DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
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Title: Insurance Standards Bulletin Series—INFORMATION

Subject: CCIIO Technical Guidance (CCIIO 2013-0001): Questions and Answers Regarding the Medical Loss Ratio Reporting and Rebate Requirements

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 or ACA), directs health insurance issuers (issuers) to submit a medical loss ratio (MLR) report to the Secretary and issue a rebate if an issuer's MLR is less than the applicable percentage established in section 2718(b) of the PHS Act. The interim final rule with public comment period 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 final rule implementing MLR standards (76 FR 76574) and the interim final rule implementing MLR rebates for non-federal governmental plans (76 FR 76596) were published on December 7, 2011. A final rule implementing an MLR notice (77 FR 28790) was published on May 16, 2012. The MLR regulations are codified at 45 CFR Part 158.

This Bulletin provides MLR guidance on the following topics:

- Affordable Care Act Fees
- Aggregation of Data
- Closed Blocks of Business

II. Questions and Answers

AFFORDABLE CARE ACT FEES (45 CFR §158.162(a)(1) and (b)(1), §158.221, §158.240)

Question #57:
May an issuer exclude from premium in its MLR and rebate calculation the fees it must pay under the Affordable Care Act, such as those required by the risk adjustment program (ACA §§1321(c)(1) and 1343, along with the Independent Offices Appropriations Act (IOAA) authority found at 31 U.S. C. 9701), for funding the Patient Centered Outcomes Research Institute (ACA §6301), and on an issuer's net premium (ACA §9010)?

Answer #57:
Yes. For MLR purposes, issuers may exclude from premium all "Federal taxes and assessments allocated to health insurance coverage reported under section 2718 of the PHS Act," as well as State taxes and assessments, which include "[a]ny industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly…". 45 CFR §§158.162(a)(1) and 158.162(b)(1). ACA assessments or fees are a state or federal assessment and therefore may be excluded from premium under the MLR reporting and rebate requirements. 45 CFR §§158.221(c) and 158.240(c). This MLR treatment is similar to the MLR treatment of Exchange user fees, which is addressed in CCIIO's Technical Guidance Bulletin 2012-02, dated April 20, 2012, Question and Answer #34 [http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf]. However, an issuer's operating costs or any administrative costs associated with taxes or fees, such as those related to implementing and operating data submission and validation systems for the risk adjustment program, are not part of a state or federal assessment and therefore may not be deducted from premium for purposes of the MLR calculation.

AGGREGATING MULTIPLE YEARS OF MLR EXPERIENCE SUBJECT TO DIFFERENT MLR STANDARDS (45 CFR §158.220(b), §158.301, §158.211)

Question #58:
In a state market in which different MLR standards apply to different MLR reporting years, may an issuer account for the difference in standards when aggregating multiple years of data in MLR and rebate calculations?

Answer #58:
Yes. While the MLR regulation does not explicitly address the interaction of the requirement to aggregate multiple years of data (45 CFR §158.220(b)) with HHS adjustments to the MLR standard in the individual market (PHS Act §2718(b)(1)(A)(ii) and 45 CFR §158.301), or higher state MLR standards substituted for the federal minimum MLR standard (45 CFR §158.211), we believe that a method that prevents issuers from being penalized for pricing to the applicable MLR standard each year is permissible.

The permitted method allows issuers in state markets with MLR standards that change over time to scale the prior year experience included in the current year MLR numerator, to account for the higher MLR standard of the current reporting year. The scaling adjustment is the reporting year standard minus the applicable prior year standard, multiplied by the applicable prior year adjusted premium. That amount is then added to the experience from the applicable prior year that is included in the current year MLR numerator. This scaling adjustment is optional for issuers in state markets with MLR standards that change over time.

For example, for an issuer subject to a 75% MLR standard in 2011 and an 80% MLR standard in 2012, who has $100 in adjusted premium in 2011, the 2011 claims and quality improving activities data would have an adjustment of [(80% -75%) * $100] or $5 added to the 2012 MLR numerator, which scales the 2011 experience by the change in the MLR standard.

AN ISSUER WITH ONLY SMALL "CLOSED BLOCKS" OF BUSINESS (45 CFR §158.401)

Question #59:
Will CMS initiate an enforcement action against an issuer of health insurance coverage for failure to file a complete MLR report if that issuer has only grandfathered plans in small closed blocks of business?

Answer #59:
No, but only under the limited circumstances stated here. Based on its enforcement discretion, CMS will not initiate an enforcement action if an issuer of group or individual health insurance coverage fails to submit a full MLR report and its only health insurance coverage exists in grandfathered plans in small closed blocks. To qualify, the issuer's CFO and CEO must attest to and provide all the following information regarding the applicable MLR reporting year:

1. The issuer has ceased offering health insurance coverage, as defined by §2791 (b)(1) of the Public Service Health Act, in the small group, large group, and individual health insurance markets in every state in which it is licensed to offer health insurance coverage;
2. The issuer has only grandfathered health plans (as defined in 45 CFR §147.140(a)) in closed blocks of business that are in run-off;
3. The issuer did not submit a Supplemental Health Care Exhibit (SHCE) or other similar state filing for business during the applicable MLR reporting year, has been exempt from filing a SHCE or similar state filing by the state in which it is domiciled, and submits to CMS evidence of this exemption on state letterhead. If the issuer is not subject to a SHCE or similar state filing requirement, this criterion is not applicable;
4. The issuer has less than 1,000 life years nationwide (combined for all health insurance coverage) for the MLR reporting year; and
5. The issuer has non-credible experience in each state market in which it provides coverage. The issuer must report the number of life-years in each state market for each MLR reporting year that is aggregated to determine whether the issuer has non-credible experience. For example, an issuer with 700 life-years in the 2011 MLR reporting year and 600 life-years in the 2012 MLR reporting year for the same state market would be partially credible in the 2012 MLR reporting year. (45 CFR §§158.230 and 158.231.)

Issuers that meet the criteria for this policy have the option of submitting a completed MLR reporting form, as required by 45 CFR §158.110, instead of this information.

If CMS determines that an issuer does not satisfy the criteria in Question and Answer #59, CMS will notify the issuer that it must complete the full MLR reporting form as specified in 45 CFR Part 158.

Question #60:
How should an issuer notify CMS that its health insurance coverage exists only in grandfathered plans in small closed blocks of business?

Answer #60:
Like all issuers subject to the MLR reporting requirements, a company that meets the criteria described in Question and Answer #59 must register with the MLR module of CMS's Health Insurance Oversight System (HIOS), and complete or confirm the "company issuer association" form in HIOS. The company should check the "small closed blocks of business" box, download the MLR reporting form from HIOS, and for the 2012 MLR reporting year, complete only Part 4, Line 3.1 of the MLR reporting form. The complete instructions are in the MLR Reporting Form Instructions, available through the HIOS MLR module and on the CCIIO website. Registration instructions for HIOS are available at: http://cciio.cms.gov/resources/data/mlr.html.

If CMS determines that an issuer does not satisfy the criteria in Question and Answer #59, CMS will notify the issuer that it must complete the full MLR reporting form as specified in 45 CFR Part 158.