MLR Provisions in the Proposed Payment Notice

Executive Summary

Medical loss ratio program
Public Health Service (PHS) Act section 2718 generally requires health insurance issuers to submit an annual MLR report to HHS and provide rebates to consumers if they do not achieve specified MLRs. On December 1, 2010, we published an interim final rule, entitled “Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act,” (75 FR 74864) that established standards for the MLR program. Since then, we have made several revisions and technical corrections to those rules. We propose in this proposed rule to amend the regulations to specify how issuers are to account for payments or receipts for risk adjustment, reinsurance, and risk corridors, and to change the timing of the annual MLR report and distribution of rebates required of issuers to allow for accounting of the premium stabilization programs. This proposed rule also proposes to amend the regulations to revise the treatment of community benefit expenditures in the MLR calculation for issuers exempt from Federal income tax.

Summary of Major Provisions

MLR
The MLR program requires issuers to rebate a portion of premiums if their MLRs fall short of the applicable MLR standard for the reporting year. MLR is calculated as a ratio of claims plus quality improvement activities to premium revenue, with adjustments for taxes, regulatory fees, and the premium stabilization programs. In this proposed rule, we propose a number of standards governing the MLR program, including:

- Provisions accounting for risk adjustment, reinsurance, and risk corridors in the MLR calculation;
- A revised timeline for MLR reporting and rebates; and
- Provisions modifying the treatment of community benefit expenditures.

Provisions of the Proposed Payment Notice

I. Medical Loss Ratio Requirements under the PPACA

1. Treatment of Premium Stabilization Payments, and Timing of Annual MLR Reports and Distribution of Rebates

Our previous rulemakings concerning PHS Act section 2718 did not address how issuers are to account for the premium stabilization programs in their MLR reports and in calculating their MLR and any rebates owing, given that the premium stabilization programs are effective beginning in 2014. This proposed rule would modify the definition of premium revenue in §158.130, the formula in §158.221(c) for calculating an issuer’s MLR, and the formula in §158.240(c) for calculating an issuer’s rebate if the MLR standard is not met, in the current MLR regulation to account for payments and receipts related to the premium stabilization programs. When the MLR annual reporting form is updated for the reporting year 2014 and later, premium stabilization amounts would be considered a part of total premium revenue reported to the Secretary, similar to other elements involved in the derivation of earned premium. The MLR annual reporting form would then account for premium stabilization amounts by
removing them from adjusted earned premium, so that these amounts do not have a net impact on the adjusted earned premium used in calculating the MLR denominator and rebates. Additionally, this proposed rule would amend §158.140(b) to include premium stabilization amounts as an adjustment to incurred claims in calculating the MLR numerator as provided in §158.221. This approach would address stakeholder concerns that netting premium stabilization amounts directly against adjusted earned premium in MLR and rebate calculations would result in an issuer paying either a higher total amount or a lower total amount for rebates and the premium stabilization programs combined, depending on whether the issuer’s net premium stabilization obligations resulted in payment or receipt of funds by the issuer.

The approach in this proposed rule would also preserve consistency between the MLR and risk corridors programs by treating premium stabilization amounts in MLR and rebate calculations the same way section 1342(c) of the Affordable Care Act treats reinsurance and risk adjustment amounts in risk corridors calculations, by applying them as adjustments to cost, not revenue. Although PHS Act section 2718 provides that premium revenue should “account for” collections or receipts for the premium stabilization programs, we believe the statutory language provides flexibility as to whether to account for the effects of such collections or receipts in determining revenue (the denominator) or costs (the numerator) of the MLR formula. We considered netting premium stabilization payments or receipts against revenue, but for the reasons discussed above, have not proposed that approach. We invite comment on this decision.

In sum, the formula for calculating the MLR would be amended as follows to take into account payments for and receipts related to the premium stabilization programs:

\[
\text{Adjusted MLR} = \left[\frac{(i + q + n + r)}{(p + n + r) - t - f - n + r}\right] + c
\]

Where,
- \(i\) = incurred claims
- \(q\) = expenditures on quality improving activities
- \(p\) = earned premiums
- \(t\) = Federal and State taxes
- \(f\) = licensing and regulatory fees
- \(n\) = reinsurance, risk corridors, and risk adjustment payments made by issuer
- \(r\) = issuer’s reinsurance, risk corridors, and risk adjustment related receipts
- \(c\) = credibility adjustment, if any.

Issuers must provide rebates to enrollees if their MLRs fall short of the applicable MLR standard for the reporting year. Rebates for a company whose adjusted MLR value in a State falls below the minimum MLR standard in a given market would be calculated using the following amended formula:

\[
\text{Rebates} = (m - a) \times \left[\frac{(p + n + r) - t - f - n + r}{(p + n + r) - t - f - n + r}\right]
\]

Where,
- \(m\) = the applicable minimum MLR standard for a particular State and market
- \(a\) = issuer’s adjusted MLR for a particular State and market.

The amendments made by this proposed rule would be effective for MLR reporting years beginning in 2014.

In addition, this proposed rule would change the MLR reporting and rebate deadlines, beginning with the 2014 MLR reporting year, to coordinate them with the reporting cycles of the premium stabilization programs. Currently, an issuer must file its annual MLR report by June 1 and pay any rebates it owes to consumers by August 1 of the year that follows the MLR reporting year. However, looking ahead, the
amounts associated with the premium stabilization programs that issuers must take into account in their MLR calculations will not be known until after June 1 each year. For example, a state, or HHS on behalf of a state, has until June 30 of the year following a benefit year to notify issuers of the risk adjustment and reinsurance payments due or charges owed for that benefit year (§153.310(e); §153.240(b)(1) as proposed in this proposed rule).

As further specified above in section III.C. of this proposed rule, issuers must submit risk corridors data and calculations by July 31 of the year following a benefit year (§153.530(d) as proposed in this proposed rule). Accordingly, we propose to amend §158.110(b) to change the date of MLR reporting to the Secretary from June 1 to July 31 beginning with the 2014 MLR reporting year, and we propose to amend §158.240(d) to change the rebate due date from August 1 to September 30 to accommodate the schedule for the premium stabilization programs beginning with the 2014 MLR reporting year.

Similarly, we propose to amend §158.241(a)(2) to change the due date for rebates provided by premium credit from August 1 to September 30, to apply to the first month’s premium that is due on or after September 30 following the MLR reporting year, beginning with the 2014 MLR reporting year. In choosing these dates, we tried to balance consumers’ and policyholders’ interests in maintaining the dates for MLR reporting and rebates as close to the June 1 and August 1 dates as possible with issuers’ interests in having the necessary data to submit their annual MLR report and sufficient time to disburse any rebates. Although we must provide issuers any reconciliation of their risk corridors calculations by August 31, as described above in Section C of this proposed rule, we believe that there will be few changes to the risk corridors calculations submitted by issuers to the Secretary by July 31. This would give issuers one additional month from any reconciliation to disburse any rebates owed, which we believe is sufficient time. Comments on the proposed timeline are welcome.

2. Deduction of Community Benefit Expenditures

While we did not specifically solicit comments on the deduction from premium for community benefit expenditures in the MLR December 7, 2011 final rule with comment period, we received a few comments that recommend that a tax exempt not-for-profit issuer should be able to deduct both community benefit expenditures and State premium tax. These commenters suggest that prior to publication of the final rule, the MLR interim final rule published on December 1, 2010 gave a tax exempt not-for-profit issuer this flexibility. Two commenters assert that a Federal income tax exempt issuer is required to make community benefit expenditures to maintain its Federal income tax exempt status, and that allowing a deduction for community benefit expenditures takes the place of a Federal income tax deduction in the MLR calculation. Commenters have made clear that deducting both State premium taxes and community benefit expenditures would help level the playing field because it would allow a Federal income tax exempt issuer to deduct its community benefit expenditures in the same manner that a for-profit issuer is allowed to deduct its Federal income taxes. We agree, and this proposed rule would amend §158.162(b)(1)(vii) to allow a Federal income tax exempt issuer to deduct both State premium taxes and community benefit expenditures from earned premium in the MLR calculation. This proposed rule would not change the treatment of State premium taxes and community benefit expenditures for those issuers that are not exempt from paying Federal income tax. Comments are welcome on the merits of allowing a tax exempt issuer to deduct both State premium taxes and community benefit expenditures from earned premium.

In its model MLR recommendation51, the NAIC determined that the deduction from premium for community benefit expenditures should be limited to a reasonable amount to discourage fraud and abuse and that this limit should be the State premium tax rate. We applied this principle in allowing issuers exempt from State premium tax to deduct community benefit expenditure, up to the State premium tax rate, in their MLR calculation. However, the MLR final rule published on December 7, 2011 allowed issuers exempt from Federal income tax to deduct community benefit expenditures in lieu of State premium taxes, not Federal income taxes. Commenters have suggested that a 3 percent limit on
the deduction from premium for community benefit expenditures would be sufficient to allow a tax
exempt issuer to maintain its current community benefit expenditure. The 2011 MLR data indicate that,
of the not-for-profit issuers that reported non-zero community benefit expenditures, the average spent
on community benefit expenditures (deductible and non-deductible) was about 1.6 percent of premium.
This suggests that a 3 percent community benefit expenditure deduction limit would not discourage a
tax exempt issuer from making community benefit expenditures. In light of the NAIC model rule and the
comments received, we propose to limit the deduction from premium for community benefit
expenditures for issuers that are exempt from Federal income tax to the higher of either 3 percent of
premium or the highest premium tax rate charged in a State. Comments are solicited on the proposed
community benefit expenditures deduction limit.

3. Summary of Errors in the MLR Regulation

a. Errors in the December 1, 2010 interim final rule

We are making two changes to the December 1, 2010 interim final rule (75 FR 74864) to make the
language of the rule consistent with the NAIC’s recommendations, which in the preamble we stated
that we were adopting:

On page 74924, in §158.140 (b)(5)(i), we mistakenly specified the date by which issuers must define
the formula they use for the blended rate adjustment as “January 1, 2011” instead of “January 1 of
the MLR reporting year.” We are updating this date to ensure that all issuers are able to choose to
make the blended rate adjustment going forward. We mistakenly omitted the words “by the issuer”
following the words “will be defined” and mistakenly used the word “will” instead of “must” in
describing the objective formula to be used in reporting group coverage at a blended rate.

On page 74928, in §158.232(d), we inadvertently used the word “For” instead of “Beginning with”
when describing the date after which partially-credible issuers that consistently fail to meet the MLR
standard will not be allowed to use a credibility adjustment.

b. Error in the May 16, 2012 Correcting Amendment

Section 158.232(c)(1)(i) of the MLR regulation was amended by the May 16, 2012 correcting
amendment (77 FR 28788), which currently reads: “[t]he per person deductible for a policy that
covers a subscriber and the subscriber’s dependents shall be the lesser of: The sum of the
deductible applicable to each of the individual family members; or the overall family deductible for
the subscriber and subscriber’s family, divided by two (regardless of the total number of individuals
covered through the subscriber).”

In this correcting amendment, we further amend §158.232(c)(1)(i) by deleting the words “The sum
of” after the words “the lesser of:” and the comma after the words “subscriber’s family,” which we
inadvertently did not delete in the May 16, 2012 correcting amendment.

L. ICRs Regarding Medical Loss Ratio Reporting (§158.130, §158.140, §158.162,§158.221, §158.240)

This proposed rule would direct issuers to include all payments and receipt amounts related to the
reinsurance, risk corridors and risk adjustment programs in the annual MLR report.

The existing information collection requirement is approved under OMB Control Number 0938-1164.
This includes the annual reporting form that is currently used by issuers to submit MLR information to
HHS. Prior to the deadline for the submission of the annual MLR report for the 2014 MLR reporting year,
and in accordance with the PRA, HHS plans to solicit public comment and seek OMB approval for an
Impact Estimate

Medical Loss Ratio
This proposed rule proposes to amend the MLR and rebate calculation methodologies to include payments and receipts related to the premium stabilization programs. The definition of premium revenue would be modified to account for these payments and receipts. When the MLR annual reporting form is updated for the reporting year 2014 and later, premium stabilization payment and receipt amounts would be considered a part of gross earned premium reported to the Secretary, similar to other elements involved in the derivation of earned premium. The MLR annual reporting form would then account for premium stabilization payment and receipt amounts by removing them from adjusted earned premium, so that these amounts do not have a net impact on the adjusted earned premium used in calculating the MLR denominator and rebates. Additionally, this proposed rule proposes to amend the MLR calculation methodology to add or subtract premium stabilization payment(s) and receipt amounts in the MLR numerator, consistent with the way the statute prescribes the calculation methodology for risk corridors. These adjustments will reduce or increase issuers’ MLRs, and may increase or reduce issuers’ rebates, respectively. The amended methodology will result in a more accurate calculation of MLR and rebate amounts, since it will reflect issuers’ actual claims-related expenditures. This approach will also support the effectiveness of both the MLR and the premium stabilization programs by correctly offsetting the premium stabilization payment and receipt amounts against rebates, consistently with the risk corridors calculation methodology adopted in §153.530.

Based on HHS’s experience with the 2011 MLR reporting year, there are 466 health insurance issuers offering coverage in the individual and group markets to almost 80 million enrollees that will be affected by the proposed amendment to account for premium stabilization payments in MLR and rebate calculations. In 2012, an estimated 54 issuers paid $396 million in rebates for the 2011 MLR reporting year to approximately 4 million enrollees in the individual markets, while 59 issuers in the small group market provided approximately $289 million in rebates to policyholders and subscribers on behalf of over 3 million enrollees, and 47 issuers in the large group market provided approximately $403 million in rebates to policyholders and subscribers on behalf of almost 6 million enrollees. Lack of data makes it difficult to predict how high-risk enrollees will be distributed among issuers and, therefore, how MLRs and total rebates would be affected. Issuers with relatively low-risk enrollees are likely to have positive net premium stabilization payments (that is, payments would be greater than receipts) and, if so, their MLRs will increase as a result of the amended MLR calculation methodology. If any of these issuers fail to meet the MLR standard, taking the premium stabilization payments and receipts into account in the MLR calculations will result in lower rebate payments. Issuers with relatively high-risk enrollees are likely to have positive net receipts (that is, receipts would be greater than payments) and, if so, their MLRs would decrease as a result. If any such issuer fails to meet the MLR standard, its rebate amount will increase. Since such issuers are likely to have high claims expenditures and therefore, high MLRs, they would be less likely to owe rebates. So we do not anticipate that rebates will go up for such issuers.

The Payment Notice proposes to also change the deadlines for MLR report submission and rebate payments so that the deadlines occur after all the premium stabilization payment and receipt amounts are determined. The change in the deadlines will allow issuers to calculate the MLR and rebate amounts based on actual calculated payments and receipts rather than estimated amounts and will improve the accuracy of the rebate payments and reports. This will also reinforce the effectiveness of the premium stabilization programs, since issuers are less likely to pay higher or lower rebates based on inaccurate payment and receipt estimations. Accordingly, we propose to change the date of MLR reporting to the updated annual form that will include reporting of the premium stabilization payments and will reflect the changes in deduction for community benefit expenditures for federal income tax exempt not-for-profit issuers.
Secretary from June 1 to July 31, and the rebate due date from August 1 to September 30. Issuers will also have to report their payments and receipts related to the premium stabilization programs in the annual MLR report beginning in the 2014 MLR reporting year. Once issuers calculate these amounts, which they will be required to do regardless of the MLR reporting requirements, the administrative cost of including these amounts in the report will be minimal.

The current MLR calculation methodology allows an issuer to deduct from premiums in the calculation of an issuer’s MLR and rebates either the amount it paid in State premium taxes, or the amount of its community benefit expenditures up to a maximum of the highest premium tax rate in the State, whichever is greater, as provided in the final rule with comment period (76 FR 76574) published on December 7, 2011. This proposed rule proposes to amend the MLR methodology and allow a federal income tax exempt not-for-profit issuer to deduct from premium both community benefit expenditures and State premium taxes, limited to the higher of the State’s highest premium tax rate or 3 percent of premium. Other issuers would continue to use the current methodology. This would create a level playing field for Federal income tax exempt not-for-profit issuers, who are required to make community benefit expenditures to maintain their federal income tax exempt status and would not discourage community benefit expenditures. This is likely to increase the MLRs for tax exempt not-for-profit issuers. If any of these issuers fail to meet the MLR standard, then this will result in lower rebate payments.

Based on MLR annual reports submitted by issuers for the 2011 MLR reporting year, we estimate that there are 132 not-for-profit issuers that will be affected by this proposed amendment. In the absence of data on tax exempt not-for-profit issuers, we use the estimates for not-for-profit issuers in our analysis. Therefore, the actual impact is likely to be lower. For the 20 not-for-profit issuers that submitted data on community benefit expenditures, such expenditures as a percentage of earned premiums ranged from 0.04 percent to 4.11 percent with an average of 1.57 percent, which is likely to be less than the current limit for most of the issuers and is less than the proposed limit as well.

We assume that issuers will maintain the level of community benefit expenditures as reported in their MLR annual reports for the 2011 MLR reporting year. We estimate that under the current policy, in the 2012 MLR reporting year, 17 not-for-profit issuers will owe approximately $182 million in rebates to approximately 1.5 million enrollees. The proposed change in treatment of community benefit expenditures for such issuers will have minimal effect on their MLRs and rebates under this assumption, since their current expenditures are below the current deduction limits. Issuers with lower rebate payments as a result of these adjustments would need to send fewer rebate notices, and therefore, would have lower administrative costs related to rebates and rebate notices.

**Risk Corridors**

The Affordable Care Act creates a temporary risk corridors program for the years 2014, 2015, and 2016 that applies to QHPs. The risk corridors program creates a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers. The Affordable Care Act establishes the risk corridors program as a Federal program; consequently, HHS will operate the risk corridors program under Federal rules with no State variation. The risk corridors program will help protect against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains.

QHP issuers must submit to HHS data on premiums earned, allowable claims and quality costs, and allowable administrative costs, reflecting data categories required under the Medical Loss Ratio Interim Final Rule (75 FR 74918). In designing the program, HHS has sought to leverage existing data reporting for Medical Loss Ratio purposes as much as possible.

As noted above, the risk corridors program is intended to protect QHP issuers in the individual and small group market against inaccurate rate setting. Due to uncertainty about the population during the first years of Exchange operation, issuers may not be able to predict their risk accurately, and their premiums may reflect costs that are ultimately lower or higher than predicted. To determine whether an issuer
pays into, or receives payments from, the risk corridors program, HHS will compare allowable costs (essentially, claims costs) and the target amount – the difference between a plan’s earned premiums and allowable administrative costs. In this proposed rule, we have provided for adjustments to the risk corridors calculation to account for taxes and profits within its allowable administrative costs. The threshold for risk corridor payments and charges is reached when a QHP issuer’s allowable costs exceed, or fall short of, the target amount by at least three percent. A QHP with allowable costs that are at least three percent less than its target amount will pay into the risk corridors program. Conversely, HHS will pay a QHP with allowable costs that exceed its target amount by at least 3 percent. Risk corridor payments and charges are a percentage of the difference between allowable costs and target amount and therefore are not on a “first dollar” basis.

In this proposed rule, HHS also specified the annual schedule for the risk corridors program, including dates for claims run-out, data submission, and notification of risk corridors payments and charges. We believe the proposals on the risk corridors program in this proposed rule have a negligible effect on the impact of the program established by and described in the Premium Stabilization Rule.

Amendments to Regulation

§158.221 Formula for calculating an issuer’s medical loss ratio.

(c) Denominator. The denominator of an issuer’s MLR must equal the issuer’s premium revenue, as defined in § 158.130, excluding the issuer’s Federal and State taxes and licensing and regulatory fees, described in §§ 158.161(a) and 158.162(a)(1) and (b)(1), and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, described in § 158.130(b)(5).

49. Section 158.232 is amended by revising paragraph (c)(1)(i) and paragraph (d) introductory text to read as follows:

§158.232 Calculating the credibility adjustment.

(c) * * * *

(1) * * *

(i) The per person deductible for a policy that covers a subscriber and the subscriber’s dependents shall be the lesser of: the deductible applicable to each of the individual family members; or the overall family deductible for the subscriber and subscriber’s family divided by two (regardless of the total number of individuals covered through the subscriber).

(d) No credibility adjustment. Beginning with the 2013 MLR reporting year, the credibility adjustment for MLR based on partially credible experience is zero if both of the following conditions are met:

* * * * *
50. Section 158.240 is amended by revising paragraphs (c) and (d) to read as follows:

§158.240 Rebating premium if the applicable medical loss ratio standard is not met.

* * * * *

(c) Amount of rebate to each enrollee.

(1) For each MLR reporting year, an issuer must rebate to the enrollee the total amount of premium revenue, as defined in §158.130 of this part, received by the issuer from the enrollee, after subtracting Federal and State taxes and licensing and regulatory fees as provided in §§158.161(a) and 158.162(a)(1) and (b)(1), and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance as provided in §158.130(b)(5), multiplied by the difference between the MLR required by §158.210 or §158.211, and the issuer’s MLR as calculated under §158.221.

(2) For example, an issuer must rebate a pro rata portion of premium revenue if it does not meet an 80 percent MLR for the individual market in a State that has not set a higher MLR. If an issuer has a 75 percent MLR for the coverage it offers in the individual market in a State that has not set a higher MLR, the issuer must rebate 5 percent of the premium paid by or on behalf of the enrollee for the MLR reporting year after subtracting taxes and fees and accounting for payments or receipts related to reinsurance, risk adjustment and risk corridors. In this example, an enrollee may have paid $2,000 in premiums for the MLR reporting year. If the issuer received net payments related to reinsurance, risk adjustment and risk corridors of $200, the gross earned premium would be $2,200. If the Federal and State taxes and licensing and regulatory fees that may be excluded from premium revenue as described in §§158.161(a), 158.161(a)(1), and 158.162(b)(1) are $150 and the net payments related to reinsurance, risk adjustment and risk corridors that must be accounted for in premium revenue as described in §§ 158.130(b)(5), 158.221 and 158.240 are $200, then the issuer would subtract $150 and $200 from gross premium revenue of $2,200, for a base of $1,850 in premium. The enrollee would be entitled to a rebate of 5 percent of $1,850, or $92.50.

(d) Timing of rebate. For each of the 2011, 2012, and 2013 MLR reporting years, an issuer must provide any rebate owing to an enrollee no later than August 1 following the end of the MLR reporting year. Beginning with the 2014 MLR reporting year, an issuer must provide any rebate owing to an enrollee no later than September 30 following the end of the MLR reporting year.

* * * * *

51. Section 158.241 is amended by revising paragraph (a)(2) to read as follows:

§158.241 Form of rebate.

(a) * * *

(2) For each of the 2011, 2012, and 2013 MLR reporting years, any rebate provided in the form of a premium credit must be provided by applying the full amount due to the first month’s premium that is due on or after August 1 following the MLR reporting year. If the amount of the rebate exceeds the premium due for August, then any average shall be applied to succeeding premium payments until the full amount of the rebate has been credited. Beginning with the 2014 MLR reporting year, any rebate provided in the form of a premium credit must be provided by applying the full amount due to the first month’s premium that is due on or after September 30 following the MLR reporting year. If the amount of the rebate exceeds the premium due for October, then any overage shall be applied to succeeding premium payments until the full amount of the rebate has been credited.

* * * * *