HEALTH CARE REFORM

update

BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Update on MLR Requirements

January 10, 2012

On March 23, 2010, President Obama signed into law the "Patient Protection and Affordable Care Act" (PPACA) as part of the national health care reform efforts. Included in this act are requirements for Medical Loss Ratio (MLR). MLR requires insurers to spend a specific percentage of their premium dollar on health care rather than administration costs. Insurers who do not meet the standard are required to provide rebates to their customers.

Summary

On December 2, 2011, the Department of Health and Human Services (HHS) issued a final regulation outlining changes regarding MLR. These new regulations specifically address how MLR is calculated and how rebates are distributed in the group market.

Reporting and Rebate Requirements

Fraud Reduction Expenses

The final regulation does not change how fraud reduction expenses are calculated for MLR. Fraud prevention activities are still not considered quality improvement activity (QIA) expenditures. However, insurers can still allow fraud reduction expenses to count as an adjustment for unpaid claims.

ICD-10 Conversion Expenses

ICD-10 conversion costs acquired in 2012 and 2013 may be included as QIA in an amount up to 0.3 percent of the earned premium for the relevant State market. ICD-10 maintenance costs and any ICD-10 costs incurred in 2014 and beyond are excluded from QIA.

Community Benefit Expenditures
Community benefit expenditures are expenses for activities or programs that aim to improve public health and access to health services. The requirements for expenses that qualify as community benefit expenditures were not changed. The MLR calculation was changed to allow an insurance company to deduct the higher of the amount it paid in State premium taxes or the amount of its community benefit expenditures up to the highest State premium tax rate. In addition, not-for-profit insurers are no longer required to estimate the amount of taxes they would have paid if they were for-profit.

Rebates to Enrollees in Group Markets

Most of the time, insurers in the group market will give the rebates to the group policyholder. For church plans, there are specific circumstances under which the rebate will need to be provided to the individual subscribers. There are also regulations limiting how the employer may use the rebates for all groups.

Group health plans are split into the following three categories:

ERISA plans: In this group the rebates may be considered a plan asset. This means the employer has a legal duty and, therefore, the rebates must not be used to benefit the employer, but must be used only to benefit plan participants or to resolve reasonable administrative costs. Examples of uses that benefit participants include expanded benefits, lower premiums or cost-sharing and direct payments. Generally, the premium amounts paid directly by the employer are not considered plan assets. Only the remaining premium amount would be considered a plan asset. For example, if the entire premium is paid out of a plan trust, then the entire rebate must be returned to the trust and used to benefit participants.

School district plans: This group consists of non-Federal government plans such as school districts, cities etc. In these plans, the rebate is distributed to the group policyholder. The portion of the rebate given to subscriber premium payments must be used to reduce premiums or be paid directly to payment-year enrollees. Payment reductions may be applied across plans or only to the plan on which the rebate was based. Cash payments can only be made to those individuals enrolled in the plan for which the rebate was paid.

Church plans: This category consists of plans that are not subject to ERISA and are not governmental plans. In these plans, insurers must obtain a written guarantee from the policyholder that the rebate will be used for the benefit of current subscribers. If this written guarantee cannot be obtained, the policymaker must allocate the rebate directly to individual subscribers by dividing the amount equally among them.

Former subscribers in the group market are not eligible for rebates unless their entire plan was terminated. If a group health plan has been terminated, the insurer must make a reasonable effort to locate the policyholder. If the policyholder cannot be located, the insurer must allocate the entire rebate to the former subscribers by dividing the rebate equally among all subscribers entitled to a rebate.

Notice of Rebates

Insurers must provide notice of the rebates to subscribers in the direct pay and group markets, and group policyholders.

Content of Notices: In general, all subscribers must receive a notice along with the distribution of the rebate. In the individual market, this notice must come with the individual's check. In the group market, individual subscribers must receive a notice when the rebate was distributed to their group policyholder. For terminated groups or church groups where the policyholder does not agree to use the rebate to benefit subscribers, subscribers who receive a rebate also receive the notice.

All MLR notices must include:

- A general description of the concept of an MLR;
- The purpose of setting an MLR standard;
- The appropriate MLR standard;
- The insurer's MLR;
- The insurer's collective premium revenue minus any Federal and State taxes or fees;
- The rebate percentage and amount; and
- A notice that the rebate for the group health plan is being provided to the policyholder in the group market.

In addition, group health plan notices must also include:

For ERISA plans, the notice must also include discussion of the plan's legal responsibilities and contact information for questions concerning the plan's handling and distribution of rebates.

For church plans, the notice must explain that the policyholder must agree to use a portion of the rebates to benefit current subscribers or the subscribers will receive the entire amount.

For school district plans, the notice must explain that a portion of the rebates will be used for the benefit of current subscribers.

De minimus Rebates

The minimum threshold for rebates when the rebate is paid directly to the policyholder is raised to $20 per group. When an insurer pays the rebate directly to subscribers in the group or in the individual market, the minimum threshold remains at $5 per subscriber.

Reporting of Rebates

An annual reporting form will be published by HHS. Insurers must report:

1. The number of subscribers in each of the markets who were paid the rebate directly, and the number of group policyholders who were paid a rebate on behalf of enrollees;
2. The amount of rebates provided as a premium credit;
3. The amount of rebates provided as a lump sum payment, regardless of method;

4. The amount of rebates that were de minimus and the number of enrollees who did not receive a rebate because it was de minimus; and
5. The amount of unclaimed rebates, a description of the methods used to locate applicable enrollees, and a description of how the unclaimed rebates were handled.

Mini-med Policies

Mini-med policies are policies with annual limits of $250,000 or less. Such plans are allowed an adjustment to their acquired claims and quality improvement expenditures to compensate for special circumstances like frequent enrollment changes and low utilization. For plan years beginning after January 1, 2014, non-grandfathered individual plans and all plans in the group market will be prohibited from imposing annual dollar limits on essential health benefits, so new mini-med policies will no longer be issued.

*Note: Blue Cross and Blue Shield of Kansas City does not offer Mini-med policies.

Expatriate Policies

The definition of expatriate policy (a group policy providing coverage for employees working outside the U.S.) was modified to clarify that all of the covered employees must be working outside their country of citizenship or non-U.S. citizens working in their home country. The definition continues to exclude policies issued in the individual market.

*Note: Blue Cross and Blue Shield of Kansas City does not offer expatriate policies.

Effective Date

These regulations take effect January 1, 2012. The regulations apply to group and individual contracts and are issued by Health Service Corporations, HMOs and Insurance companies.