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Title: Insurance Standards Bulletin Series--INFORMATION

Subject: CCIIO Technical Guidance (CCIIO 2011—002): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule

I. Purpose

Section 2718 of the Public Health Service Act (PHS Act), as added by the Patient Protection and Affordable Care Act (Affordable Care Act), requires health insurance issuers (issuers) to submit a medical loss ratio (MLR) report to the Secretary and requires them to issue a rebate to enrollees if the issuer's MLR is less than the applicable percentage established in section 2718(b) of the Affordable Care Act. The interim final rule implementing MLR requirements was published on December 1, 2010 (75 FR 74864) and modified by technical corrections on December 30, 2010 (75 FR 82277). The IFR is to be codified at 45 CFR Part 158.

This Bulletin provides guidance on the following topics regarding the MLR Interim Final Rule:

- Definition of Small Employer;
- Mini-Med Plan MLR Reporting;
- Expatriate Plan MLR Reporting;
- Reimbursement for Clinical Services Provided to Enrollees (Incurred Claims);
- Third Party Vendor Payments;
- Activities that Improve Health Care Quality; and
- A State Request for Adjustment to the MLR Standard.

II. Questions and Answers

DEFINITION OF "SMALL EMPLOYER" (45 CFR §158.103)

Question #1:
The MLR interim final regulation, 45 CFR §158.103, defines small employer as having up to 100 employees, but allows a state to substitute "50" employees for "100" employees until 2016, as provided in the Public Health Service Act and the Affordable Care Act. What actions should a state take to make an election to stay at 50 employees?

Answer #1:
If a State uses 50 employees in its definition of small employer for other purposes, absent indication to the contrary, this will be deemed to be an election to use 50 as the upper limit for purposes of MLR reporting for that State's experience

"MINI-MED" PLANS AND EXPATRIATE PLANS (45 CFR §158.120(d)(3) and (4), §158.221(b)(3) and (4))

Question #2:
Must issuers of so-called mini-med plans and expatriate plans report the experience for those plans separately from other types of plans?

Answer #2:
Yes. 45 CFR §158.120(d)(3) and (4) clearly require aggregating and reporting of mini-med and expatriate plans' experience separately from other types of policies, and 45 CFR §158.110(b)(2) requires quarterly reporting of such experience for the first three quarters of 2011. Aggregation and reporting of mini-med plans and expatriate plans are both addressed in separate Questions and Answers.

Some have questioned whether §158.221(b)(3) and (4) allow issuers the "option," at the issuer's sole discretion, of applying the special adjustment to the numerator of the medical loss ratio. Such special adjustment under the regulation is not optional or permissive. For the 2011 MLR reporting year, it requires that the numerator for such mini-med and expatriate plans be multiplied by a factor of two. Similarly, for the 2011 MLR reporting year, §158.110(b)(2) requires quarterly reporting, and such quarterly reporting requirement is not optional or permissive.

"MINI-MED" PLANS (45 CFR §158.120(d)(3), 158.220 and 158.221(b)(3))

Question #3:
How should experience under so-called mini-med policies, 45 CFR §158.120(d)(3), be aggregated?

Answer #3:
The experience of so-called mini-med policies (defined in the MLR IFR as policies with a total annual limit of $250,000 or less) is to be aggregated separately from other coverage, as stated in §158.120(d)(3). However, similar to other health insurance coverage and as specified in §158.120(a), it should be aggregated by State, and by large group, small group, and individual market within each State. There is no national aggregation or other variation from the aggregation rules set forth in §158.120 for mini-med policies.

Question #4:
What aggregation should be used for calculating the MLR and rebates, if any, for so-called mini-med policies?

Answer #4:
The experience of mini-med policies is to be aggregated separately from other coverage, as stated above and in 45 CFR §158.120(d)(3). An issuer's MLR for its mini-med policies is also to be calculated separately from its MLR for other types of health insurance coverage. This is necessary in order for the issuer to apply the MLR calculation for mini-med coverage as set out in §158.221(b)(3). Sections 158.120(d)(3) and 158.221(b)(3) apply to the 2011 MLR reporting year only. However, like other types of health insurance coverage, an issuer's MLR for its mini-med policies must be calculated separately for the large group, small group, and individual markets within each State, §158.220(a). Thus, an issuer will have a separate mini-med MLR for each State and market (large group, small group, and individual) in which it issues these policies. Similarly, any rebates an issuer of mini-med policies must provide based upon its MLR must be calculated for each State and market in which it issues such policies.

EXPATRIATE PLANS (45 CFR §158.120(d)(4), §158.220 and §158.221(b)(4))

Question #5:
How should experience under expatriate group policies, 45 CFR §158.120(d)(4), be aggregated?

Answer #5:
The experience of expatriate group policies is to be reported separately from other coverage. Because of the unique nature of expatriate plans as compared to plans that primarily provide coverage within the United States, such experience may be aggregated on a national basis. However, the large group market must meet an 85% MLR standard and the small group market must meet an 80% MLR standard, thus the experience of the large group market must be aggregated and reported separately from the experience of the small group market. Section 158.120(d)(4) applies only to group policies and not to individual policies. Individual expatriate policies are not included in the separate aggregation. This applies to the 2011 MLR reporting year only.

Question #6:
What aggregation should be used for calculating the MLR and rebates, if any, for expatriate group policies?

Answer #6:
The experience of expatriate group policies is to be aggregated separately from other coverage as stated in §158.120(d)(4). An issuer's MLR for its expatriate group policies is also to be calculated separately from its MLR for other types of health insurance coverage. This is necessary in order for the issuer to apply the MLR formula adjustment for expatriate plans as set forth in §158.221(b)(4). Sections 158.120(d)(4) and 158.221(b)(4) apply to the 2011 MLR reporting year only. However, unlike other types of health insurance coverage, an issuer's MLR for its expatriate group plans may be calculated on a national basis for the large group and for the small group markets. (Section 158.120(d)(4) does not apply to individual expatriate policies.) Because the large group market must meet an 85% MLR standard and the small group market must meet an 80% MLR standard, an issuer's MLR and any rebates for its expatriate policies in the large group market must be aggregated and reported separately from its MLR and any rebates

for its expatriate policies in the small group market. Any rebates an issuer of expatriate large group policies must provide will be based upon the same MLR, and any rebates an issuer of expatriate small group policies must provide will be based upon the same MLR.

Question #7:
How should issuers report MLR data for expatriate policies where the employee is outside of the United States but his or her dependents are in the United States?

Answer #7:
Section 158.120(d)(4) requires issuers to aggregate the experience from policies that cover employees working outside their country of citizenship, employees working outside of their country of citizenship and their employer's country of domicile, and non-U.S. citizens working in their home country. The determining factor is the location of the employee, rather than the dependent. Thus, if a group policy covers a U.S. citizen working in France as well as that employee's dependents living in the U.S., the experience of that employee and his/her dependents is included in the expatriate policy's experience and data.

REIMBURSEMENT FOR CLINICAL SERVICES PROVIDED TO ENROLLEES (INCURRED CLAIMS) (45 CFR §158.140)

Question #8:
Is the entire amount paid to a clinical provider in a capitation arrangement considered an incurred claim?

Answer #8:
Generally, yes. Where an issuer has arranged with a clinical provider for capitation payments rather than fee-for-service reimbursement for covered services to enrollees, and such capitation payments include reimbursement for certain provider administrative costs, then the entire per member per month capitation payment paid to the provider may be included in incurred claims, as provided in 45 CFR §158.140(a).

The term "provider" in this question and answer does not refer to or include third party vendors.

Question #9:
Is the entire payment to a non-physician clinical provider in a capitation arrangement considered an incurred claim?

Answer #9:
Generally, yes. Although 45 CFR §158.140(a) refers to the fact that it includes capitation arrangements with *physicians*, the intent was to include capitation arrangements with non-physician providers that are licensed, accredited, or certified to perform clinical health services, consistent with State law, and who are engaged in the delivery of medical services to enrollees.

Question #10:
Does 45 CFR §158.140(b)(3)(ii) or any other portion of the interim final rule require reporting of information on a claim-by-claim basis or pricing information?

Answer #10:
Nothing in the IFR requires claim-by-claim reporting or for a third party vendor to disclose proprietary data concerning pricing arrangements. If an issuer seeks to include incurred claims paid through third party vendors in its MLR calculation, the issuer must obtain from the third party vendor the aggregate portion of the fees the vendor received from the issuer attributable to providing direct clinical services to enrollees.

Question #11:
Does 45 CFR §158.140(b)(3)(ii) -- which excludes from incurred claims amounts paid to third party vendors for network development, administrative fees, claims processing, utilization management and profits -- require issuers to disclose the administrative and other fees that they pay to particular third party vendors?

Answer #11:
No. Issuers are not required to report at an individual vendor level the amount of payment that reflects a vendor's administrative expenses. The portion of the fees an issuer pays to a third party vendor for network development, administrative fees, claims processing, utilization management, and profit would simply be combined with, and reported as part of, the issuer's overall administrative expenses.

Question #12:
When a third party vendor provides clinical services directly to enrollees, how does 45 CFR §158.140(b)(3)(ii) -- which excludes from incurred claims amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management -- affect how an issuer reports payments to that third party vendor?

Answer #12:
Section 158.140 treats payments to providers as reimbursement for clinical services to enrollees (also referred to as incurred claims). Section 158.140(b)(3)(ii) recognizes that issuers often pay third party vendors to perform services such as network development, administrative fees, claims processing, and utilization management, that are considered non-claims administrative costs if performed by the issuer and thus should be considered non-claims administrative costs if performed by a third party vendor.

However, when a third party vendor, through its own employees, provides clinical services directly to enrollees, the entire portion of the amount the issuer pays to the third party vendor that is attributable to the third party vendor's direct provision of clinical services should be considered incurred claims, even if such amount includes reimbursement for third party vendor administrative costs directly related to the vendor's direct provision of clinical services. The term "through its own employees" does not include a third party vendor's contracted network of providers because such network providers are not considered employees of the third party vendor

For example, an issuer may contract with a PBM to provide clinical services directly to enrollees through a mail order pharmacy. The amount the issuer pays to the PBM for mail order pharmacy services provided directly by the PBM's employees, including administrative costs related to the

PBM's direct provision of such mail order pharmacy services, would be included in the issuer's incurred claims.

Question #13:
Does 45 CFR §158.140(b)(3)(iii) -- which excludes from incurred claims amounts paid (including amounts paid to a provider) for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee -- require issuers to separate out claims payments or providers to separate out their bills into their component parts for clinical services to enrollees and overhead costs?

Answer #13:
No. This section of the IFR does not require any change in the way providers prepare or process their bills and it does not require providers to break out portions of claims attributable to administrative expenses or overhead. No modifications to claim preparation or process are required. This subsection simply clarifies that to the extent that there is a separate, identifiable charge in a bill or invoice that represents a separate charge for something other than reimbursement for clinical services to enrollees, payment for such a charge should be treated as a non-claim cost and is excluded from incurred claims. For example, a provider may charge for items such as medical record copying costs or attorneys' fees incurred as part of a payment dispute with the issuer. Such costs or payments are separate and apart from reimbursement for clinical services to enrollees and are to be treated as a non-claims cost and excluded from incurred claims.

ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY (45 CFR §158.150)

Question #14:
Does the IFR allow portions of the amounts paid to third party vendors to be counted as expenditures for activities that improve health care quality?

Answer #14:
Yes. An issuer may count a vendor's expenses as activities that improve health care quality to the extent that the issuer and vendor can show that these expenses were incurred for performing allowable quality improving activities on behalf of the issuer. Accordingly, the concept addressed specifically in 45 CFR §158.140(b)(3)(ii) regarding incurred claims and third party vendors applies, to the extent permitted under §158.150 and §158.151, to expenditures for activities that improve health care quality.

For example, to the extent that a PBM performs functions that are designed primarily to identify quality concerns, such as potential adverse drug interactions, those costs may be reported, in aggregate, as expenditures for activities that improve health care quality.

Question #15:
Must an activity be specifically listed in 45 CFR §158.150(b) in order to be included as an allowable quality improving activity (QIA)?

Answer #15:
No. Section 158.150(b)(2) states that, in order to be reported as a QIA, the activity must be primarily designed to do one of four things: (i) improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations; (ii) prevent hospital readmission through a comprehensive program for hospital discharge; (iii) improve patient safety, reduce medical errors, and lower infection and mortality rates; or (iv) implement, promote, and increase wellness and health activities. Section 158.150(b)(2) provides a list of examples following each of these four things. Each list of examples is intended to be illustrative and not exhaustive.

For example, activities that may be an allowable QIA (assuming that they also meet the criteria listed in §158.150(b)(1)) that are not specifically listed in §158.150(b)(2) include blood glucose monitoring programs and medication adherence programs.

A STATE REQUEST FOR ADJUSTMENT TO THE MLR STANDARD (45 CFR §158.301 et seq.)

Question #16:
The interim final regulation was published on December 1, 2010, and the process for making a determination on a State's request for an adjustment to the MLR standard for the individual market will mean that a determination will be made at least several weeks after January 1, 2011. Will the adjustment be retroactive to January 1, 2011?

Answer #16:
Any request for adjustment of the MLR standard for a State's individual market, if approved for MLR reporting year 2011, will be effective for the entire 2011 MLR reporting year.

Question #17:
45 CFR §158.322 requires a State to provide its own proposal as to the adjustment it seeks to the MLR standard. May a State propose an adjustment to how the MLR is calculated? For example, may a State include or exclude factors that are not part of the federal formula for calculating the MLR, or substitute its State MLR definition or formula for the federal definitions and formula as well as an adjustment to the percentage?

Answer #17:
A State may propose to substitute a lower minimum loss ratio standard for the 80 percent standard established in the Public Health Service Act §2718(b)(1)(A)(ii), as amended by Section 1001 of the Affordable Care Act, and by regulation codified at 45 CFR §§158.301 and 158.210(c). A State may not propose an adjustment to how the MLR is calculated. By way of example, a State may not propose definitions or methods for calculating the MLR that differ from those established by the federal law and regulations.