



HHS Issues Regulations on Medical Loss Ratio Requirements and the Implementation of Reporting and Rebate Requirements for Insurers

Starting on January 1, 2011, the Affordable Care Act will require insurance companies to spend 80 to 85 percent of premium dollars on medical care and health care quality improvement, rather than on administrative costs. If they don't, the insurance companies will be required to provide a rebate to their customers starting in 2012.

On **November 22, 2010**, HHS issued a regulation implementing this policy, known as the "medical loss ratio" provision of the Affordable Care Act. This regulation requires health insurers (regardless of grandfather status) to report to HHS on how they spend premium dollars and must provide rebates to enrollees unless at least 80 cents of each premium dollar--85 cents in the large group market--is spent on clinical services and health care quality improvement.

Insurance companies will have to report the following information by June 1st of each year: total earned premiums; total reimbursement for clinical services; total spending on activities to improve quality; and total spending on all other non-claims costs excluding federal and State taxes and fees. This information will show how premium dollars are being spent, how much money goes toward actual medical care and activities to improve health care quality, and how much is spent on administrative expenses such as marketing, advertising, underwriting, executive salaries and bonuses. HHS will post these reports publicly.

Timing of Reporting and Rebates

The first report, containing calendar-year 2011 data, is due from insurers by June 1, 2012—insurers are required to make the first round of rebates by August 2012 based on their 2011 MLR.

Rebates

Insurance companies not meeting the medical loss ratio standard will be required to provide rebates to their consumers. Enrollees owed a rebate will see a reduction in their premiums, receive a rebate check, or, if the enrollee paid by credit card or debit card, a lump-sum reimbursement to the same account used to pay the premium.

Rebates owing to individuals covered by a group health plan may be paid to the person or entity that paid the premium on their behalf. In the case of an employer plan, this will typically be the employer. The insurer remains ultimately liable and must ensure that each enrollee receives a rebate proportional to the amount of premium paid by that enrollee and that the employer does not retain more of the rebate than is proportional to the amount of premium it paid.

Notice to Enrollees of Rebates

When a rebate is provided, each enrollee must be provided with a notice explaining the rebate and how it was calculated. HHS has indicated that “in the near future” it will publish model disclosure language. This notice will also include the amount paid or credited to the employer.

Enforcement

The Regulation imposes civil monetary penalties if an insurer fails to comply with the reporting and rebate requirements. The regulation’s penalty for each violation is \$100 per entity, per day, per individual affected by the violation.

As always, we will keep you posted of significant developments as they occur.

If you have any questions, please contact your HARDEN Employee Benefits Account Manager.

Sources:

U.S. Department of Health & Human Resources. Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act, 45 CFR Part 158, Vol. 75, No. 230 Fed. Reg. 74864 (Dec. 1, 2010) Available at: http://www.hhs.gov/ociio/regulations/medical_loss_ratio.html

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