comments provided to HHS on the December 2010 interim final regulations included concerns about the significant administrative burden this process would put on insurers to distribute the funds to subscribers. Concerns were also raised that rebate amounts paid directly to subscribers would be taxable to subscribers in many cases.

The final regulations help address the subscriber taxation and insurer administration concerns in the group markets by allowing the insurer to pay the rebate directly to the policyholder and the policyholder to use the rebates for the benefit of subscribers.

The final regulations discuss the distribution of rebates paid to three different types of group health plan policyholders:

Policyholders that sponsor plans subject to the Employee Retirement income Security Act (ERISA). In the preamble to the final regulations, HHS notes that rebates paid in connection with plans subject to ERISA may be considered plan assets that must be handled in accordance with ERISA and cites Department of Labor Technical Release 2011-04, issued contemporaneously with the final regulations. The Technical Release notes that the policyholder will have to determine the extent to which any rebates are considered plan assets and that this will depend on a number of factors, including the terms of the governing plan documents. To the extent the rebates are considered plan assets, the policyholder must apply or expend such assets consistent with its fiduciary responsibilities under ERISA. The Technical Release also provides that the Department will not assert a violation of ERISA's trust requirement against plans receiving rebates that do not otherwise maintain a trust, as long as the rebate is used to pay premiums or refunds within three months of receipt of the rebate as permitted by ERISA. Alternatively, the trust requirement may be avoided if the plan sponsor directs the insurer to apply the rebate against future participant contributions or benefit enhancements.

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COMPLIANCE ALERT: Plan sponsors should review their plan documents to confirm that the language will support a claim that not all of the rebate should be considered a plan asset and instead belongs to the employer.

Policyholders that are non-Federal governmental group health plans. Because there is no similar framework for plans not subject to ERISA, HHS also issued interim final regulations that set out rules for non-Federal governmental plans. These rules require the policyholder to use the amount of the rebate that is proportionate to the total amount of premium contributed by subscribers to reduce the portion of premiums charged in subsequent policy years to subscribers who were covered under the group health plan at the time the rebate is received. The policyholder can either limit the premium reduction to subscribers who were covered under the option generating the rebate or make a cash refund to those individuals. The policyholder may determine whether to evenly divide the rebate among all subscribers, to divide it based on each subscriber's actual contributions, or to apportion it on any other reasonable basis.

The preamble to the interim final regulations provides an example in which the policyholder receives $20,000 in rebates from the insurer. If the subscribers paid in the aggregate 40% of the total premium, then the policyholder must use 40% of the rebates, or $8,000, for the benefit of subscribers.

INSIGHT

HHS has recognized the administrative difficulty that policyholders would have in tracking subscribers who were enrolled in the year in which the rebate was calculated. The requirement that rebates be used in connection with subscribers enrolled in the plan at the time the rebates are received is a welcome development for employers.

Plans that are not ERISA or government plans. The final regulations provide that an insurer can pay the rebate to the policyholder only if the policyholder agrees in writing that the rebate will be paid to subscribers in the same manner as required for non-Federal governmental plans. If no agreement is obtained, the insurer must pay the full amount of the rebate, including the amount based on the premium paid by the policyholder, to subscribers in equal amounts.

The regulations also provide that if a plan entitled to a rebate was terminated and the issuer cannot locate the policyholder, the issuer must distribute the full amount of the rebate directly to the subscribers of the plan in equal amounts.

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COMPLIANCE ALERT: Employers with insured plans must comply with the MLR requirements for any rebates received in 2012 or later years, including the distribution and communication requirements.

Notice Requirements

The final regulations require an issuer that is paying a rebate to provide a notice to both the policyholder receiving the rebate and to the affected subscribers. The notice must contain information regarding the amount of the rebate, the amount owed to enrollees, and other prescribed information. The Secretary of HHS will prescribe the form of the notice.

"Mini-med" Policies

The December 2010 interim final regulations effectively allowed large group mini-med plans to have a 42.5% MLR in 2011 (40% for individual and small group plans). Mini-med plans are defined by the regulations as plans with annual limits of $250,000 or below. The final regulations phase out this special treatment over the next three years, effectively allowing an MLR for large group plans of 48.6% in 2012 and 56.7% in 2013.

INSIGHT

It is anticipated that mini-med plans will no longer be allowed as of 2014 due to the prohibition under health care reform of annual and lifetime dollar limits. However, to satisfy the MLR requirements for 2012 and 2013, insurers may have to reduce administrative expenses or raise benefit levels to comply with the MLR requirements. This could result in employers needing to modify their benefit strategy for mini-med plans sooner than 2014.

Expatriate Policies

The December 2010 interim final regulations allowed large group expatriate plans to have an MLR of 42.5% in 2011 (40% for individual and small group plans). The final regulations continue this special treatment in 2012 and future years.

Conclusion

Employers with insured health programs will need to familiarize themselves with these MLR requirements in case rebates are received from insurers. Employers will want to coordinate with the insurer the possibility of receiving any rebates and quickly establish a process for sharing any rebates with employees. Buck's consultants are available to discuss these requirements in more detail and to assist in developing a compliance strategy.

Buck Can Help

- Review plan asset issues arising in connection with rebates received by ERISA plans
- Revise plan document language to possibly limit treatment of a rebate as a plan asset
- Ensure compliance with the rebate distribution and communication requirements
- Develop a benefit strategy as mini-med plans are phased out under health care reform