MLR

Medical Loss Ratio

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SEC. 2718
BRINGING DOWN THE COST OF HEALTH CARE COVERAGE

(a) CLEAR ACCOUNTING FOR COSTS.—

A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

(1) on reimbursement for clinical services provided to enrollees under such coverage;

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

(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

(A) REQUIREMENT.—

Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

(B) REBATE AMOUNT.—

(i) CALCULATION OF AMOUNT.—

The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

(ii) CALCULATION BASED ON AVERAGE RATIO.—

Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

(2) CONSIDERATION IN SETTING PERCENTAGES.—

In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

(3) ENFORCEMENT.—

The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

(c) DEFINITIONS.—

Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

(d) ADJUSTMENTS.—

The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

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BRINGING DOWN THE COST OF HEALTH CARE COVERAGE

(c) DEFINITIONS.—

Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

NAIC Role

The NAIC, in discharging its statutory obligations, conducted a thorough and transparent process in which the views of regulators and stakeholders were discussed, analyzed, addressed and documented in numerous open forums held by staff from State insurance departments, by NAIC staff, and by the commissioners, directors, and superintendents of insurance from the States.

This interim final regulation certifies and adopts the NAIC's model regulation in full.

(HHS IFR Page 14)

NAIC Process

NAIC formed two groups:

- Health Reform Solvency Impact (E) Subgroup
  - Reports to Financial Condition (E) Committee
  - Chaired by Lou Felice of NY
  - Charged with developing reporting form (Supplemental Health Care Exhibit)
- PPACA Actuarial Subgroup
  - Reports to Health (B) Committee
  - Chaired by Steve Ostlund of AL
  - Charged with drafting response to information request
  - Charged with developing rebate methodology (NAIC MLR Regulation)

Supplemental Health Care Exhibit

- Supplement to Annual Statement
- Due April 1
- Instructions define “quality improvement expenses” and other terms
- Includes a “Preliminary Medical Loss Ratio,” which is NOT the final MLR for federal reporting and rebates
- Changes expected for 2011.

Taxes and Fees

- Includes federal income tax except taxes on investment income and capital gains.
- Includes most state taxes, state assessments such as guaranty fund assessments, state fees to defray operating expenses of state insurance departments, and examination fees if in lieu of premium taxes.
- Includes certain community benefit expenditures by not-for-profit health plans in lieu of premium tax.
- Excludes regulatory fines and penalties.

Quality Improvement (QI) Expenses

General QI Definition:

- expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs),
- for all plan activities that are designed to improve health care quality, and
- increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements...

Quality Improvement Expenses

- Fraud detection and recovery expenses:
  - Are not a Quality Improvement Expense
  - Recoveries up to amount of expense added back to claims

Quality Improvement Expenses

- “Note: The NAIC will review requests to include expenses for broadly excluded activities and activities not described under Columns 1 through 5 above. Upon an adequate showing that the activity’s costs support the definitions and purposes therein, or otherwise support monitoring, measuring, or reporting health care quality improvement, the NAIC may recommend that the HHS Secretary certify those expenses as Quality Improvement.”

PPACA Actuarial Subgroup

- Responded to HHS information requests (May 14 deadline)
- Developed 78 “Issue Resolution Documents”
- Developed NAIC MLR Regulation

PPACA Actuarial Sub-Group

- David Ball, Oregon
- Gloria Dee, New York
- Rick Diamond, Maine
- Leslie Jones, South Carolina
- Gerald Lucht, Illinois
- Lichiou Lee, Washington
- Steve Ostlund, Alabama
- Julia Philips, Minnesota
- Frank Stone, Oklahoma
- Neil Vance, New Jersey

PPACA Actuarial Sub-Group

- Scheduled Calls
  - 3:00 – 5:00 EDT
  - Monday & Wednesday
  - June 1 – September 29
  - Adopt Issue Resolution Documents (IRD)
  - 300 +

PPACA Actuarial Sub-Group

- Planes, Trains, and Automobiles
  - And phones, dogs, babies, ...
- If you think you are on mute, but not sure, ask me.
  - “I’m just listening to a bunch of boring actuaries.”

NAIC MLR Regulation

- Provides the “uniform definitions” and “standardized methodologies” with which NAIC was charged under the law
- Incorporates definitions from the Supplemental Health Care Exhibit and decisions made in IRD’s
- Sets forth rebate methodology
- Addresses “the special circumstances of smaller plans, different types of plans, and newer plans”
- Intended as a base from which HHS would develop its regulation

NAIC MLR Regulation: Timing

- Incurred claims experience includes three months of runout plus reserve for future runout: i.e. incurred claims estimated as of March 31 of the following year.
- All other experience determined as of December 31 (annual Statement basis).
- Calculated MLRs reported to states by May 31 (changed to June 1 in HHS regulation, with report going to the Secretary).
- MLR rebates paid by June 30 (changed to August 1 in HHS regulation).

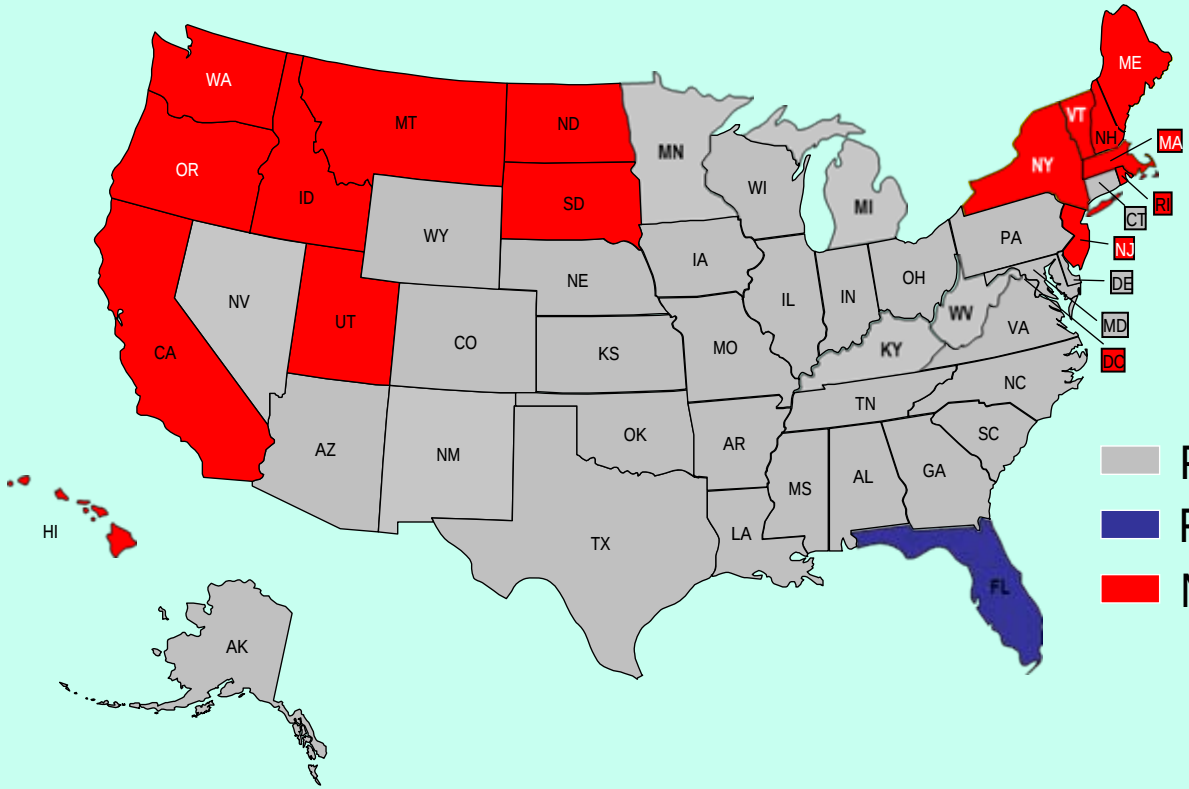
NAIC MLR Regulation:
Smaller, Newer, and Different Plans

- "Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans."
  - Smaller: Credibility issues
  - Newer: Lower first-year MLR
  - Different: Dual contracts, dual option, group conversions, and expatriate plans

NAIC MLR Regulation:
Smaller Plans: Credibility

- NAIC contracted with Milliman to develop factors and methodology reflecting 50% confidence interval
- Fully credible: 75,000 life years
- Partially credible: 1,000 – 74,999 life years
- If 2012 experience is not fully credible, 2012 MLR is based on 2011 and 2012 experience combined.
- If cumulative experience (2011, 2012, 2013) is less than 1,000 life years, no rebates are payable.
- If experience is partially credible, a credibility adjustment is applied.

NAIC MLR Regulation: Smaller Plans: Credibility



Large National Carrier, 600,000 Insureds

- Partially Credible
- Fully Credible
- Not Credible

NAIC MLR Regulation:
Newer Plans

- If at least 50% of earned premium for the year is attributable to policies with less than 12 months of experience, then the experience for those policies may be excluded.
- If this option is used, the excluded experience must be added to the following year.

NAIC MLR Regulation: Different Plans: Dual Contracts

- "Dual contract": an employer purchasing in-network coverage from one issuer and out-of-network coverage from an affiliate of the in-network issuer.
- Experience for out-of-network affiliate may be aggregated with in-network issuer's experience.
- An issuer that chooses to use this adjustment must use it for a minimum of three years.

NAIC MLR Regulation: Different Plans: Dual Option

- "Dual option" means a small or large group policyholder offers employees two or more different health plans from two or more affiliates.
- An issuer that provides dual option insurance coverage to a single employer at blended rates may make an adjustment to each affiliate's numerator calculation to reflect the MLR calculated for the employer as a whole.
- For each employer group, the adjustment shall result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the year as the ratio of incurred claims to earned premium calculated for that employer group in aggregate.
- An issuer that chooses to use this adjustment must use it for a minimum of three years.

NAIC MLR Regulation:
Different Plans: Expatriate Plans

- "Expatriate" plans are group policies that provide coverage for employees working outside their country of citizenship and non-U.S. citizens working in their home country.
- Not addressed in NAIC MLR Regulation but in NAIC Advisory Letter and in HHS MLR Regulation.

NAIC Advisory Letter

- Potential for market destabilization and the need to maintain solvency
- The possible need for a phase-in of the 80% standard in the individual market and the process and standards to be used by the Secretary to determine whether to adjust the standard in each state
- Application of MLR to Expatriate Policies
- Distribution of rebates (to whom and how)

For More Information:

- HHS MLR Regulation:
  http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf
  - 12/29 Technical Corrections:
  http://edocket.access.gpo.gov/2010/pdf/2010-32526.pdf
- NAIC MLR Regulation:
  http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf
- NAIC Supplemental Health Care Exhibit:
  http://www.naic.org/documents/index_health_reform_mlr_blanks_proposal.pdf
- NAIC Advisory letter:
  http://www.naic.org/documents/committees_ex_grlc_mlr_sebelius_letter_101013.pdf
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