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HHS Issues Final Rule Addressing Matters Related to Affordable Care Act's Medical Loss Ratio Requirements; DOL Issues Guidance on Rebates for Group Health Plans

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The Department of Health and Human Services' Centers for Medicare & Medicaid Services (HHS) has issued a final rule[1] (Final Rule) regarding the Affordable Care Act's medical loss ratio (MLR) requirements. The MLR requirement is intended to reduce the portion of consumers' premium dollars that health insurance issuers spend on administrative costs and profits. Specifically, the new health care law mandates that health insurance companies in the individual and small group markets are required to spend at least 80% of premium dollars on medical care and health care quality improvement. In the large group market, health insurance issuers are required to spend at least 85% of premium dollars on medical care and health care quality improvement. If they fail to do so, health insurers must rebate the difference to their customers starting in 2012.

HHS published interim final regulations on the MLR requirement on December 1, 2010.[2] Most notably, the Final Rule changes the process for distributing rebates to enrollees in group health plans and requires issuers to provide notice about the rebate to consumers. The Department of Labor (DOL) simultaneously published a technical release[3] providing direction to employer-sponsored health plans governed by the Employee Retirement Income Security Act (ERISA) on how to handle the rebates from insurers who fail to meet MLR minimum standards. In addition, the Final Rule modifies the MLR calculation for "mini-med" and expatriate health plans and the treatment of ICD-10 conversion costs, fraud reduction expenses and community benefit expenditures.

Rebates to Enrollees in Group Health Plans

The interim final rule directed issuers in the large and small group markets that have not met the applicable MLR standard to provide any owed rebate to the policyholder and each subscriber, generally the employees, in amounts proportionate to the amount of premium each paid. Rebates are based upon aggregated market data in each state and not upon a particular group health plan's experience. The interim final rule also allowed an issuer to enter into an agreement with the group policyholder to distribute the rebates on behalf of the issuer if the policyholder agrees to distribute it proportionately as directed and provide detailed documentation regarding the distribution to each subscriber. However, under the interim final rule, the issuer would remain liable for complying with all of its obligations under the statute and for maintaining records that demonstrate rebates were provided accurately to individual enrollees.

HHS notes that many commenters expressed significant concern about the logistical and tax problems inherent in the interim final rule's mechanism for providing rebates in the group markets. Disbursing rebates directly to subscribers would result in a tax burden for consumers and also a tax-administration burden for the issuers making the payment, as most premiums are paid with pre-tax dollars and thus the rebates may be wages subject to withholding obligations. To address these concerns, the Final Rule directs issuers in group markets to provide rebates to the group policyholder (generally, the employer) for distribution. Issuers must provide rebates, if any, to policyholders covered during the MLR reporting year on which the rebate is based. The agency acknowledges that this change in the process for disbursement of rebate payments for enrollees in group health plans may result in a transfer of benefits from enrollees who have left the group health plan to enrollees new to the group health plan.

The Final Rule also directs issuers to provide a notice of rebates, if any, to current group health plan subscribers as well as group policyholders, and to subscribers in the individual market. The notice must include information about the MLR and its purpose, the MLR standard, the issuer's MLR, and the rebate being provided. If the plan is subject to ERISA, the notice to policyholders and subscribers must contain an explanation that the policyholder may have obligations under ERISA's fiduciary responsibility provisions with respect to the handling and allocation of the rebate and contact information for questions concerning the handling and allocation of the rebate under their plan.

The Final Rule also modifies the minimum threshold for issuer payments of rebates in the group market from $5 per subscriber to a total of $20 for the policyholder portion and subscriber portion of the rebate combined when the rebate is paid directly to the policyholder. When an issuer pays the rebate directly to each subscriber in a group health plan or pays rebates in the individual market, the minimum rebate threshold remains at $5 per subscriber.

The Final Rule establishes separate standards for ERISA-covered group health plans regarding the distribution of rebates to enrollees. DOL generally has jurisdiction to oversee the distribution of rebates under employee benefit plans covered by Title I of ERISA. Thus, to the extent MLR rebates constitute plan assets of an ERISA-covered group health plan, decisions regarding the handling and allocation of the rebate would have to be made by a plan fiduciary consistent with ERISA. To this end, DOL has published guidance regarding the duties of employers/plan sponsors and other fiduciaries responsible under sections 403, 404 and 406 of ERISA for decisions relating to MLR rebates.

The DOL guidance explains that, assuming plan documents and other extrinsic evidence do not resolve the allocation of the rebate, the portion of a rebate that is attributable to participant contributions would be considered plan assets. Thus, if the employer paid the entire cost of the insurance coverage, then no part of the rebate with respect to the particular policy would be attributable to participant contributions. However, if participants paid the entire cost of the insurance coverage, then the entire amount of the rebate would be attributable to participant contributions and considered to be plan assets. If the participants and the employer each paid a fixed percentage of the cost, a percentage of the rebate equal to the percentage of the cost paid by participants would be attributable to participant contributions.

The DOL guidance also explains that decisions on how to apply or expend the plan's portion of a rebate are subject to ERISA's general standards of fiduciary conduct. For example, if a fiduciary finds that the cost of distributing shares of a rebate to former participants approximates the amount of the proceeds, the fiduciary may properly decide to allocate the proceeds to current participants based upon a reasonable, fair and objective allocation method. Similarly, if distributing payments to any participants is not cost-effective (*e.g.*, payments to participants are of *de minimis* amounts, or would give rise to tax consequences to participants or the plan), the fiduciary may utilize the rebate for other permissible plan purposes, including applying the rebate toward future participant premium payments or toward benefit enhancements.

HHS issued a separate interim final rule on MLR rebate requirements for non-federal governmental plans.[4] For such plans, the policyholder must use the rebate: to reduce subscribers' portion of the annual premium for the subsequent policy year for all subscribers covered under any group health policy offered by the plan; to reduce subscribers' portion of the annual premium for the subsequent policy year for only those subscribers covered by the group health policy on which the rebate was based; or to provide a cash refund only to subscribers that were covered by the group health policy on which the rebate is based.

Mini-Med Plans

The MLR is the ratio of incurred claims plus any expense to improve quality – adjusting for certain conditions – to the earned premiums less federal and state taxes and licensing or regulatory fees. The numerator, therefore, is the amount of incurred claims less any expenses to improve

quality, as adjusted. The interim final regulations made special allowances for limited benefit "mini-med" plans with total annual benefit limits of $250,000 or less by requiring issuers to use a special methodology for calculating the MLR numerator for calendar year 2011.

Issuers of mini-med policies asserted that such plans have higher administrative costs relative to benefits paid, as compared to other more comprehensive coverage, which result in higher enrollee turnover, shorter enrollment periods and lower incurred claims due to high deductibles and limited coverage. Some commenters asserted that an adjustment is necessary to preserve access to mini-med policies for employers and participants. The Final Rule extends special treatment of mini-med plans beyond 2011. For 2012, the appropriate multiplier for mini-med policy experience is 1.75; in 2013, the appropriative multiplier is 1.50; and in 2014, the appropriate multiplier is 1.25. Beginning in 2014, the Affordable Care Act imposes a total prohibition on annual dollar limits for essential health benefits, other than for grandfathered plans in the individual market, effectively eliminating mini-med plans.

Expatriate Plans

Expatriate plans receive special consideration under MLR requirements. Issuers of expatriate policies are directed to use a separate methodology for calculating the MLR numerator for reporting and rebate purposes. As defined in the interim rule, expatriate plans are those group policies that provide coverage for employees who are working outside their country of citizenship, working outside of their country of citizenship and outside the employer's country of domicile, and non-U.S. citizens working in their home country. The Final Rule revises this definition to cover policies for employees, *substantially all of whom are*: working outside their country of citizenship; working outside of their country of citizenship and outside the employer's country of domicile; or non-U.S. citizens working in their home country. This change was made to ensure that issuers do not classify a policy as an expatriate policy when expatriates account for only a limited proportion of the covered population. The Final Rule states that incurred claims and activities that improve health care quality are to continue to be multiplied by a factor of 2.00 to calculate the MLR.

Fraud Reduction Expenses

The Final Rule continues to allow plans to include in incurred claims the amount of claim payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. In addition, the Final Rule maintains that fraud prevention activities will continue to be excluded from quality improvement activities (QIAs). An increase in the QIAs would generally increase the MLR, therefore making it easier for insurers to meet the minimum standards set by the Affordable Care Act.

ICD-10 Conversion Expenses

The Affordable Care Act requires health insurance issuers to submit to HHS an annual report documenting their expenditures for activities that improve health care quality. The health care industry currently is undergoing transitions that will require significant system and business changes. A new medical coding system, ICD-10, will be in effect as of October 1, 2013. According to HHS, this new system will affect medical coding for every entity covered by the Health Insurance Portability and Accountability Act (HIPAA). To this end, the agency is requesting comments on whether including ICD-10 conversion costs and QIA is appropriate, and if the cap set at up to 0.3% of an issuer's earned premium is an appropriate amount based on past and future conversion costs.

Community Benefit Expenditures

Under the interim final rule, a not-for-profit, tax-exempt issuer was permitted to deduct from earned premiums the amount of its community benefit expenditures, limited to the state premium tax rate applicable to for-profit issuers. The Final Rule provides that the amount an issuer may deduct from earned premiums is the higher of either the total amount paid in state premiums tax, or actual community benefit expenditures up to the highest premium tax rate in the state.

Effective Date

The effective date of the Final Rule is January 3, 2012. HHS has sought comments on specific issues outlined in the Final Rule, including those

related to the process for providing rebates to group enrollees and reporting of rebates that are received. Comments must be received by January 6, 2012. Insurers must provide any MLR rebates to group policyholders by August 1, 2012 for the 2011 MLR reporting period. Employer-sponsored group health plans receiving rebates must ensure that the enrollee portion of the rebate is properly distributed for the benefit of enrollees.

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[1] 76 Fed. Reg. 76,574 (Dec. 7, 2011).

[2] 75 Fed. Reg. 74,864 (Dec. 1, 2010); for more information see www.employeebenefitscounsel.com/2010/11/23/hhs-issues-medical-loss-ratio-regulations/.

[3] Technical Release 2011-04, *available at* www.dol.gov/ebsa/newsroom/tr11-04.html.

[4] 76 Fed. Reg. 76,596 (Dec. 7, 2012).