



... Health Care Reform

MLR Rules Are Game Changers for Everyone

While some anticipated or hoped for a delay of the implementation of the medical loss ratio (MLR) rules under the Patient Protection and Affordable Care Act (PPACA), no such delay occurred. In fact, the Department of Health and Human Services (HHS) issued interim final regulations assuring the implementation of the MLR requirements by the statutorily prescribed date of January 1, 2011. In doing so, HHS adopted the prior recommendations of the National Association of Insurance Commissioners (NAIC).

The MLR rules obviously impact health insurance issuers—these carriers are the direct target. But the MLR rules will also impact all plans and service providers in the post reform marketplace.

Impact on insurers

By way of background, PPACA requires all insurers to provide an annual rebate to enrollees to the extent by which non-claims costs exceed 15% in the large group market, and 20% in the individual and small group markets (or lower percentages as states may determine).

To fulfill this requirement, PPACA requires insurers to submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. The report must be provided by June 1 of the year following the end of an MLR period. Carriers must pay the rebates to each enrollee on a pro rata basis by August 1 of that same period.

This report must include the amount of premium revenue received and the amount spent on the following activities:

- Reimbursement for clinical services;
- Activities that improve health care;
- All other non-claim expenses; and
- Federal and state taxes and licensing or regulatory fees.

Each of these terms was the subject of extensive discussion, lobbying and scrutiny by the regulation writers at both the NAIC and HHS. For example, the rules provide that small groups are defined as 2-50 employees, and large groups are defined as 51 or more employees. Even this was not easy, as different states define small groups differently.

The regulations address a vast array of issues well beyond the actual percentages. For example, the rules provide that the data is to be reported at the state level, not regional or national level. The regulations also address special circumstances of smaller plans and newer plans. The regulations also set forth special rules for different types of plans, including mini med plans, association health plans, and expatriate plans.

Impact on plans, brokers and other service providers

How will these rules affect other types of plans or service providers? Well, for example, some sponsors of fully insured plans may migrate to self funded status to avoid the impact of the MLR rules. Self funded plans may experience costs being reallocated from fully insured plans to self funded plans.

Brokers and other service providers already are witnessing changes in how fees and commissions will be calculated or paid—some carriers are now requiring these costs to be paid by the plan sponsor directly. We could go on and on, but it is clear that all plans and service providers will be affected.

Examine the impact on your organization

We urge all plans and service providers to examine carefully the impact of the MLR rules on current business and plan practice models. We also encourage consideration of whether current operating models need to be adjusted to maximize opportunities in the post reform marketplace. Our health benefits team understands the post reform marketplace and stands ready to assist you in these efforts.

Dated: February 8, 2011

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