



Date: May 24, 2012
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Title: Insurance Standards Bulletin Series– INFORMATION
Subject: CCIIO Technical Guidance – (CCIIO 2012-003): Questions and Answers Regarding the Medical Loss Ratio Reporting Form

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 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 requirements (76 FR 76574) and the interim final rule implementing MLR rebate requirements for non-Federal governmental plans (76 FR 76596) were published on December 7, 2011. The MLR regulations are codified at 45 CFR Part 158. A final rule implementing an MLR notice requirement (77 FR 28790) was published on May 16, 2012.

This Bulletin provides MLR guidance, including regarding the MLR Reporting Form instructions and the Health Insurance Operating System (HIOS) instructions, on the following topics:

- Applicability of MLR Rule to Excepted Benefits Plans
- Determining the Number of Employees of an Employer
- Attestation, Uploading and Submission of MLR Report
- Group Health Insurance Coverage with Dual Contracts
- Experience Rating Refunds
- Notices
- Enforcement

II. Questions and Answers

APPLICABILITY OF THE MEDICAL LOSS RATIO RULE TO CERTAIN TYPES OF PLANS (45 CFR §158.102)

Question 38:

Must an issuer that offers only excepted benefit plans submit a Medical Loss Ratio (MLR) Reporting Form?

Answer 38:

No. Section 2718(a) of the PHS Act and its implementing regulation, 45 CFR §158.102, provide that the MLR requirements apply only to a health insurance issuer offering group or individual health insurance coverage.

PHS Act §2722(b) provides that excepted benefits, as defined in PHS Act §2791(c), are exempt from the requirements of subparts 1 and 2 of the PHS Act for individual coverage or any group health plan. PHS Act §2718 is in Subpart 2 of the PHS Act and, therefore, an issuer of only excepted benefits is not subject to the MLR filing and rebate requirements. However, an issuer that offers health insurance coverage that is subject to §2718 of the PHS Act and also has experience that is not subject to §2718 of the PHS Act is required to file an MLR Reporting Form that includes the issuer's experience that is not subject to the MLR requirements.

DETERMINING THE NUMBER OF EMPLOYEES OF AN EMPLOYER (45 CFR §158.103)

Question #39:

How should an issuer determine the number of employees of an employer, for the purpose of determining if an employer is a large employer or a small employer?

Answer #39:

An issuer should determine the number of employees of an employer in accordance with Public Health Service Act (PHS Act) §2791(e), as referenced in 45 CFR §158.103. PHS Act §2791(e) defines a "large employer" as one that "employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year," and a "small employer" as one that "employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year."

On May 16, 2012, CMS published Interim Final Rule, Correcting Amendment (77 FR 28789), which indicated that we were revising the preamble language of the Medical Loss Ratio Interim Final Rule (75 FR 74864 (December 1, 2010)) to "eliminate any ambiguity resulting from the fact that Federal and State law may differ on how an issuer determines the number of employees an employer has . . .". The Correcting Amendment had inadvertently identified the incorrect Federal standard (using the last day of the year to determine the number of employees), instead of using the correct standard set forth in PHS Act §2791(e).

ATTESTATION, UPLOADING AND SUBMISSION OF MLR REPORT (45 CFR §158.110(b)):

Question 40:

Which individuals may act as the primary attestors for an issuer's MLR Reporting Form?

Answer 40:

A health insurance issuer offering group or individual health insurance coverage must designate four separate individuals who may attest to the information being submitted on the issuer's MLR

Reporting Form: two primary attesters and two back-up attesters. Using the HIOS registration form, the issuer must designate the Chief Executive Officer (CEO) or President as one primary attester and the Chief Financial Officer (CFO) as the other primary attester. If the issuer does not have such officers, the next highest ranking officers acting in the capacity of either the CEO or President, and the CFO should be designated as the primary attesters.

Question 41:

Which individuals may act as back-up attesters for an issuer's MLR Reporting Form?

Answer 41:

The next highest ranking officers that are designated by the issuer to act in the capacity of either the CEO or President, and the CFO should be designated as the back-up attesters.

If the issuer does not have four officers, the issuer may request an exception to the requirement that it designate four officers – two as primary attesters and two as back-up attesters. The exception process should be initiated by an email from the issuer's CEO or President which affirms that the issuer has fewer than four officers. The email should be addressed to HIOS Helpdesk at insuranceoversight@hhs.gov.

Question 42:

May an issuer designate a primary attester as a back-up attester?

Answer 42:

No. An issuer must designate four different individuals – two as primary attesters and two separate individuals as back-up attesters.

Question 43:

May the CEO of a parent company act as an attester for a subsidiary?

Answer 43:

A subsidiary without a CEO or President, or without a CFO, may designate its next highest ranking officers as one of its primary attesters. A subsidiary without a CEO or President, or without a CFO may also designate its holding company's chief officers (CEO or President, and CFO) as back-up attesters for the subsidiary.

Question 44:

May an issuer's primary attesters and back-up attesters act as the issuer's "up-loaders," i.e. the individuals authorized to upload the issuer's MLR Report to the HIOS system?

Answer 44:

An issuer must designate two individuals as MLR Reporting Form "up-loaders." These individuals are responsible for uploading the issuer's completed MLR Reporting Form to HIOS. An issuer's up-loader and back-up loader may not be a primary attester or back-up attester.

Question 45:

May an issuer designate an employee of its third party administrator as one of its authorized up-loaders?

Answer 45:

Yes. The issuer may designate an employee of its third party administrator as one of its authorized up-loaders.

Question 46:

How many HIOS registration numbers may an issuer have for any one State?

Answer 46:

Each issuer must have only one HIOS registration number for each State in which the issuer offers health insurance coverage. An issuer with multiple HIOS registration numbers in a State should contact the HIOS Helpdesk at insuranceoversight@hhs.gov.

Question 47:

How many MLR forms must each issuer file?

Answer 47:

Each company will download a HIOS-created zip file that contains an MLR Reporting Form for each State in which the issuer indicated, on its HIOS registration form, that it offered health insurance coverage, as well as a Grand Total report that the issuer will use to aggregate its experience nationwide. One MLR Reporting Form must be prepared and submitted for each State in which the issuer has written direct health insurance coverage or has direct amounts paid, incurred or unpaid for the provision of health care services. In addition, each issuer that offers health insurance coverage and is subject to the MLR reporting requirements must submit a Grand Total report.

AGGREGATE REPORTING (45 CFR §158.120)

Question 48:

How should an issuer report “dual contract group health coverage” in the “12/31” column of the MLR Reporting Form, since the instructions indicate that the 12/31 column matches the NAIC’s Supplemental Health Care Exhibit (SHCE) but the SHCE does not allow an issuer the option to include the dual contract group health coverage in its report?

Answer 48:

CMS recognizes that some cells in the “3/31” columns cannot be edited by the issuer and are based on information that is entered into the corresponding “12/31” columns. For such data elements, an issuer must enter into the “12/31” column the experience as instructed by the “3/31” column instructions, to ensure that the “3/31” column has accurate data and yields correct MLR and rebate calculations.

The MLR regulation and MLR Reporting Form allow an issuer the option to aggregate dual contract group health coverage, and the SHCE does not allow that option. Thus, entering on the

MLR reporting form the amount reported by the issuer on the SHCE would not accurately capture the data required by the MLR regulation and MLR Reporting Form. For an issuer that chooses to aggregate dual contract group health coverage on its MLR Reporting Form:

- the in-network issuer should, in the “12/31” column cells which correspond to the “3/31” column cells that cannot be edited by the issuer, report premium and other required data including the experience of the affiliated issuer providing the out-of-network coverage along with the in-network experience being reported; and
- the out-of-network affiliated issuer should, in the “12/31” column cells which correspond to the “3/31” column cells that cannot be edited by the issuer, report premium and other required data excluding that out-of-network experience being reported by the in-network issuer.

We recognize that in such cases the “12/31” column will not match the NAIC SHCE.

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

Question 49:

The MLR Reporting Form Instructions (Instructions) direct an issuer to report “experience rating refunds” in both the premium and claims sections of Part 2. Is this correct?

Answer 49:

Yes. 45 CFR § 158.140(a)(5) states that incurred claims, which are included in the MLR numerator, must include experience rating refunds. However, CMS recognizes that issuers traditionally report this experience as premium, which is included in the MLR denominator. Therefore, the Instructions direct an issuer to report experience rating refunds separately in both the Premium and Claims sections of Part 2 of the MLR Reporting Form, but to exclude experience rating refunds from written premium. An issuer’s MLR and MLR rebates are calculated with experience rating refunds factored into only the issuer’s incurred claims as provided in 45 CFR § 158.140(a)(5).

NOTICES (45 CFR §158.251)

Question 50:

When the regulation requires that notice be sent to “each policyholder and subscriber of a group health plan,” does the term “subscriber” refer to an employee enrolled in the group health plan?

Answer 50:

Yes. 45 CFR §158.251, published on May 16, 2012 (77 FR 28790), requires an issuer in a group market to send the MLR information notice to the group policyholder (typically an employer) and to each subscriber of the group policyholder (typically an employee). If there are multiple enrollees in the same household enrolled in the same health plan, an issuer needs to provide only one subscriber notice to the household. In addition, as stated in §158.251, the “notice may be included with other plan documents” sent to employees.

ENFORCEMENT (45 CFR §158.401)

Question 51:

There are various MLR provisions that apply to aggregating experience that require issuers to report information in a different manner than they have been required to do in the past, or in some cases under current State law, for example, how to report policies sold to sole proprietors. If issuers do not have accurate information to classify sole proprietor policies, what should they do now?

Answer 51:

CMS is working together with stakeholders to help them come into compliance with the MLR provisions as well as other provisions of the Affordable Care Act. We expect issuers to make reasonable efforts, in good faith, to obtain and accurately categorize the information issuers are required to report regarding the experience of sole proprietors. However, we recognize that for the 2011 MLR reporting year, certain information that is necessary to attribute this experience to the small group or individual market may not be known to the issuer. For the 2011 MLR reporting year, an issuer may not know whether a policy that under State law may be considered a group of one and thus a small group policy has as its only insured a sole proprietor's spouse, and thus should be considered an individual policy under Federal law that should be aggregated with the issuer's individual market experience. Under this circumstance, an issuer should make a good faith effort to submit an accurate filing based on the information it has at the time of the filing.