The Medical Loss Ratio: What is it, how is it calculated... and what if I get a rebate check?

BACKGROUND
The Medical Loss Ratio ("MLR") was introduced as a provision in The Patient Protection and Affordable Care Act ("ACA") of March 23, 2010. This provision requires that all health insurers, as of January 1, 2011, spend a percentage of each premium dollar received to pay claims and related expenses and activities that improve health care quality. The goal of the MLR provision is to ensure that a minimum percent of premiums are being used to pay claims and to maximize the value of health care dollars spent for all participants in group medical plans.

Under the ACA and the provisions of the MLR, insurers and health maintenance organizations ("HMO") are required to spend the majority of the premium dollars on health care quality improvement, not on profits and overhead. The majority of the premium dollars is defined as 85% for the large group market and 80% for the individual and small group markets. In the event that insurers and HMOs do not meet this minimum MLR standard, they are required to pay rebates to policyholders; generally employers. As outlined above, the MLR requirements are effective for the 2011 calendar year. All insurers were required to file an MLR rebate report with the Center for Consumer Information & Insurance Oversight on June 1, 2012. The first rebates were calculated based on calendar year 2011 performance and rebate checks were required to be issued by August 1, 2012.

SMALL V. LARGE GROUP MARKETS
For the purposes of the requirement, currently, the small group market is generally defined as 1 to 50 total average employees based on the preceding calendar year, until 2016. Effective January 1, 2016, the small group will be defined as 1 to 100 total average employees. The large group market will be determined based on the upper limit established by the small group rules. Until 2016, the large group market will be defined as more than 50 average employees.

CALCULATION OF THE REBATE
The MLR rebates are determined on a state by state basis and are calculated by dividing the cost of medical services including total claims paid and other expenses that are used to improve health care quality by the total premiums; exclusive of federal or state taxes and licensing and regulatory fees. Rebates are calculated separately for the individual, small group and large group markets in each state.

FINAL REGULATIONS
The Department of Health and Human Services ("HHS") issued interim regulations with respect to the MLR provisions in December of 2010. The final regulations were issued on December 7, 2011. The final regulations are similar to the interim regulations; however, there were several significant changes as outlined in more detail below.

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Rather than having to provide the rebate directly to the policyholder and enrollees in the plan as outlined in the interim regulations, the final regulations allow the insurer to issue the rebate directly to the policyholder. The policyholder is then given the responsibility of utilizing the rebate for the betterment of the plan and its enrollees.

The final regulations also go into detail with respect to the distribution of the rebates to three different types of group health plan policyholders:

- Plans subject to the Employee Retirement Income Security Act ("ERISA").
- Plans that are not Federally Governmental group health plans.
- Plans that are non ERISA or government plans.

In addition to the above, the final regulations outline certain types of plans that contain exceptions or adjustments to/from the MLR requirements. These types of adjustments/exceptions include, but are not limited to, the following:

- "Mini-Med" Policies which are defined in the final regulations as policies that cover the same types of medical services as comprehensive medical policies but have annual benefit limits of $250,000 or less. The final regulations contain a graduated adjustment for "Mini-Med" plans with respect to the MLR that will allow them to multiply their numerator in the MLR calculation by a factor of 1.75 in 2012, 1.5 in 2014 and 1.25 in 2014. With the prohibition of annual and lifetime dollar limit prohibition in 2014 included in the ACA it will be interesting to see if "Mini-Med" policies continue to be allowed.
- Expatriate Policies are defined in the final regulations as policies that provide coverage for employees, substantially all of whom work outside of their country of citizenship, work outside their country of citizenship and their employer's country of domicile and non-W.S. citizens working in their home country.

**TECHNICAL RELEASE 2011-04**

Technical Release ("TR") 2011-04, released on December 2, 2011, provides guidance on rebates for group health plans paid pursuant to the MLR requirements. TR 2011-04 concludes that, for group health plans covered by ERISA, rebates may constitute plan assets. MLR rebates received by policyholders that are covered by ERISA will be considered plan assets and these policyholders will be required to comply with ERISA's fiduciary provisions of Title I of ERISA with respect to what they decide to do with an MLR rebate received; unless their plan contains specific language to the contrary.

TR 2011-04 provides that it is the Internal Revenue Service's ("IRS") responsibility; not HHS, to determine the tax consequences to policyholders with respect to the receipt of a rebate check.

**WHAT TO DO WITH A REBATE CHECK RECEIVED**

There is still much uncertainty when it comes to how to handle an MLR rebate check received. There currently is no "correct" answer to this question for employers to follow in calculating the amounts for and distributing rebate checks to enrollees.

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The final regulations provide several ways for employers to handle MLR rebate checks received; each of which have advantages and disadvantages. Employers can use the rebate checks to:

- Reduce future premiums.
- Enhance plan benefits.
- Refund to participants in the group medical plan.

Overall, it is important to note that the method an employer uses to handle an MLR rebate check will depend on (1) the type of group health plan that it represents; an ERISA plan, a non-federal governmental group health plan or plans that are not covered by ERISA or the government and (2) whether the MLR rebate is considered a plan asset. Employers should consider all advantages and disadvantages associated with the above outlined options before deciding how to handle an MLR rebate check. TR 2011-04 provides that an employer should “properly weigh the costs to the plan and the ultimate plan benefit as well as the competing interests of participants or classes of participants.

TR 2011-04 also provides methods for utilization of an MLR rebate check as follows:

“In deciding on an allocation method, the plan fiduciary may properly weigh the costs to the plan and the ultimate plan benefit as well as the competing interests of participants or classes of participants provided such method is reasonable, fair and objective. Similarly, if distributing payments to any participants is not cost-effective (e.g., payments to participants are de minimis amounts, or would give rise to tax consequences to participants or the plan), the fiduciary may utilize the rebate for other permissible plan purposes including applying the rebate toward future participant premium payments or toward benefit enhancements.”

**TAXABILITY TO RECIPIENTS**

Generally, MLR rebate checks received are taxable to recipients if premiums were paid with pre-tax dollars or if tax benefits were received by deducting premiums paid in 2011 on a 2011 tax return.

**CONCLUSION**

Of the total amount that the U.S. spends on health care, approximately 25% represents overhead costs. The MLR provision contained in the ACA is aimed at reducing this amount to a more acceptable level.

The Kaiser Family Foundation performed a study that determined that approximately $1.3 billion will be returned to employers and consumers in the form of MLR rebates. The results provided that, of the total, the individual market represents approximately $426 million; the small group market represents approximately $377 million and the large group market will account for the remaining $541 million.
Employers should be cognizant of and familiar with the MLR provisions contained in the ACA in the event they receive an MLR rebate check.

The IRS has released a set of frequently asked questions which can be accessed at the following website address:

http://www.irs.gov/newsroom/article/0,,id=256167,00.html

A copy of the final regulations issued by HHS and Technical Release 2011-04 may all be accessed at the healthcare reform advisory services section of our Firm's website.

*Please contact a member of WS+B’s Healthcare Reform Advisory Team for further questions or assistance.*