An Update on Medical Loss Ratio Issues

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As part of President Obama's federal health care reform program, the Patient Protection and Affordable Care Act (Pub. L. 111-148) enacted on March 23, 2010 and the Health Care and Education Reconciliation Act (Pub. L. 111-152) enacted on March 30, 2010 (collectively, "ACA") amended the Public Health Service Act to establish minimum "medical loss ratio" ("MLR") standards that health insurance issuers must meet. The MLR serves as a financial indicator of the amount of premium dollars a health insurance issuer spends on enrollees' medical claims and other activities that improve health care quality. Recently issued federal regulations have clarified certain MLR issues, while other related issues are still being debated.

MLR Reporting Obligations

Starting in June 2012, health insurance issuers offering individual or group coverage are required to submit annual reports to the United States Department of Health and Human Services evidencing compliance with the MLR standards. In particular, to meet the MLR standards, each health insurance issuer's annual report must show that the issuer spent at least eighty percent (80%) (for individual and small group markets) or eighty-five percent (85%) (for large group markets) of premiums in the past year on clinical services provided to enrollees and activities that improve health care quality (as defined in 42 C.F.R. § 158.150). The remaining fifteen percent (15%) or twenty percent (20%) may be spent on non-claims costs (e.g., administrative activities) (as defined in 42 C.F.R. § 158.160). If in any given year such MLR standards are not met by the health insurance issuer, the issuer is faced with paying rebates by August of such year. To whom such rebates must be paid was recently settled with the release by the Centers for Medicare & Medicaid Services ("CMS") of a final rule on December 7, 2011 (76 Fed. Reg. 76574) (the "Final Rule") addressing the distribution of rebates by health insurance issuers who have not met the MLR standards.

New Guidelines for Rebates

With the release of the Final Rule, enrollees will no longer have to pay taxes on rebates they receive when health insurance issuers do not meet the MLR standards.

Prior to the release of the Final Rule, CMS had issued an interim final rule on December 1, 2010 (75 Fed. Reg. 74864) (the "Interim Final Rule") that preliminarily established rules governing the distribution of rebates. The Interim Final Rule directed health insurance issuers to pay any necessary rebates directly to enrollees. In response to such guidance, CMS received numerous comments that such a rebate mechanism would have unintended tax consequences for the individual enrollee. In recognition of such concerns and after consultation with the

Departments of Labor and Treasury, CMS issued the Final Rule in which it directed health insurance issuers to provide rebates to the group policyholder (e.g., an employer) in a way that benefits enrollees in a non-taxable manner (e.g., through lower premiums).

With the January 3, 2012 effective date of the Final Rule and the looming June and August deadlines by which annual reports and rebates to policyholders are due, respectively, health insurance issuers and group policyholders alike are working to ensure compliance with the new guidelines. Specifically, on the same date as the Final Rule was released, CMS issued another interim final rule requesting comments on the methodologies by which group policyholders may distribute rebates to enrollees (see 76 Fed. Reg. 76596). With the comment period on such interim rule now closed, group policyholders await further clarity on how best to distribute the rebates they may see for the first time come August of this year.

Agents and Brokers: Compensation Issue Resolved – Or Is It ?

One significant issue not changed by the Final Rule was the treatment of agents' and brokers' fees and commissions in the calculation of an issuer's MLR. In calculating its MLR, the Interim Final Rule provided that an issuer could include in the numerator its expenses for "quality improvement activities" (see 45 C.F.R. § 158.150) but not "other non-claims costs" (see 45 C.F.R. § 158.160) such as expenses for administrative services including agents' and brokers' fees and commissions.

Both before and after the issuance of the Interim Final Rule, the National Association of Insurance Commissioners ("NAIC") expressed its concern that excluding such fees and commissions from only the numerator of the MLR calculation will cause issuers to decrease their payments to such producers in order to satisfy their applicable MLR requirements. Decreasing those payments, the NAIC fears, will lead to a reduction in services by agents and brokers – just at a time of huge transition in the health insurance market when their services will be needed most, especially by individual purchasers and small employers. The NAIC's reaction to the Interim Final Rule culminated in its adoption of a resolution on November 22, 2011 urging an amendment of the MLR provisions of ACA "in order to preserve consumer access to agents and brokers."

The Final Rule, however, did not change the treatment of agents' and brokers' fees and commissions as the NAIC proposed in its resolution. As a result, under current law and the Final Rule, many expect at least some issuers to decrease compensation to agents and brokers immediately in their efforts to meet the applicable MLR requirements.

Like many issues under ACA, though, the treatment of agent and broker compensation remains a political football. On February 2, 2012, a bipartisan group of United States senators introduced Senate Bill 2068 (titled the "Access to Independent Health Insurance Advisors Act of 2012") that would exempt such compensation entirely from the MLR calculation (both numerator and denominator). The health insurance industry will be monitoring closely the progress of this proposed legislation.

Requests for Adjustments to MLR Standards

While the Final Rule did not provide relief for the MLR treatment of agents' and brokers' fees and commissions, it did continue to allow individual states to apply to CMS' Center for Consumer Information and Insurance Oversight ("CCIIO") for a temporary downward adjustment of the required MLR standard in the individual health insurance market, as was allowed by the Interim Final Rule. CCIIO is

permitted to grant an adjustment “only if there is a reasonable likelihood” that application of the 80% MLR standard may destabilize the particular state’s individual health insurance market (see 45 C.F.R. § 158.301). In assessing this risk, there are six “main criteria” CCIIO is instructed to consider including, for example, the number of issuers reasonably likely to exit the state or cease offering coverage in the state absent an adjustment and the resulting impact on competition in the state (see 45 C.F.R. § 158.301).

To date, seventeen states and Guam have submitted complete applications to CCIIO requesting adjustments. The first application from Maine has been the only one granted in full. Maine is also unique because it is the only state so far where CCIIO granted an adjustment for the year of 2013. However, as a caveat, Maine’s 2013 adjustment was granted on the condition that the state provide CCIIO with updated data in 2012 indicating a continued need for the adjustment. Five other states’ requests have been granted in part; nine have been denied; one was found not to require any adjustment based on the fact that the issuers in the individual market were non-credible due to the small number of enrollees; and two requests are still pending from North Carolina and Wisconsin.

In rendering these decisions, CCIIO has expressed the intent to create a “glide path” for each state’s compliance with the 80% standard by 2014 while balancing the interests of consumers, the state and the issuers. As a result, CCIIO has often effectively denied applications in part because it perceived that the adjustment sought by the state exceeded what was necessary to avoid the likelihood of market destabilization and would deny consumers an excessive amount of the intended benefit of the ACA. For example, Georgia requested an adjustment to 65% in 2011, 70% in 2012 and 75% in 2013, but CCIIO only approved 70% for 2011 and 2012 and denied any adjustment in 2013.

While CCIIO approved Georgia’s request for adjustment in November 2011, it had not approved a request since July 22, 2011, and it has not approved another request since then. Most recently, CCIIO denied Texas’ request on January 27, 2012, finding that Texas laws provide little incentive for issuers to withdraw from the market, and further, if any issuers were to exit, Texas has a “diverse market” with sufficient alternative options for Texas consumers, including for those with pre-existing conditions. In contrast, when CCIIO approved a portion of Georgia’s request it concluded that two Georgia issuers could exit the individual market absent an adjustment leaving up to 55,650 enrollees temporarily without coverage. CCIIO assessed that Georgia did not have mechanisms in place to provide consumers with options in the event the issuers withdrew.

In the future, we are awaiting two more decisions, additional states may make requests for adjustment, and states that have already applied and received a response are permitted to make a subsequent request. In the meantime, issuers must assess and potentially adjust their current business models to meet the applicable MLR standards in their respective states.