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Health care reform provision at-a-glance

Medical Loss Ratios

The Patient Protection and Affordable Care Act (or health care reform law) added a new provision to the Public Health Service Act that sets requirements for the minimum medical loss ratio. The medical loss ratio is the percentage of premiums that insurers spend on medical care (including claims and activities that improve health care quality), as opposed to the percentage spent on administrative expenses.

Health insurance issuers offering insured group or individual coverage must meet the following minimums:

- 85% in the large group market
- 80% in the small group and individual market

Issuers who do not meet these minimums will be required to issue rebates.

The National Association of Insurance Commissioners (NAIC) was responsible for recommending to the U.S. Department of Health and Human Services which activities count as medical and quality improvement expenses, as well as how plans should calculate the medical loss ratio. The interim final regulations issued by Health and Human Services on November 22, 2010, adopted the NAIC's model regulation in full but modified some of NAIC's recommendations and added other provisions to the NAIC model.

Some key points from the interim final rules:

- Medical loss ratio calculation would include premium used to pay medical claims and premium used for quality improvement activities. It would exclude federal and state taxes, and licensing and regulatory fees.
- Issuers will need to report calendar-year premium, claims and other expenses for all insured group and individual health insurance coverage as an aggregate by legal entity state by state and by health insurance market (small group, large group, individual).
- Reports must be submitted to Health and Human Services by June 1 of each year. Rebates must be paid by August 1 of each year.
- The medical loss ratio provision does not apply to self-insured or ASO plans; it applies only to the issuer of insurance plans in the large and small group and individual markets.
- Rebates will be provided to the enrollee (defined in the interim final rules as anyone covered by a group plan, as well as anyone covered by an individual policy, despite the fact that this term is not ordinarily used in the individual market).

We will submit to the U.S. Department of Health and Human Services secretary a report concerning the ratio of the incurred claims plus expenses related to improving health care quality to earned premiums. The report will be submitted annually by June 1 based on the calendar year. Rebates must be paid to enrollees before August 1 of each year.

The medical loss ratio provision does not apply to self-insured or ASO plans.

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Questions and answers

What is considered an activity that improves health care quality?
The interim final rules follow the NAIC recommendations for activities that improve health care quality that will be counted with incurred claims when calculating the medical loss ratio. These activities must meet all of the following criteria:

- Be designed to improve health quality
- Increase the likelihood of desired health outcomes in ways that can be objectively measured
- Be directed toward enrollees or a specific segment of enrollees or provide health improvements to the population beyond those enrolled
- Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations

Additionally, the interim final rules add three categories of health information technology expenses, related to meaningful use of electronic health records, that insurers may count as quality improvement activities.

The interim final rules also list health plan issuer expenses that are explicitly not considered activities that improve quality. Examples include:

- Activities that are designed primarily to control or contain costs
- Upgrades to health information technology that are designed primarily to improve claims payment capabilities or to meet regulatory requirements (for example, costs of implementing new administrative simplification standards)
- Fraud prevention activities (other than fraud detection/recovery expenses up to the amount recovered that reduces incurred claims)
- The costs of maintaining provider networks
- Provider credentialing
- Retrospective and concurrent utilization review
- Prospective utilization review that does not meet the definition of activities that improve health outcomes

How will the rebates be paid?
According to the interim final rules, rebates may be paid via check, premium credit or credit to the bank account from which premium is paid. Former enrollees must be paid by check or credit to bank account.

How will medical loss ratio be calculated by state when the customer is a multistate employer?
For multistate employers, medical loss ratio will be reported according to the state identified in the insurance policy or certificate as having primary jurisdiction over the policy – often the headquarters of the company.

What qualifies as a large group or small group for medical loss ratio calculations?
The Affordable Care Act amended the definitions of large and small employer in the Public Health Service Act, defining a small employer as 1-100 employees and a large employer as 101 or more employees. However, the Affordable Care Act also allows states to continue to define “small employer” as an employer with 50 and fewer employees until 2016. For states that do so, that definition shall apply to the medical loss ratio reporting and rebate requirements.