Illinois Insurance Facts

Illinois Department of Insurance

Rebates and the Medical Loss Ratio Standard in the Group Market

January 2015

Note: This information was developed to provide consumers with general information and guidance about insurance coverage and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

Background

- On October 22, 2010, a new regulation, called the Medical Loss Ratio (MLR) provision was issued as part of the Affordable Care Act (ACA). This regulation will make the marketplace more transparent.
- To be sure your premium dollars are spent primarily on health care itself, the ACA MLR standards require that insurers in the individual and small group markets meet a minimum MLR of 80%. Insurance sold to large groups is subject to a minimum MLR of 85%. Each year that these insurance companies do not meet MLR standards established by ACA for individual, small group, and large group policies, they must issue rebates to policyholders on the plan.
- Three MLRs are calculated annually in each state that a health insurer does business in: the individual market, the small group market, and the large group market (if all apply). In each of these three markets, the calculation is done using the premiums, claims and quality improvement expenses for that entire market in that state.
- In Illinois, small groups are defined as groups with 50 or fewer employees. Large groups are defined as having 51+ employees
- The Federal MLR Requirements are codified as 45 CFR Part 158.

When Did the Medical Loss Ratio Rule Take Effect?

- The Medical Loss Ratio Rule took effect in 2011, and the first rebates were paid in August 2012. The MLRs were based on premiums, claims, and quality expenses for the period January – December 2011.
- Rebate calculations for January-December 2013 were paid in August 2014.
- Rebates for Calendar Year 2013, and after, will be calculated using MLRs based on cumulative data for the current year and the prior two years. For example, the MLR used for 2013 rebates used combined data for 2011, 2012, and 2013.

Which Group Plans are Subject to the MLR Requirements?

Fully funded small and large group health plans, including grandfathered plans. (Fully funded health plans are plans where insurance companies assume the full risk for medical expenses incurred)

Which Group Plans are NOT Subject to the MLR Requirements?

- MLR rebate rules do not apply to cases where an insurer has fewer than 1,000 enrollees in a particular state or market.
- The MLR requirement does not apply to self-funded plans, which are health care plans offered by businesses in which the employer assumes the financial risk for medical care.
- The ACA's MLR requirements also do not apply to "excepted benefits" because these benefits are not considered health insurance, as defined by the Department of Labor. These include: long-term care plans, accident only plans, disability income insurance, workers' compensation, limited-scope dental or vision plans.
- Other benefits are also treated as excepted benefits, and therefore not subject to MLR requirements, if they are offered separately, including: specific disease plans, hospital indemnity or other fixed indemnity plans.
- In addition, the following plans are also not subject to MLR requirements: Medicare Advantage, Medicare Supplement Plans, and Medicare Prescription Drug Plans

Reporting Requirements Related to Premiums and Expenditures

- In December 2010, HHS published interim final regulations to implement the MLR provisions, based largely on a model regulation drafted by the NAIC. Since then, HHS has issued a final regulation on May 16, 2012.
- Insurers are required to submit a report to HHS by June 1st of each year concerning premium revenue and expenses related to the individual and group health insurance coverage that it issued during the previous calendar year (January – December). If an insurer has failed to use 80% of each premium dollar on health care services and health care improvements (in the individual and small group market) and (85% in the large group market), it must refund the policyholders in the applicable market (either small or large group) by August 1st of the following year.
- To assist the insurer with reporting its experience, HHS developed and published an MLR Annual Reporting Form, with instructions on how to complete and submit the report.

http://www.cciio.cms.gov/resources/files/mlr-annual-form-instructions051612.pdf

Reports

2012
http://www.cms.gov/CCIIO/Resources/Files/Downloads/mlr-report-02-15-2013.pdf
2013
http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report_07-22-2014.pdf

Formula for Calculating the MLR

$$\text{MLR} = \frac{\text{(health care claims) + (quality improvement expenses)}}{\text{(Premiums) – (taxes, licensing and regulatory fees)}}$$

Health Care Claims: Payments made by insurers for medical care and prescription drugs.

Quality Improvement Expenditures: To be included in this calculation, health improvement activities must lead to measurable improvements in patient outcomes or patient safety, prevent hospital readmissions, promote wellness, or enhance health information technology in a way that improves quality, transparency, or outcomes.

Premiums: All premiums earned from policyholders

Taxes, Licensing and Regulatory Fees: Includes federal taxes and assessments, state and local taxes, and regulatory licenses and fees.

Rebates to Policyholders

Health insurers that fail to meet the minimum MLR requirements in the ACA must provide rebates to policyholders. Rebates are to be issued by August 1 each year following the calendar year used in calculating the MLR (January – December). Insurers were required to issue rebates for calendar year 2011 premiums by August 1, 2012. Policyholders include employers and individuals, and there are slightly different procedures between employer-sponsored plans and those in the individual market, as discussed below.

Who Is Eligible for Rebates in the Group Market?

- For the purpose of determining who is entitled to a rebate, HHS has defined the term "enrollee" to mean the subscriber, policyholder, and/or government entity that paid the premium for the health care coverage received by an individual during a respective calendar year.
- In the case of employer-sponsored coverage, a rebate would be paid by the insurer to the employer, which would then distribute a portion of the rebate to the enrollee (employee). The amount of the rebate due to the employer and the employee is based on their relative shares of the original premium payment. Thus, if the employer paid 70% of the premium

and the employee paid 30%, the rebate would be split 70%/30% accordingly. In addition, enrollees who were covered by insurance for only part of a calendar year would have their share of any rebate adjusted to partial year coverage.

- Enrollees who paid premiums to an insurance plan that did not meet its required MLR are entitled to a rebate, even those who are no longer covered by the specific insurance plan (***with certain exceptions***). For example, if an employer finds that the cost of distributing shares of a rebate to a former plan enrollee is approximately the value of the rebate; the employer may allocate the rebate to current enrollees based upon a reasonable, fair, and objective allocation method.[1]

How Do Group Policy Rebates Work?

Many Americans do not pay the full insurance premium because they obtain coverage through an employer that assumes a part of the costs. Thus, rebates under group policies must be coordinated through the employer. Under ACA, an insurer can enter into an agreement with the group policyholder (employer) to distribute rebates on behalf of the insurer, under the following conditions:

- The insurer remains liable for complying with the ACA requirements.
- The insurer keeps records documenting that the rebates have been distributed accurately.

Documentation must include the amount of the premium paid by the employer, the amount paid by the worker, the amount of the rebate to each enrollee, and the amount of any rebate either retained by the employer or that is unclaimed and distributed.

Tax Implications of MLR Rebates in the Group Market

Rebates provided to workers from employers in the form of a lump-sum payment will be treated as regular income and therefore may be taxed. Thus, in order to prevent tax consequences, there will be an incentive for employers to provide rebates in the form of premium credits for the upcoming enrollment period.

Form of Rebates to Current and Former Employees

- The NAIC recommended, and HHS agreed, that the entity distributing the rebates may choose whether to disburse payments to current enrollees as a lump-sum check or a deposit to a credit or debit card.[2] Current enrollees can also receive refunds in the form of

[1] Department of Labor, "Guidance On Rebates For Group Health Plans Paid Pursuant To The Medical Loss Ratio Requirements Of The Public Health Service Act," Technical Release 2011-04, December 2, 2011, http://www.dol.gov/ ebsa/pdf/tr11-04.pdf

[2] Department of Health and Human Services, 45 CFR Part 158, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," Federal Register, December 1, 2010, (§158.241); https://www.federalregister.gov/articles/2010/12/01/2010-29596/healthinsurance- issuers-implementing-medical-loss-ratio-mlr-requirements-under-the-patient

a credit against future premium payments. If an employer or insurer provides a premium credit to an enrollee, the full amount of the rebate must be applied to the first plan premium due on, or after, August 1.

- If the amount of the rebate is greater than the first premium payment, any remaining money will be applied to future premium payments until the rebate is used up.
- Rebates to people who are former enrollees can take the form of a check or a transfer to a debit or credit card.

De Minimis Rebates

There are special rules for de minimis, or minor, rebates defined as group policies where the insurer distributes the rebate to the policyholder (generally an employer), and the total rebate owed to the policyholder and the enrollees combined is less than $20 for a given year; or group policies where the insurer issues the rebate directly to the enrollee and the enrollee rebate is less than $5 for a given year; or individual policies, where total rebate owed by the insurer to each subscriber is less than $5 for a given MLR reporting year.[3]

Under these scenarios, direct rebates are not required given that the cost of administering such small benefits may exceed their value. Insurers issuing the rebates do not get to keep these de minimis amounts, but must aggregate the money and distribute it to other enrollees in the state who are due a rebate.[4]

In addition, employers, rather than insurers, that oversee plans are not required to issue rebates if the cost of doing so would exceed the cost of the rebates, but they must use the de minimis amounts for allowable activities to benefit enrollees.

Notification Requirements

Medical Loss Ratio Rebate Notice Requirements When a Rebate Is Being Issued

Each insurer must provide a notice to:

- All group employers who receive a rebate;
- All current employees enrolled on the plan where the employer receives a rebate;
- All current employees in the group market who receive a rebate directly from the insurer.

The notices are standard and contain information about the insurer's MLR and the rebate. Insurers may not deviate from the content of the standard notices unless populating variable fields or adding the insurer's or the plan's logo.

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[3] Department of Health and Human Services, 45 CFR Part 158, "Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans; Interim Final Rule," Federal Register, December 7, 2011, § 158.243, p. 76596-76600, http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/.

[4] Centers for Medicare & Medicaid Services, Medical Loss Ratio (MLR) Annual Reporting Form Filing Instructions for all Parts, http://cciio.cms.gov/resources/files/mlr-annual-form-instructions051612.pdf.

Notices must be provided by the insurer and not the employer. Notices in the form and manner stated above must be provided in addition to the actual rebate check or premium credit.

Notices must be mailed to employers and subscribers at the mailing address on file by United States first-class mail, postage prepaid. Notices may instead be provided electronically if the insurer regularly communicates electronically with its policyholders and/or subscribers.

All reasonable effort should be made to ensure that each subscriber and employer receives the required notice.

There are two standard notices for the group market. Each is labeled with a number in the top-right corner, for ease of reference. (Form # 1 refers to participants in the individual market)

Form #2 – Group Policyholders and Subscribers when the insurer sends the rebate to the employer, and also to each employee currently enrolled on the group plan.
http://www.cciio.cms.gov/resources/files/mlr-notice-2-group-markets-rebate-to-policyholder.pdf

Form #3 – Group subscribers when the insurer sends the rebate directly to subscribers. This includes (1) church plans that have not agreed to distribute the rebate in the same manner as non-federal governmental plans are required to do, and (2) group health plans that have been terminated at the time the rebate has been issued and the insurer cannot locate the policyholder whose plan participants for employees were enrolled in the group health plan.
http://www.cciio.cms.gov/resources/files/mlr-notice-3-group-markets-rebate-to-subscribers.pdf
Notices must be provided by August 1 of the year following the MLR reporting year for which the rebate is being issued. For example, notices of rebates based on the 2014 MLR reporting year must be provided by August 1, 2015.

The rebate itself may either be included with the Notice, or may be sent separately. The Notice may be sent prior to or after payment of the rebate as long as each is provided by August 1 of the year following the MLR reporting year for which the rebate is issued.

Medical Loss Ratio Rebate Notice Requirements When a Rebate Is Not Being Issued

- For the 2011 MLR reporting year, an issuer whose MLR meets or exceeds the applicable MLR standard required by § 158.210 or § 158.211 must provide each plan participant in the group market, a notice using standard language to inform them that the insurer has met the minimum MLR standards established by the ACA.
- This notice will not include the insurer's MLR for the current or prior reporting year. Instead, the notice will help educate consumers about the MLR measures and direct them to the HealthCare.gov website for information about insurers' actual MLRs.
- In addition, insurers will only need to produce this notice for the 2011 MLR reporting year, when consumer knowledge of MLR is low and the greatest benefit can be achieved by providing enrollees with educational information.

- An insurer who meets or exceeds the applicable MLR standard may provide the one-time notice of MLR separately from any other plan documents provided that they do so prior to or along with the first plan documents that are provided to participants on or after July 2012. (Examples of plan documents include policies, summary plan descriptions and benefit summaries)

http://cciio.cms.gov/resources/files/Files2/2012-0511-medical-loss-ratio-information.pdf

For Additional Guidance:

The MLR guidance is available at: http://cciio.cms.gov/programs/marketreforms/mlr/index.html
DOL's Technical Release 2011-4 is available at: www.dol.gov/ebsa/newsroom/tr11-04.html
IRS's FAQ's is available at: www.irs.gov/newsroom/article/0,,id=256167,00.html

For More Information

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