Why States Should Perform Commercial Medical Loss Ratio Exams and What Do I Need to Know?

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The Medical Loss Ratio (MLR) ensures that policyholders receive value for the premium they pay for their health insurance coverage. The MLR exams are about validating that health insurance issuers (issuers) offering commercial individual or group health insurance coverage are complying with the MLR requirements established by the Affordable Care Act (ACA).

Why Perform MLR Exams?
The purpose of a MLR exam is to assess compliance with state MLR regulations, if applicable, and the requirements of Title 45 of the Code of Federal Regulations (CFR), Part 158, which implements section 2718 of the Public Health Service Act (PHS Act). Section 2718 of the PHS Act was added by the ACA and generally requires issuers offering individual or group health insurance coverage to submit an MLR Annual Reporting Form (MLR Form) to the Secretary of the U.S. Department of Health and Human Services (HHS) for each state in which the issuer has written direct health insurance coverage.

The MLR is the proportion of direct premium revenue expended by an issuer on clinical services and activities that improve health care quality in a given state and market (e.g., individual, small group, large group, etc.). Section 2718 of the PHS Act also requires an issuer to provide rebates to the subscriber, policyholder, and/or government agency that paid the premium if it does not meet the MLR standards established by the law for the relevant market. The MLR Form is used by issuers to report the MLR data elements, calculate the MLR ratio and determine the amount of rebates, if applicable.

In order to assess compliance with the federal requirements, a MLR examination should be conducted in accordance with the NAIC's 24 MLR Agreed Upon Procedures (MLR AUPs). The MLR AUPs set forth the procedures to evaluate the validity and accuracy of the data elements and calculated amounts reported on the MLR Form, and the accuracy and timeliness of any rebate payments. The examination includes assessing the accuracy of reported premiums, claims, quality improvement activities (QIA), etc., the principles used and significant estimates made by the issuer, evaluating the reasonableness of expense allocations, evaluating the accuracy and timeliness of rebate payments, if applicable, and determining compliance with relevant statutory accounting principles, MLR regulations and guidance, and the MLR Annual Reporting Form Filing Instructions.

What Do I Need to Know?
There are several components to the MLR calculation along, with some new changes that will start with the 2017 MLR Form filing due July 31, 2018. The MLR is calculated on Part 3 of the MLR Form for each market and contains a numerator, denominator, credibility adjustment and credibility-adjusted MLR. However, the calculation cannot be performed without all of the underlying information that is reported on Parts 1 and 2 of the MLR Form as the information from Part 2 flows into Part 1, and then ultimately to Part 3.

MLR Numerator
The numerator calculation includes reported amounts for incurred claims, QIA, federal premium stabilization program adjustments, and until October 2017, cost-sharing reduction payments from the Federal Government.

There are several key items which must not be included in claims for MLR purposes. Title 45 CFR §158.140(b)(3) details the adjustments that cannot be reported within incurred claims. These include amounts paid to third party vendors for secondary network savings, network development, administrative fees, claim processing and utilization management, as well as amounts paid for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee, including amounts paid to a provider. Generally, based upon our MLR examination experience, when reporting issues arise related to improper inclusion of these types of items, it is in connection with claim amounts reported for capitation arrangements, pharmacy benefit manager contracts and intercompany agreements. In these instances, the issuer is compensating the affiliate or non-affiliated third party vendors for administrative and overhead type expenses and incorrectly reporting these amounts with the claims reimbursement portion of the payment. It is important to understand how transactions related to these type of agreements are recorded and reported by the issuer within the MLR Form to ensure they are properly excluded in accordance with the regulation.

Historically, one of the most significant risk areas with regard to the MLR Form has been the reporting of QIA expenses. Title 45 CFR §158.150 and Title 45 CFR §158.151 provide the guidelines and reporting requirements for QIA expenses. There are five categories of QIA activities: 1) improving health outcomes, 2) preventing hospital readmissions, 3) improving patient safety and reducing medical errors, 4) implementing, promoting and increasing wellness and health activities, and 5) enhancing the use of health care data to support these objectives.

The reporting of QIA expenses generally requires significant judgment on behalf of the issuer, not only regarding the determination of which expenses qualify as QIA expenses, but also the quantification of those activities. In addition, reporting of QIA often involves a complex and detailed cost aggregation and allocation process, which varies by issuer. Issuers may outsource certain QIA programs, which creates additional challenges in the determination and reporting of QIA expenses. For all of these reasons, the frequency of issuers misreporting QIA and the number of issues noted in this area are generally higher than other MLR reporting areas, at least based upon our experience.

A recent change issued by the Centers for Medicare & Medicaid Services (CMS) may significantly change the QIA reporting requirements in the MLR

Form. In the HHS Notice of Benefit and Payment Parameters for 2019 Final Rule, CMS amended Title 45 CFR §158.221 by adding a new paragraph (b)(8), which provides issuers with the option to report QIA expenses as a single fixed percentage of 0.8 percent of earned premium beginning with the 2017 MLR reporting year, in lieu of determining and reporting actual QIA expenses.

The objective of the simplified fixed percentage QIA option is to alleviate the administrative cost and substantial effort required by issuers to identify, track and report actual QIA expenses. This change is optional and issuers can continue to report actual QIA expenses if they undertake the effort to identify, track and document actual QIA expenses. In the final ruling, CMS included specific conditions which must be adhered to by those issuers who elect the option to report QIA as a single fixed percentage. These conditions apply to issuers and their affiliates and are as follows: 1) apply the option consistently across all of the states and markets subject to the MLR requirements, 2) apply the reporting method for a minimum of three consecutive MLR reporting years, and 3) elect the option for all affiliated issuers. If an issuer decides to use the fixed percentage option, it does not have to prove that it has actual QIA expenditures.

For the 2014 through 2016 MLR reporting years, the numerator of the MLR calculation included the impact of amounts received and paid by the issuer in connection with the federal premium stabilization programs. The federal premium stabilization programs were comprised of amounts reported by the issuer for the Federal Transitional Reinsurance Program payments expected from HHS, Federal Risk Adjustment Program receivables or additional payables, and Federal Risk Corridor Program receivables or additional payables. However, regulations covering the Federal Transitional Reinsurance Program and the Federal Risk Corridor Program expired at the end of 2016, which will impact not only the amounts reported in the MLR numerator, but will also impact the reporting of taxes in Part 1, Section 3 of the MLR Form as contributions related to the Federal Transitional Reinsurance Program are no longer required of issuers. In addition, for the 2017 MLR Form, there will no longer be reporting in the Risk Corridor columns on Parts 1, 2 and 3 of the MLR Form. As a result, the Federal Risk Adjustment Program, which is a permanent program, will be the only remaining premium stabilization program that will impact the amounts reported on the 2017 MLR Form and beyond.

In addition, there has been other recent regulatory actions that will impact issuers' reporting of cost-sharing reduction (CSR) payments reported on Part 3 of the numerator calculation on the MLR Form. In October 2017, President Trump issued an executive order which effectively ended the payment of CSR to issuers selling qualified individual health plans. Prior to this executive order, the Federal Government made CSR payments to issuers to compensate them for complying with the ACA requirements to ease the patient's share of

costs in Silver plans on the Exchange through the reduction of deductibles and co-pays of enrollees. Unless there is a change to the current executive order or additional legislation enacted through Congress to fund the CSR payments, issuers will no longer receive or report CSR payments on Part 3, Line 1.4 of the MLR Form. The elimination of the CSR payments, which is accounted for as a reduction to incurred claims in the MLR Form, will cause an increase in incurred claims as issuers will still be responsible for the CSR payments with no reimbursement from the Federal Government. The potential exists that the elimination of CSR payments may cause increases in premium rates charged by issuers in order to offset the loss of the reimbursement of these payments. The status of CSR payments should be monitored for any changes as they will directly impact the MLR calculation.

Beginning in 2015, the MLR Form Filing Instructions included a key change to the reporting of experience rating refund reserves. The instructions explicitly state that premium stabilization reserves must be excluded from the amounts reported for experience rating refund reserves in Part 2. Given that this exclusion was added in 2015, there is a risk that an issuer many not have properly captured this reporting change and, as a result, is improperly including premium stabilization reserves within incurred claims. Improper inclusion of these reserves would result in an overstatement of incurred claims, which increases the MLR numerator as well as the issuer's MLR, leading to a potential inappropriate reduction or elimination of rebates.

MLR Denominator

The denominator calculation includes earned premium reported on a direct basis less taxes, which are comprised of federal income tax, state income tax and other taxes, along with licensing and regulatory fees.

Title 45 CFR §158.130 defines direct earned premium as all the monies paid by a policyholder or subscriber as a condition of receiving coverage from an issuer. These monies are to include any fees or other contributions associated with the health policy. These fees and contributions include all monies received by an issuer under advanced payment tax credits (APTC) for on-exchange subscribers, any administrative fees charged to a policyholder, the 9010 fee that is charged with premium, and agent/broker commissions that are a part of the premium charged to a policyholder. The impact of assumed and ceded reinsurance is not included in the premium or claims reported in the MLR Form unless 1) it is a 100% assumption with novation, or 2) a 100% indemnity reinsurance and an administrative agreement effective prior to March 23, 2010. If either of these two criteria are met, then only the assuming reinsurer reports the experience for the entire year, regardless of the date of the assumption.

A key objective in the testing of premiums is to ensure a policy is reported in the proper market on the MLR Form. There are four types of commercial markets: individual, small group, large group and student health. Whereas the individual, small group and large group markets are reported according to the situs state of the policy (the state the policy was issued), student health insurance is reported only in the Grand Total page of the MLR Form and the situs state is not applicable. This is due to the fact that student health is considered national coverage and not determined by the specific state in which the policy was issued. The issues that arise in determining the market classification involve sole proprietors, partners in partnerships and the size of the group. Section (c) of Title 29 CFR §2510.3-3 defines single business owners, whether incorporated or unincorporated, and partners in a partnership as individuals and not employees. Although some states allow sole proprietors and partners to be reported as a small group, the federal definition states that unless a sole proprietor or partnership provides health coverage for one or more unrelated employees, it is to be reported in the individual market.

Issuers are allowed to use the state definition of a small group for market classification purposes. Prior to 2016, if the state defined a small group as up to 50 employees, an issuer could classify groups having up to 50 total average employees in the preceding calendar year as a small group, but the federal definition of small group was 100 total average employees for the preceding calendar year. Issuers were allowed to use the state definition of the situs state until 2016, when issuers were required to use the federal definition. As many states already defined a small group as one that has 50 employees, and there was state support for keeping that, CMS lowered the total average employees for the preceding calendar year from 100 to 50 for purposes of determining group size. Approximately 15 states had already changed their small group definitions to 100 in anticipation of the required change, effective as of January 1, 2016. Issuers writing policies in states that changed the small group definition to 100 must now use the state definition of 100 and not the federal definition of 50 for small group classification purposes. Additionally, issuers are allowed the option of restating the prior two years' experience (PY1 and PY2 columns) reported on the MLR Form, if the situs state defines small group as 100 instead of the previous definition of 50. If an issuer chooses to restate the prior two years' experience, the restatement must also include all of the related claims, QIA, taxes, life years, etc., related to the restated experience.

In addition to the changes related to MLR group size market classification above, there was also recently issued guidance regarding the requirements for how issuers count and define employees in the determination of market size. For the 2016 MLR reporting year and prior, the federal definition for determining the number of employees for market classification purposes must be used, which is the total average number of employees in the preceding calendar year. The total average number of employees includes all employees in the preceding calendar year, i.e., full time, part-time and seasonal

employees, not just eligible employees. However, the Center for Consumer Information and Insurance Oversight (CCIIO) recently issued new guidance in an Insurance Standards Bulletin dated April 9, 2018 with regard to counting employees for the determination of group size for MLR reporting. Based on this guidance, beginning with the 2017 MLR reporting year, an issuer may elect to use either the federal definition described above or the counting method used in the HHS operated Risk Adjustment Program for determining market classification, which defers to the applicable state counting method subject to certain criteria as more fully described in the issued bulletin.

Recently, there have been discussions concerning allowing the formation of Association Health Plans (AHP) to help individuals and small groups obtain more affordable health coverage. On October 12, 2017, President Trump issued Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States". The Executive Order proposes to accomplish this by prioritizing three areas for improvement in the near future, as follows: 1) use of AHPs; 2) short-term limited duration insurance, and 3) health reimbursement accounts (HRAs). Regarding the AHPs, the Executive Order directed the Secretary of Labor to, within 60 days of the Order, consider proposing regulations or revising guidance consistent with the law to expand access to health coverage by allowing more employers to form AHPs. One of the major issues with AHPs is that, under section 3(5) of Employee Retirement Income Security Act (ERISA), associations must have a bona fide purpose to form other than just offering health coverage. The United States Department of Labor (DOL) has issued proposed rules to modify the ERISA guidance regarding associations, allowing associations to form solely for the purpose of offering health care coverage. Qualifications to this rule would be the association could form only if there is commonality between the employers in the group, such as industry or geography. As for geography commonality, the proposed rule requires that the region the association would cover not exceed the boundaries of the same state or metropolitan area if that metropolitan area includes more than one state. The proposed rules would require that only employees and former employees of employer members (and family/beneficiaries of those employees and former employees) may participate in a group health plan sponsored by the association and does not allow the association to make coverage available to anyone other than as previously described. The purpose of the proposed rule is to provide affordable healthcare for small groups, which would also include sole proprietors and partnerships. The change is based on the assumption that associations would have economies of scale that would translate to lower cost health insurance. The proposed rule was issued for comment in January 2018 with the comment period ending on March 6, 2018, with a final rule anticipated to be issued in the summer of 2018. If the proposed rule passes, it will require the Associations' market to be classified in the MLR Form according to the number of total subscribers.

Taxes are reported in Part 1, Section 3 of the MLR Form and flow into the Part 3 denominator section. As premiums are also part of the denominator, the two sections are usually associated with each other. Total taxes reported in Part 1 are subtracted from premium in Part 3. An increase or decrease in taxes has an inverse effect on the denominator. Therefore, the overstatement of taxes is the risk on which to focus, as higher taxes lead to a lower denominator, which improves the issuer's MLR and potentially lowers or eliminates a rebate liability.

Taxes include federal and state income taxes, Patient Centered Outcomes Research Institute (PCORI) fees, 9010 fees, other federal taxes and assessments, state excise, business and other taxes, state premium taxes, community benefit expenditures, Federal Transitional Reinsurance Program Contributions (not applicable after 2016) and other federal and state regulatory authority licensing and other fees.

The reporting of federal and state income taxes is generally self-explanatory, except that not only are tax expenses reported, but tax benefits are to be reported as negative values. Federal and state income taxes that are expressly excluded from reporting on the MLR Form are taxes related to investment income and capital gains. These taxes are reported in Part 1, Section 9 of the MLR Form, but only for informational purposes.

PCORI fees are based on covered lives and assessed to health plan sponsors and issuers by the Internal Revenue Service (IRS) code. They are designed to assist patients, clinicians and policymakers in making informed health decisions by advancing the quality and relevance of evidence-based medicine. PCORI fees are paid by both health insurance issuers and self-funded employer health plans, which are not subject to MLR reporting and which report their PCORI fees through the issuer that administers the claims of the self-funded plan.

The ACA 9010 fees are imposed on issuers generally with net written premiums exceeding $25 million, and charged to policyholders as part of premium. There are some exceptions, but they are complex and beyond the scope of this article. An issuer acts as a pass-through for collection of the 9010 fee, much in the same way sales taxes are handled through a retailer. The 9010 fees are due to the government by September 30th, called the fee year, in which the fees are payable. The actual fees, however, were collected for the previous calendar year. For example, fees that were paid on September 30, 2017, were actually the fees collected in the 2016 calendar year. The government declared a moratorium on the 2017 and 2019 calendar years, therefore, no 9010 fees were collected in 2017 and will not be collected in the 2019 calendar year. Fees start to be collected again in 2018 and will be remitted to the Federal Government by September 30, 2019.

Other federal taxes and assessments are those that are not specifically excluded by regulation. However, this does not include fines, penalties or examination fees. If an issuer underwent an IRS audit and had to pay penalties and interest, those penalties and interest are not treated as a deduction from earned premium on this line in the MLR Form. State excise, business and other taxes do not include sales tax or real estate/property taxes. Although these taxes are not expressly excluded under the regulation, they are not included as a specific state tax. Real estate/property taxes are not state taxes and CCIIO has determined that sales taxes are not includable as 'other taxes' or business taxes. Examples of allowable taxes are industry-wide assessments paid to the state directly, but surcharges directly related to claims are not includable; premium subsidies designed to cover the cost of providing indigent care or other access to health care, as long as they are directly related to indigent care or improving health access; and, guaranty fund assessments, which also may be deferred if the assessments will be offset in future years through reductions in state taxes or premium surcharges by state law. If these are deferred, the assessments are reported in the year of offset. Assessments of state boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes and advertising required by law, regulation or ruling, except advertising associated with investments are also considered allowable taxes.

Payroll taxes were specifically not allowed as a deduction from premium on Part 1 of the MLR Form, starting with the 2016 MLR reporting year; however, in CMS's proposed 2019 changes issued for comment, it is reevaluating allowing issuers to report federal and state employment taxes in the tax section once again.

Credibility Adjustment

The credibility adjustment consists of the base credibility factor and the deductible factor, which are multiplied by each other to determine the total credibility adjustment. Each factor is calculated separately for each market on the MLR Form. The ACA requires the MLR calculation to include methodologies to account for special circumstances, such as smaller or newer plans and, as a result, these two adjustments were adopted. The base credibility factor exists to address the statistical unreliability of experience of plans with low enrollment and which may have more variability in claims experience from year to year. The deductible factor exists for issuers that have a large share of high deductible plans, which generally have more variability in claims experience from year to year. An issuer that reports a deductible factor other than 1.0 tends to have an extremely high error rate based upon past examination experience, due to issuers incorrectly calculating the average deductible, which results in an incorrect deductible factor and thus an incorrect credibility adjustment.

Credibility-Adjusted MLR
The credibility-adjusted MLR is the calculation of the numerator to the denominator, plus the credibility adjustment, and is calculated for each market. The credibility-adjusted MLR by market is compared to the MLR standard (generally 80% for the individual and small group markets and 85% for large group market). If the credibility-adjusted MLR is below the standard, then rebates are required to be paid to enrollees.

Conclusion
The regulations and reporting requirements for the MLR Form can be complex, so understanding the different components and staying well informed about the evolving changes to the MLR Form and updates to existing guidance or the issuance of new guidance is essential to conducting a quality and efficient MLR examination.

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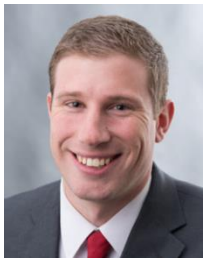

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