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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 158

[CMS-9998-IFC3]

Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Under the Patient Protection and Affordable Care Act; Correcting Amendment

AGENCY: Center for Medicare and Medicaid Services (CMS), Department of Health and Human Services.

ACTION: Interim final rule; correcting amendment.

SUMMARY: This document corrects technical errors that appeared in the interim final rule published in the **Federal Register** on December 1, 2010, entitled “Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act” and in the correction notice published in the **Federal Register** on December 30, 2010, entitled “Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Corrections to the Medical Loss Ratio Interim Final Rule With Request for Comments.”

DATES: Effective date: This document is effective on [**OFR insert date of publication in the Federal Register**].

Applicability date: The corrections are applicable on January 1, 2011.

FOR FURTHER INFORMATION CONTACT:

Carol Jimenez, (301) 492-4457, MLRQuestions@cms.hhs.gov.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2010-29596 of December 1, 2010 (75 FR 74864) and FR Doc. 2010-32466 of December 30, 2010 (75 FR 82277), there were a number of technical errors that are identified and corrected in the “Correction of Errors” section below.

A. Regulatory Overview

On December 1, 2010, we published an interim final rule in the **Federal Register** (75 FR 74864) (hereinafter referred to as the “2010 MLR rule”) to implement medical loss ratio (MLR) requirements for health insurance issuers under section 2718 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act. The regulations in the 2010 MLR rule became effective January 1, 2011.

On December 30, 2010, we published a correction notice in the **Federal Register** (75 FR 82277) (hereinafter referred to as the “2010 MLR correction notice”) to correct several regulations set forth in the 2010 MLR rule. The regulations in the 2010 MLR correction notice became effective January 1, 2011, as if they had been included in the 2010 MLR interim final rule.

The provisions in this correcting amendment are also effective as if they had been included in the 2010 MLR interim final rule. Accordingly, the corrections are effective January 1, 2011.

B. Overview of the Deadline for Issuers to Report Their Annual Experience

The 2010 MLR rule established details regarding an issuer’s obligation under section 2718 to report information (for the prior calendar year) to the Department of Health and Human Services (HHS) by June 1st of each year on how it used its premium revenue. The first such

report is due on June 1, 2012. This information is used by HHS to determine the issuer's MLR for the year in question, which reflects the percentage of premium revenue expended on medical claims and health care quality improvement. Section 2718 establishes MLR standards for the percentage that must be spent on such costs: 80 percent for the individual and small group insurance markets and 85 percent for the large group market. An issuer that fails to meet the applicable MLR standard must pay a premium rebate to policyholders. To assist the issuer with reporting its experience, HHS developed and published an MLR Annual Reporting Form, with instructions, that the issuer must complete and submit. This correcting amendment makes minor revisions to the regulations to help clarify how an issuer will capture and report its 2011 experience. Because these corrections merely clarify the terms of the 2010 MLR interim final rule that took effect on January 1, 2011, the changes in this correcting amendment are applicable on January 1, 2011.

II. Summary of Errors

A. Corrections of Errors in the 2010 MLR Rule Preamble

We are making several technical and clarifying changes to the 2010 MLR rule. On page 74868, in the section regarding small group market and large group market, the 2010 MLR rule described how the PHS Act defined "small group" before the enactment of the Affordable Care Act, without explicitly addressing how to determine the number of employees for purposes of that definition. Therefore, we are revising the preamble language to reflect the fact that the PHS Act defined a group in terms of the number of employees on the last day of the calendar year with "2 to 50 employees in a small group and 51 or more employees in a large group." This change will 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, and accurately reflects

that the Employee Retirement Income Security Act (ERISA) of 1974 governs this issue and ERISA instructs an issuer or employer to use the last day of the year to determine the number of employees.

On page 74884, in the section regarding *de minimis* rebates, the 2010 MLR rule stated that issuers must aggregate the *de minimis* rebates and distribute them in equal amounts to all then-current enrollees who receive a premium credit. We are revising the preamble language by removing the words “then current” before “enrollees” because these words are technically inaccurate and conflict with language elsewhere in the preamble, as there are circumstances when those receiving rebates are no longer enrollees at the time of the rebate. In addition, we are deleting the words “premium credit” and replacing them with the word “rebate.” This change reflects the fact that, as made clear elsewhere in the rule, the rebate may be provided in one of several ways and not just by a premium credit.

B. Corrections of Errors in the Regulations Text

1. Errors in the 2010 MLR Rule

On page 74922, in §158.103 “Definitions,” for clarity we are renaming “Multi State Blended rate” to read as “Blended Rate.” This change corrects an inadvertent error in this section that qualifies “blended rate” by the words “multi-State.” As clear from other parts of the 2010 MLR rule, an issuer can take advantage of this provision even if the employer’s employees are in the same State as long as the coverage meets the remaining elements of the definition and the rate is blended.

On pages 74922 through 74923, we are revising §158.120(d)(1) to make explicit that where the individual market business is sold through an association or a trust, the experience of the issuer must be included in the State report for the issue State of the certificate of coverage.

As made clear elsewhere in the 2010 MLR rule, an individual policy may also be issued to a trustee who is the policyholder, and thus the word “trust” should be added to §158.120(d)(1). We are also revising §158.120(d)(2) to state that for employer business issued through a group trust or multiple employer welfare association (MEWA), the experience of the issuer must be included in the State report for the State where the employer (if sold through a trust) or the MEWA (if the MEWA is the policyholder) has its principal place of business. These changes reflect in the text of §158.120(d)(2) when it is appropriate to report the policy’s experience based on the situs of the employer versus that of the MEWA.

On page 74923, we are revising §158.130(b)(3) to specify that earned premium must include adjustments to account for any experience rating refund when it is incurred, rather than when it is paid, and revising §158.140 (a), General requirements, to specify that the report required in §158.110, which includes reserves for contingent benefits, include any incurred experience rating refunds (rather than just those that are paid or received). These changes are necessary in order to make the language in §158.130(b)(3) consistent with the National Association of Insurance Commissioners (NAIC’s) recommendations, which in the preamble we stated that we were adopting.

On page 74923, we are also revising §158.140 (a), General requirements, to make our intent explicit that the report required in §158.110 only include the medical claim portion of the total amount claimed in lawsuits, and not claims for pain and suffering damages, legal fees, court costs, punitive damages or anything other than the underlying medical claim. We are also adding language to §158.140 (a) referencing a 3-month run out period for incurred claims, which was inadvertently omitted. This correction is needed to make this provision consistent with the NAIC’s recommendations to the Secretary, dated October 27, 2010, which contain a 3-month

run-out for incurred claims, and with our statements in the 2010 MLR rule that we were following the NAIC's recommendations to the Secretary. For the same reason, we are further clarifying that although there is a 3-month run-out period for incurred and paid claims, contract reserves should still be determined as of the last day of the reporting year as there is no parallel 3-month extension for calculating contract reserves.

On page 74923, in §158.140(a)(5), we inadvertently used the word "paid" and omitted the word "incurred" before the words "exclude rebates paid as required". Therefore, we are correcting this typographical error.

On page 74924, in §158.150(b)(2)(i)(A)(1), we mistakenly made an incorrect reference to "section 3606 of the Affordable Care Act" when it is clear from context that the reference was to "section 3502 of the Affordable Care Act". Therefore, we are correcting this error.

On page 74925, in §158.150(c)(14), we mistakenly made an incorrect cross reference to "paragraph (c)" instead of referencing "paragraphs (a) or (b)." The correction makes clear that items not included as activities to improve health care quality are exclusions.

On page 74928, in §158.232(c)(1)(i), we are revising the calculation of the per-person deductible for a policy that covers a subscriber and the subscriber's dependents to mirror the NAIC's recommendations, which we indicated in the 2010 MLR rule.

2. Error in the 2010 MLR Correction Notice

The 2010 MLR rule established §158.120(d)(1), describing exceptions. This section was amended by the 2010 MLR correction notice (see 75 FR 82278) and currently reads: "For individual market business sold through an association, the experience of the issuer must be included in the State report for the issue State of the certificate of coverage." In this correcting amendment, we further amend §158.120(d)(1) by adding the words "or trust" after the word

“association” to reflect the fact that under the 2010 MLR rule the exception also applies to individual market business sold through a trust.

III. Correction of Errors in the Preamble

In FR Doc 2010-29596 of December 1, 2010, make the following corrections:

1. On page 74868, third column, second full paragraph—

A. In line 21, insert the phrase “the number of employees on the last day of the calendar year, with” before “2 to 50 employees.”

B. In lines 21 and 22, insert the phrase “in a small group and 51 or more employees” before “and a large group.” Remove the word “and” before “a large group” and the words “in terms of 51 or more employees” after the words “a large group.”

2. On page 74884, third column, fifth full paragraph—

A. In line 14, remove the words “then current.”

B. In line 15, revise the phrase “premium credit” to read “rebate.”

IV. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)), and section 553(d) of the APA ordinarily requires a 30-day delay in effective date of final rules after the date of their publication in the **Federal Register**. These requirements may be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued.

In this case, we believe that it is unnecessary to provide for a public comment period or to delay implementing these corrections, as they clarify provisions of a final rule that has been subjected to notice and comment procedures and do not make any substantive changes to it.

List of Subjects in 45 CFR Part 158

Administrative practice and procedure, Claims, Health care, Health insurance, Health plans, Penalties, Reporting and recordkeeping requirements.

Accordingly, 45 CFR part 158 is corrected by making the following correcting amendments:

PART 158--ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

- 1. The authority citation for part 158 continues to read as follows:

Authority: Sec. 2718 of the Public Health Service Act (42 U.S.C. 300gg-18, as amended.)

- 2. Amend §158.103 as follows:

- A. Remove the definition for “Multi-State blended rate.”

- B. Add a new definition for “Blended rate” in alphabetical order.

The addition reads as follows:

§158.103 Definitions.

* * * * *

Blended rate means a single rate charged for health insurance coverage provided to a single employer through two or more of an issuer's affiliated companies for employees in one or more States.

* * * * *

- 3. Amend §158.120 by revising paragraphs (d)(1) and (d)(2) to read as follows:

§158.120 Aggregate reporting.

* * * * *

(d) * * *

(1) For individual market business sold through an association or trust, the experience of the issuer must be included in the State report for the issue State of the certificate of coverage.

(2) For employer business issued through a group trust or multiple employer welfare association (MEWA), the experience of the issuer must be included in the State report for the State where the employer (if sold through a trust) or the MEWA (if the MEWA is the policyholder) has its principal place of business.

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§158.130 [Amended]

4. In §158.130(b)(3) remove the words “paid or received” and add the word “incurred” in their place.

5. Amend §158.140 by revising paragraph (a) introductory text and paragraph (a)(5) to read as follows:

§158.140 Reimbursement for clinical services provided to enrollees.

(a) General requirements. The report required in §158.110 must include direct claims paid to or received by providers, including under capitation contracts with physicians, whose services are covered by the policy for clinical services or supplies covered by the policy. In addition, the report must include claim reserves associated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the medical claim portion of lawsuits, and any incurred experience rating refunds. Reimbursement for clinical services, as defined in this section, is referred to as “incurred claims.” All components of and adjustments to incurred claims, with the exception of contract reserves, must be calculated based on claims incurred only during the MLR reporting year and paid through March 31st of the following year. Contract reserves must be calculated as of December 31st of the applicable year.

* * * * *

(5) Incurred claims must include incurred experience rating refunds and exclude rebates paid as required by §158.240 based upon prior MLR reporting year experience.

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§158.150 [Amended]

6. Amend §158.150 as follows:

A. In paragraph (b)(2)(i)(A)(1), remove “section 3606” and add in its place “section 3502.”

B. In paragraph (c)(14), remove the reference “paragraph (c) of this section” and add in its place the reference “paragraph (a) or (b) of this section.”

7. Amend §158.232 by revising paragraph (c)(1)(i) to read as follows:

§158.232 Calculating the credibility adjustment.

* * * * *

(c) * * *

(1) * * *

(i) The per person deductible for a policy that covers a subscriber and the subscriber's dependents shall be the lesser of: the sum of the deductible applicable to each of the individual family members; or the overall family deductible for the subscriber and subscriber's family, divided by two (regardless of the total number of individuals covered through the subscriber).

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Dated: May 10, 2012

Jennifer Cannistra,

Executive Secretary to the Department.

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