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HHS Releases Guidance on Medical Loss Ratio Requirements

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The Department of Health and Human Services (HHS) recently issued technical guidance regarding medical loss ratio (MLR) requirements in the form of a questions and answers bulletin issued by the Office of Oversight.

The MLR requires health insurers to submit reports to the HHS Secretary and spend 80% or 85% of all premium dollars on medical care or activities that improve health care quality or provide rebates to customers. The final rule implementing the MRL requirements was published in December 2011 and codified at 45 CFR Part 158. Our blog post with more information on the final rule is available here.

The bulletin provides guidance on the following concepts:

- Applicability of the MLR to certain types of plans: Self-funded, Medicaid managed care, and Medicare Advantage plans are not subject to MLR reporting and rebate requirements. Blanket health insurance policies that meet the definition of group or individual health insurance coverage under the ACA are subject to MLR requirements despite differing state laws.
- Employer groups of one: When a sole proprietor and/or spouse-employee are the only enrolled employees, the plan would not be considered a group health plan. However, one non-spouse employee will result in classification of the plan as part of the small group market for MLR purposes.
- Counting employees for determining market size: Unless the insurer has information which puts it on notice that the total number of employees would cause the plan to be a large group for MLR purposes, the insurer may determine the number of employees solely based on the number of employees in the state in which the policyholder makes the policy available.
- Individual association policies: Insurers should report MLR data for individual or non-group association policies in the state where the individual resides at the time the certificate of coverage is issued and not the state where the insurer, policyholder or association is located.
- Offering policyholders a “premium holiday”: Premium holidays are governed by state law, but premium holiday must be provided in a non-discriminatory manner (i.e., offered to every policyholder in a state’s market and not based on product type or the experience of a particular policy).
- Reinsurance and reporting: The assuming insurer, not ceding insurer, is responsible for filing the annual MLR report only if both the reinsurance and administrative agreements are effective prior to March 23, 2010, and the assuming entity is responsible for 100% of the financial risk and administration. If the ceding insurer retains responsibility for any

administrative functions after the effective date of the reinsurance and administrative agreement, then the ceding insurer remains responsible for MLR reporting and rebates.

- Exchange user fees: Should be included in licensing and regulatory fees that are subtracted from premium in MLR calculations.
- States with a higher MLR standard: HHS will only apply the higher state MLR standard in states that have implemented the higher standard since March 23, 2010.
- “Mini-med” experience – application of the adjustment: Mini-med insurers should add the reported experience for each MLR year together to obtain the numerator and then apply the multiplier (provided in the final rule) for the current reporting year to the aggregated experience.
- Form of rebate: Form of rebate may include premium credit, lump-sum check or credit or debit card (if the enrollee paid premium using a credit or debit card). Certain conditions must be met for use of a credit/debit card, including: card requirements (policyholder’s name on card, no expiration date, no fees); entire balance of the card must be convertible to cash at the policyholder’s request; policyholder may opt and request a check instead; issuing institution can be contacted to obtain cash value/balance on card; and easy to understand notice of rights and explanation of terms must be provided.

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