Health Care and Health Insurance ADVISORY

December 15, 2010

Medical Loss Ratio Interim Final Rule to Take Effect January 1, 2011

On November 22, 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) of the Department of Health and Human Services (HHS) issued an interim final rule (IFR) implementing the medical loss ratio (MLR) requirements under the Patient Protection and Affordable Care Act (ACA).[1] The IFR was published in the December 1, 2010 Federal Register and will be effective on January 1, 2011.

By way of background, the IFR implements section 2718(a) through (c) of the Public Health Service Act (PHSA), as added by ACA, which required input from the National Association of Insurance Commissioners (NAIC) on the MLR requirements. Accordingly, the NAIC developed a model regulation and sent its regulation to the Secretary of HHS on October 27, 2010. In the IFR, HHS adopts and certifies in principle the recommendations in the NAIC's model regulation. In some instances where the NAIC's model regulation did not address particular issues, the IFR includes regulations based on informal NAIC recommendations and/or public comments. The IFR is a "significant rule" under Executive Order 12866 and therefore includes a regulatory impact analysis.

The MLR provisions of ACA and the IFR apply to health insurance issuers offering group or individual coverage (including grandfathered plans). The MLR rules do not apply to self-insured plans.

This advisory provides a brief overview of the IFR, followed by a general summary of key provisions and a discussion of potential implications of the rule. ***Comments on the IFR must be submitted by January 31, 2011****.*

I. Brief Overview

The IFR is applicable to plan years beginning on or after January 1, 2011. Under the IFR, issuers of health insurance must publicly report on major categories of spending of policyholder premium dollars. Specifically, issuers need to report the amount of premium revenue received and the amount expended on:

(1) reimbursement for clinical services provided to enrollees;

(2) activities that improve health care quality for enrollees;

(3) all other "non-claims" costs; and

(4) federal and state taxes and licensing and regulatory fees.

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[1] The IFR is available at 75 Fed. Reg. 74864 (to be codified at 45 C.F.R. pt. 158) (http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf). The IFR and this advisory refer to both the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152), collectively, as the Affordable Care Act, or ACA.

Each issuer must report this data separately for the large group, small group and individual markets within each state (as applicable to the issuer). The IFR sets forth the methods for calculating MLR and includes credibility adjustments recommended by the NAIC for smaller plans. There are also adjustment factors for expatriate and "mini-med" plans for 2011 to account for these plans' higher administrative costs. HHS intends to revisit these adjustment factors in 2012 and subsequent years.

As required by ACA, each issuer of health insurance must provide rebates to enrollees when the issuer's spending on reimbursement for clinical services and quality improving activities, in relation to the premiums charged, is less than the applicable MLR standard, which is generally 85 percent in the large group market and 80 percent in the small group and individual markets. For states with higher or more stringent MLR requirements, issuers must comply with state law. Notably, the IFR allows issuers to deduct most federal and state taxes from premium dollars for purposes of calculating MLR. The IFR does not, however, permit a deduction for commissions paid to agents or brokers, or for expenses used for concurrent or retrospective utilization review or to uncover fraud and abuse (over the amount of fraudulent claims recovered). Additionally, the IFR allows for deferments in certain instances where required rebates threaten an issuer's solvency. With regards to the individual market, the IFR also provides that, to the extent they can show the reasonable likelihood of market destabilization, states can submit requests for a transition period for up to three years.

II. SUMMARY OF KEY PROVISIONS

Definitions (§§ 158.103)[2]

Key definitions include the following.[3]

- **MLR Reporting Year.** HHS interprets "plan year," as used in the statute, as "MLR reporting year," which is defined as meaning the calendar year during which group or individual health insurance is provided by an issuer.
  - ***Comment:*** The preamble to the IFR notes that this definition of "plan year" varies from the definition used generally for purposes of the health care reforms under ACA for fully insured and self-insured plans. The IFR does not change the definition of plan year except for purposes of the MLR requirements.
- **Enrollee.** For reporting purposes, "enrollee" refers to anyone covered by a group plan, including dependents of the subscriber or employee, as well as anyone covered by an individual policy.
- **Small Group Market and Large Group Market.** Generally, the small group market refers to coverage sold to a "small employer," while the large group market refers to coverage sold to a "large employer." The IFR defines "large employer" and "small employer" by reference to section 2791(e) of PHSA, as amended by ACA, and section 1304 of ACA. Before ACA, PHSA section 2791(e) defined a small employer, in general, as an employer with no more than 50 employees. ACA amended section 2791 to change this threshold to 100. The IFR adopts this change. Thus, under the IFR, an employer must

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[2] Citations to specific pages in the Federal Register are omitted herein. Instead, this advisory is organized by headings listing the topics addressed in the IFR and the section numbers where the topics are addressed. In several instances, this advisory also refers to the discussion of the IFR sections in the preamble to the IFR.

[3] A number of definitions are set forth in connection with the discussion of specific sections and are not repeated here.

ordinarily employ 101 or more employees to be classified as "large." In accordance with ACA section 1304(b)(3), however, the IFR provides that, until 2016, a state may define a small group as having a maximum of 50 employees for purposes of the MLR requirements.

– ***Comment:*** The definition of small and large groups and the change in the threshold for a small employer from 50 to 100 has potential implications beyond the MLR requirements. For example, the definition of small group is relevant for determining whether a group health plan is subject to mental health parity requirements. The preamble to the IFR says that its definition applies to MLR reporting and rebates, and that the IFR does not address the definition of the term "small employer" for purposes of ERISA or the Internal Revenue Code, or how the definitions in these statutes relate to the definition in PHSA for purposes other than the MLR provisions in section 2718. HHS indicates that these issues will be addressed in further guidance.

Subpart A – Disclosure and Reporting

Reporting Requirements (§ 158.110)

HHS requires that issuers submit reports to the Secretary by June 1 of the year following the end of an MLR reporting year. HHS will announce at a later time the precise form and content of the data to be reported, but anticipates that the data will be in line with the information included on the Supplemental MLR Exhibit, filed with state insurance departments as part of each issuer's Annual Statement. The Supplemental MLR Exhibit refers to the "blanks" form approved by the NAIC on August 17, 2010, which describes in some detail the items and services to be included in and excluded from the MLR calculation.[4]

Aggregate Reporting (§ 158.120)

For the most part, each issuer must report premium, claims and other expenses for all group and individual health insurance coverage on an aggregate basis by state and health insurance market (not by type of coverage). To summarize very generally, the aggregate reporting requirements are:

- issuers must report on a state-by-state basis;[5]
- issuers must report separately for the large group, small group and individual markets;[6] and

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[4] The NAIC's Supplemental Health Care Exhibit is available at http://www.naic.org/documents/index_health_reform_mlr_blanks_proposal.pdf.

[5] In response to comments suggesting that aggregation at the state level will disadvantage large or multi-state employers, the IFR provides that MLR reporting should be based on the "situs of the contract," such that premiums and claims experience attributable to employees in multiple states are combined and reported by the issuer in the MLR report for the state identified in the insurance policy or certificate as having primary jurisdiction, which is typically the headquarters of the company. However, a group coverage issued by multiple affiliated issuers, covering employees in multiple states, must be attributed by each state based on the situs of the contract.

[6] The preamble to the IFR states: "Coverage obtained through an association or trust that is not offered in connection with a group health plan should be attributed to the individual market."

- each issuer must report separately, even if issuers are under common ownership.[7]

Experience must typically be included in the report with regards to the state in which the policy or contract was issued. Additionally, as noted above, the IFR and the preamble offer guidance with respect to expatriate plans (i.e., plans covering "employees working outside their country of citizenship, employees working outside their country of citizenship and outside the employer's country of domicile, and citizens working in their home country") and mini-med plans (described in the comment below). Under the IFR, for 2011, issuers should report experience under each of these types of plans separately from other coverage, and issuers may multiply the calculation of incurred claims and quality improving activities by a factor of two. To determine whether and what type of adjustment is appropriate for 2012, however, expatriate plans and mini-med plans that use this "special circumstances" adjustment for 2011 must report MLR data on a quarterly schedule. HHS will revisit the "special filing circumstances" after reviewing the quarterly filings.

– ***Comment:*** The term "mini-med" plan is not a term that is defined by statute. For purposes of the IFR, as discussed in the preamble, a "mini-med" plan is one that has a total of $250,000 or less in annual limits. This definition does not apply generally for purposes of ACA. For example, HHS has established a process for plans to obtain a temporary waiver of the application of the restricted annual limits imposed under PHSA section 2711. While this waiver process is often referred to as applying to "mini-med" plans, the waiver process is not by its terms limited to any particular type of plan and the definition of "mini-med" plan adopted in the MLR IFR does not restrict the types of plans that may apply for a waiver from the annual limits.

Newer Experience (§ 158.121)

Under the IFR, an issuer is permitted to defer to the next MLR reporting year any experience associated with newly issued policies with less than 12 months of experience in the reporting year, if these policies account for 50 percent or more of the issuer's total premium in a market segment for an individual state.

– ***Comment:*** The preamble suggests that to qualify for this deferral, "more than half" of the issuer's policies must be newer experience (i.e., issued after the start of the MLR reporting period), while the rule itself uses the language "50 percent or more." Thus, it is not entirely clear how HHS would view an issuer taking the deferral if exactly 50 percent of its policies were newer experience.

Premium Revenue (§ 158.130)

The IFR defines "earned premium" as "all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan." Earned premiums must be reported on a direct basis, subject to certain exceptions. For example, earned premium must account for unearned premiums, which are defined as "that portion of the premium paid in the MLR reporting year that is intended to provide coverage during a period which extends beyond the MLR reporting year." The IFR provides that issuers cannot report any premium for a period outside of the MLR reporting year as earned premium for the MLR reporting year. Moreover, the preamble to the IFR also states that "earned

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[7] However, in the IFR, HHS adopts the NAIC's recommendations for combined reporting across affiliates for "dual contracts" in which a single group health plan obtains coverage from two affiliated insurers for in-network and out-of-network coverage. The IFR also provides that affiliated issuers offering blended insurance rates to an employer can adjust claims and expenses among affiliates to reflect the experience of the employer as a whole. The reporting requirements and exceptions are set out in section 158.120.

premium is net of premiums associated with group conversion charges that the issuer collects in connection with transfers between group and individual lines of business." Earned premium excludes:

- Premium assessments paid to or subsidies received from federal and state high risk pools; and
- Adjustments for experience rating refunds.

HHS rejected industry suggestions that it adjust premium revenue for commercial reinsurance, with the exception of 100 percent assumption reinsurance.[8] Earned premium for policies that were originally issued by one entity and later assumed by another entity must be reported, for the whole MLR reporting year, as direct earned premium by the assuming entity and excluded from premium revenue by the ceding entity. Along the same lines, "[r]einsured earned premium for a block of business that was subject to indemnity reinsurance and administrative agreements effective prior to March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer."

Finally, the preamble to the IFR states that issuers must report earned premium *prior to* deducting premium refunds to enrollees for health and wellness promotion.

– ***Comment:*** The rationale for requiring that earned premium be calculated before deducting refunds for health and wellness promotion is that these refunds are considered quality improvement expenses. If they were also deducted from premiums, it would result in a double counting of such expenses.

Reimbursement for Clinical Services Provided to Enrollees (§ 158.140)

Incurred claims are defined as "direct claims paid to or received by providers, including under capitation contracts with physicians, whose services are covered by the policy for clinical services or supplies covered by the policy." Incurred claims also include "unpaid claim reserves associated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the claim portion of lawsuits, and any experience rating refunds paid or received." Incurred claims exclude rebates based on an issuer's MLR, as well as any claims recovered through fraud and abuse programs.[9]

Unpaid claim reserves are determined based on claims processed within three months after the end of the MLR reporting year, while contract reserves are established reserves "which, due to the gross premium pricing structure at issue, account for the value of the future benefits that at any time exceeds the value of any appropriate future valuation of net premiums at that time." Contract reserves exclude premium deficiency reserves or reserves for expected MLR rebates.

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[8] The preamble notes that ACA Section 2718(a) requires reporting of premiums after accounting for collections and receipts for risk adjustment and risk corridors and payments of reinsurance. HHS interprets this requirement as applying exclusively to payments under ACA sections 1341, 1342 and 1343, which do not become effective until 2014. HHS plans to provide additional guidance at a later time on these provisions.

[9] In addition, section 158.140 addresses the treatment of conversion charges for purposes of calculating incurred claims, changes in reserves, changes in claims incurred but not reported from a prior year, blended rates and other issues.

Additionally, the IFR provides that:

- prescription drug rebates must be deducted from incurred claims;
- state stop loss, market stabilization and claims/census based assessments may be included in incurred claims; and
- incurred medical incentive pools and bonuses to incurred claims (e.g., through shared savings programs) may be included in incurred claims.[10]

The IFR also adopts a rule that relates to expenses of third-party vendors for reporting purposes. The IFR further states that amounts paid, including to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee, are not included as "incurred claims."

Expenditures on Activities to Improve Quality (§§ 158.150-158.151)

As previously noted, issuers must report expenses related to activities that improve health care quality. HHS certifies and adopts the NAIC's model regulation definitions of activities that improve health care quality, which track the categories set forth in section 2717 of the PHSA – i.e., activities that (A) improve health outcomes; (B) prevent hospital readmissions through a comprehensive program of hospital discharge; (C) improve patient safety, reduce medical errors and lower infection and mortality rates; and (D) implement, promote and increase wellness and health activities.[11] HHS also adopts illustrative examples of such activities developed by the NAIC. The IFR could be read to suggest that, to be counted as a quality improvement (QI) activity, the expense must meet all of these categories, but the preamble to the IFR makes clear that the expense only needs to satisfy one of these categories. The IFR, as interpreted by the preamble, also provides that a non-claims expense may be classified as a QI activity *only if* the activity falls into one of the categories in PHSA section 2717 *and* meets *all* of the following requirements set forth in the IFR.

The activity must be designed to:

(1) improve health quality;

(2) increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;

(3) be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees; and

(4) grounded in evidence-based medicine, widely accepted best clinical practice or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

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[10] However, these payments may not be counted under quality improvement expenditures.

[11] The IFR also lists the following activity as improving health care quality: An activity that is primarily designed to "[e]nhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with §158.151 of this subpart." This activity is discussed below.

HHS also explains in the preamble that it adopts the NAIC's list of activities that are not to be reported as QI activities, including:

- activities designed primarily to control or contain costs;
- concurrent and retrospective utilization review;
- fraud prevention activities (other than fraud detection/recovery up to the amount recovered that reduces incurred claims);[12]
- development, execution and management of a provider network;
- provider credentialing;
- marketing expenses;
- costs associated with calculating/administering individual enrollee or employee incentives;
- clinical data collection without any subsequent data analysis;
- establishment and/or maintenance of a claims adjudication system; and
- 24-hour customer service or health care professional hotlines addressing non-clinical member questions.

Section 158.150 (c) of the IFR itself reiterates most of these specific exclusions and includes other expenses that will not be considered QI activities, including "[a]ny function or activity not expressly included in paragraph (c) of this section, unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity's costs support the definitions and purposes in this Part or otherwise support monitoring, measuring, or reporting health care quality improvement."

Moreover, HHS adopts the NAIC's recommendation to exclude the ICD-10 transition as a QI activity. However, the NAIC supplemental forms allow for collection of data on this conversion, and HHS notes its intention to examine reported costs to determine whether to revisit the issue.

Finally, IFR section 158.151 addresses when health information technology (HIT) may be considered a QI activity. While a number of requirements are set forth in that section, HHS states in the preamble that the agency allows HIT expenditures attributable to improving health care, preventing hospital readmissions, improving patient safety and reducing errors, or promoting health activities and wellness to an individual or an identified segment of the population, to be classified as QI activities. Specifically, subject to the requirements in Section 158.151, HIT expenses consistent with Medicare and Medicaid "meaningful use" requirements may be treated as a QI expenditure.

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[12] The preamble notes that prospective utilization review and fraud recovery activities up to the amount of fraudulent claims recovered may qualify as QI activities.

Other Non-Claims Activities (§ 158.160)

The IFR provides that issuers must account for the use of *all* premium revenue. Thus, issuers must report non-claim expenses for administrative services, including cost containment expenses that are not included as a QI expenditure, loss adjustment expenses, salaries and benefits, agents' and brokers' fees and commissions, general and administrative expenses, and community benefit expenditures.

Federal and State Taxes and Licensing and Regulatory Fees (§§ 158.161 - 158.162)

Federal and state taxes and licensing or regulatory fees are generally excluded from the total amount of premium revenue when calculating an issuer's MLR, but federal income taxes on investment income and capital gains may not be excluded. Mandatory community benefit expenditures made by non-profits in lieu of income taxes may be reported as a deduction from premium revenue. The IFR sets for the method for calculating the deduction.

With respect to treatment of licensing and regulatory fees, HHS states in the preamble that the agency adopts the NAIC's approach "under which statutory assessments to defray operating expenses of any State or Federal department, and examination fees in lieu of premium taxes as specified by State law are included in the licensing and regulatory fees that may be used as an adjustment to premium revenue." HHS explains that issuers must separately report other fines and penalties and fees for examinations, but such expenses may not be used as a premium revenue adjustment.

- ***Comment:*** The rationale for not allowing an exclusion for taxes on investment income and capital gains, as expressed in the preamble, is that such taxes are not taxes based on premium revenues.

Allocation of Expenses (§ 158.170)

Rather than prescribing a standardized method for allocating costs, HHS provides that each issuer must allocate costs according to "a generally accepted accounting method that is expected to yield the most accurate results." The IFR requires detailed descriptions of the methods used to allocate expenses, and an issuer's allocation method must illustrate the costs associated with a specific activity and any resulting effect the activity has had on a particular line of business. Issuers must allocate their non-claims and quality improving expenses on a state-by-state basis, and further allocate such expenses to each line of business within a state. For purposes of MLR reporting requirements, all health insurance issuers also need to report an appropriate percentage of federal taxes paid on their behalf.

Subpart B – Calculating and Providing the Rebate

Calculating an Issuer's MLR (§§ 158.220-158.221)

As noted in the preamble, HHS accepted the NAIC's calculation methods for the next three MLR reporting years.[13] For the 2011 reporting year, the MLR will be calculated using only the data reported for the 2011 MLR reporting year. For the 2012 reporting year, the data to be used depends in part on whether the issuer's experience is "credible" (as discussed below). If the issuer's experience for 2012 is fully credible, then only

[13] For purposes of calculating the MLR rebate, insurers can combine the small group and individual markets if the state in which the coverage is issued requires that the two markets be combined for rating purposes. But experience for these two markets must still be separately reported.

2012 data will be used for the calculation. On the other hand, if the issuer's experience for 2012 is partially credible or non-credible, then data reported for both the 2011 and 2012 MLR reporting years will be used. For the 2013 reporting year, an issuer's MLR will be calculated using the data for a three-year period: "The data for the MLR reporting year being calculated" and "[t]he data for the two prior MLR reporting years" (i.e., the 2013, 2012, and 2011 MLR reporting years). This three-year MLR will be based on accumulated experience over the three-year period rather than the average of three MLRs.

In general, the numerator of the MLR equals the issuer's incurred claims plus QI expenditures, while the denominator is the issuer's premium revenue, as calculated under section 158.130, minus the issuer's federal and state taxes and licensing and regulatory fees.[14] After dividing the numerator by the denominator, the resulting MLR is rounded to the nearest one-tenth of one percentage point.

Credibility Adjustment (§§ 158.230-158.232)

Under the IFR, any reported MLR that is based on experience from fewer than 1,000 life-years is "non-credible." Issuers owe no rebates for non-credible experience/plans. Credibility adjustments are allowed for MLRs based on experience of at least 1,000 but fewer than 75,000 life-years, which are "partially credible." The size of the adjustment depends on the life-years' experience used to calculate the MLR and the average deductible of the policies whose experience went into the reported MLR. The specific manner of calculating the credibility adjustment is set forth in sections 158.230-158.232 of the IFR.[15] On the other hand, any reported MLR based on experience of 75,000 or more life-years is "fully credible." There is no credibility adjustment for such plans. HHS intends to monitor the effects of and update the adjustment method, as appropriate.

Rebating Premium if MLR Standard Not Met (§158.240)

As previously discussed, subject to the calculations and adjustments set forth in the IFR, any issuer that does not meet the applicable MLR standard must provide a rebate to each enrollee. The amount of the rebate paid to each enrollee is the premium paid by or on behalf of the enrollee minus taxes and other permissible adjustments, multiplied by the amount by which the issuer's MLR is below the applicable standard. Issuers must provide any rebates no later than August 1 following the end of the MLR reporting year.

Form of Rebate (§158.241)

Under the IFR, HHS will allow issuers to choose to provide current enrollees with a rebate in the form of a premium credit, lump-sum check, or, if an enrollee paid by credit card or debit card, by lump-sum reimbursement to the same account that the enrollee used to pay the premium. If an issuer chooses to provide a premium credit, the issuer must apply the full amount of the rebate to the first premium due on or after August 1. If the rebate exceeds the amount of the first premium due on or after August 1, the issuer must apply that excess to each subsequent premium in full until the entire rebate has been credited. For former enrollees, the issuer must provide the rebate as a lump sum, but may choose to provide it by check or using the same method

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[14] The numerator for the 2012 and 2013 year may include rebates paid for a prior year in specified circumstances. The preamble explains that: "To prevent double counting, an adjustment will be made to incurred claims when any rebate owed for the 2012 and 2013 MLR reporting years is calculated using data from 2011 or 2012, as provided in § 158.221 (b) (1)."

[15] No credibility adjustment is allowed for 2013 if the MLR prior to any credibility adjustment in each of the three MLR reporting years was below the MLR standard for the year and each of the three reporting years included at least 1,000 life years.

that was used for payment.

Recipients of Rebates (§158.242)

Issuers need to provide any rebate on a pro rata basis to each enrollee if he or she paid the premium, or to the person or entity that paid the premium on behalf of the enrollee (to the extent that someone else paid). While the IFR allows an issuer to delegate its rebate distribution functions to a group policyholder, the issuer remains liable for complying with all of its obligations and must maintain records received from the group policyholder demonstrating accurate distribution.

De Minimis Rebates (§158.243)

An issuer need not provide rebates when the total dollar amount of a rebate owed to the policyholder and subscribers under a group policy, or to the subscriber in the individual market, is less than $5 per subscriber covered by the policy. At the same time, issuers cannot retain unpaid rebate funds. Instead, they must aggregate the de minimis rebates by market and distribute them in equal amounts to all enrollees who are entitled to a rebate (above the minimum threshold) as a premium credit.

Unclaimed Rebates (§158.244)

In response to the issue of unclaimed rebates, HHS requires that issuers make a good faith effort to locate enrollees and to distribute to them any rebate that is owed. Even if the issuer is unable to locate an enrollee, the issuer cannot retain the unclaimed rebates and must comply with applicable state law.

Notice of Rebates to Enrollees (§158.250)

HHS also requires issuers to send a notification with a rebate check or at the same time as a premium credit is applied. While the IFR sets forth certain information that must be included, HHS states that the form of the rebate notification will be established by the Secretary and published in subsequent guidance.

Reporting Rebates to the Secretary (§158.260)

Issuers must report to the Secretary:

(1) the number and percent of enrollees who receive a rebate;

(2) the number and amount of premiums provided as a premium credit and as a lump sum check or reimbursement to a subscriber's credit card or bank account;

(3) the amount of rebates provided to enrollees, including a breakdown of how much of the rebates were paid to policyholders and how much of the rebates were paid to subscribers;

(4) the amount of de minimis rebates that were aggregated and a breakdown of how they were disbursed to enrollees; and

(5) the amount of unclaimed rebates, a description of the good faith efforts that were made to locate the applicable enrollees, and a description of how the unclaimed rebates were disbursed.

This information must be aggregated by state, and by the large group, small group and individual markets

within a state. The report must be submitted with the MLR report required by section 158.110 (i.e., typically by June 1), with the exception of the information related to unclaimed rebates, which needs to be submitted with the MLR report for the following year.

Effect of Rebate Payments on Solvency (§158.270)

In spite of these requirements, the Secretary may defer the payment of rebates by an issuer if a state insurance commissioner, superintendent or other responsible official informs the Secretary that the timely payment of rebates would cause the issuer's risk-based capital (RBC) level to fall below specific regulatory thresholds. In that instance, the state must provide the Secretary with the issuer's RBC reports for the current year and the prior two years, along with a calculation of the amount of rebates that would be owed by the issuer. Upon review of this and any other information requested from the issuer, the Secretary will determine whether the timely payment of rebates would reduce the RBC below the specified level. If the Secretary determines it would, the Secretary will require that the issuer pay these rebates, with interest, in a future year in which payment of the rebates would not cause the issuer's RBC level to fall below the specified level.

Subpart C – Potential Adjustment to the Medical Loss Ratio for a State's Individual Market

Pursuant to PHSA Section 2718(b)(1)(A)(ii), the IFR provides that the Secretary can adjust the MLR requirement in the individual market in a state when the Secretary determines, in her discretion, that there is a reasonable likelihood of market destabilization, and therefore harm to consumers in that state. The IFR establishes detailed procedures and criteria that the Secretary will use to assess requests to adjust the MLR standard applicable in the individual market in a state. Each state can request an adjustment to the MLR standard for one, two or three MLR reporting years, as deemed appropriate by the state based on the condition of its individual health insurance market.

Subparts D–F – HHS Enforcement, Additional Requirements on Issuers and Federal Civil Penalties

Section 2718(b)(3) of the PHSA requires the Secretary to promulgate regulations to enforce the provisions of section 2718. In the IFR, HHS highlights the agency's belief that states should have an oversight role with respect to the MLR reporting and rebate requirements. Thus, under the regulations, HHS may accept the findings of audits conducted by state regulators under certain, specified conditions.

HHS also retains discretion to conduct its own audits of issuers, including in states with acceptable audit results. Under the IFR, the procedures set forth for conducting an audit—to determine whether an issuer's reports are accurate and valid—resemble the procedures used by HHS in conducting audits of Medicare Advantage plans. The IFR requires issuers to retain documentation related to reported data and provide access to the data and their facilities to HHS for verification purposes.

Notably, the IFR provides for the imposition of civil monetary penalties (CMPs) in the event an issuer fails to comply with the reporting and rebate requirements under the regulations. The CMPs mirror those set forth in the current regulations on enforcement, 45 CFR 150.301 et seq., providing for a maximum penalty for each violation of $100 per entity, per day, per individual affected by the violation. The IFR further adopts the provisions in the existing enforcement regulation regarding aggravating and mitigating factors that HHS

will take into account in determining whether to impose (and if so, the amount of) civil monetary penalties. HHS will also consider a state's assessment of a penalty against an issuer when determining whether HHS should assess a penalty for a violation of the MLR regulations.

III. IMPLICATIONS

The recently released IFR, which has not yet become effective, leaves open a number of questions as to how the MLR rules will work in practice. While the IFR provides guidelines for the treatment of the types of costs that qualify as QI expenditures or that otherwise are exempted from the MLR calculation, the treatment of some types of costs could remain open to interpretation in certain circumstances. The law and guidance in this area and other aspects of the IFR may be fluid as the MLR requirements take effect and are enforced based on experience and results.

Indeed, HHS is seeking comments on a number of issues. For example, in the IFR, HHS requests comments regarding the potential negative impact that the MLR rules may have on agents and brokers, and the NAIC formed a task group to work with HHS and consider this issue. Under the IFR, HHS also notes that the impact of the IFR on agents and brokers will be considered in connection with the determination as to whether a particular individual market would be destabilized. There are currently lobbying efforts to change the rules related to agents and brokers. By way of another example, HHS expressly intends to examine reported costs in connection with the ICD-10 transition to determine whether the exclusion of these costs as a QI activity should be revisited, and is seeking comments on that issue as well. In addition, HHS notes in the preamble to the IFR that the agency shares concerns that the MLR standard related to community benefit expenses could create a disincentive for not-for-profits to make such expenditures beyond those required in lieu of taxes, and HHS invites comments on the proper treatment of community benefit expenses. HHS also seeks comments on the level of the CMPs. These are all areas with respect to which HHS may adjust the rules and/or provide additional guidance going forward.

It also appears that, in practice, the MLR requirements may not be uniform across state lines. As noted above, to the extent that states' MLR laws are stricter than federal requirements, issuers must comply with state law. On the other hand, states may seek downward adjustments, referred to by many as "waivers," to the federal standards for up to three years in the individual market, and such requests will be granted if the Secretary determines that there is a reasonable likelihood that the application of the 80 percent MLR requirement will result in market destabilization, and thus harm to consumers. At least 10 states—Alabama, Florida, Georgia, Iowa, Louisiana, Maine, Mississippi, Oklahoma, South Carolina and West Virginia—have reportedly already applied for, indicated their intent to seek and/or are leaning towards seeking such adjustments. On the other hand, at least 14 states—Colorado, Idaho, Kansas, Maryland, Massachusetts, Montana, New Hampshire, New Jersey, New Mexico, New York, Oregon, Vermont, Wisconsin and Washington—and the District of Columbia are reportedly not intending to seek, or are leaning towards not seeking, adjustments.[16] Other states appear to be considering the issue. Given the possible variations among states, it will be important for stakeholders to continue to monitor not only the federal guidance regarding MLR, but also state activity.[17]

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[16] *Politico Pulse* has been reporting on the states' positions with respect to whether they will seek adjustments. (*See* http://www.politico.com/politicopulse/).

[17] Additionally, stakeholders will want to monitor cases involving the ACA. A discussion of such cases is beyond the scope of this advisory.

Although there are open questions about the specific effects that the IFR will have, it is clear that this IFR is a major development in the implementation of the ACA and an important change in health insurance regulation. While many states already have MLR requirements and/or guidelines in place, this is the first comprehensive and detailed regulation at the federal level governing issuers' MLR and mandating rebates in the event that specific standards are not met. Some have expressed concern that the new rules will be disruptive to the market. There has also been some debate over specific provisions of the IFR, such as the treatment of costs related to preventing fraud and the issues discussed above. Whatever view one takes, the IFR is clearly a very significant development that is bound to have important implications for stakeholders.

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