MEDICAL LOSS RATIO REQUIREMENTS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The comprehensive health care reforms enacted into law in the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 make significant statutory changes affecting the regulation of and payment for many types of private health insurance.

Professionally licensed agents, brokers and benefit specialists will be at the forefront in helping to implement many of the changes coming in the months and years ahead, and to educate employers, individuals and families on complying with many of the new rules and requirements and making the most of their health insurance and other benefit options.

The new laws specifically include health insurance agents and brokers as the marketing force and source of subsidy assistance for the purchase of private health insurance coverage both inside and outside the new exchanges.[1] Moreover, agent and broker commissions and compensation will continue to be established in the marketplace with state oversight—through negotiations between agents/brokers, insurance carriers and those for whom they provide services, based on the particular services involved and the competitive environment. Government regulators will not set agent commissions and fees, as was initially proposed when the Senate was considering the legislation.[2]

Among the provisions that may affect the agent/broker industry and its role in the new health reform law is the requirement for health insurance carriers to adhere to federal minimum medical loss ratio (MLR) requirements. Below is a discussion of issues of the new MLR standards and how agents' and brokers' services and compensation may be impacted.

Provisions of New Medical Loss Ratios

The new law requires all health insurance providers offering group or individual health insurance coverage to report publically—in a manner to be established by the Department of Health and Human Services through regulation—the percentage of total premium revenue that such coverage expends:

- on reimbursement for clinical services provided to enrollees under such plan or coverage
- for activities that improve health care quality
- on all other non-claims costs, including costs associated with compliance with the PPACA, with an explanation of the nature of such costs.[3]

Not later than December 31, 2010, and subject to the certification of the HHS secretary, the National Association of Insurance Commissioners (NAIC) is charged with establishing uniform definitions and standardized methodologies for calculating these activities of health insurance carriers.

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[1] §1312(e) of the PPACA (P.L. 111-148)

[2] §1312(e) of the PPACA as amended by §10104

[3] §1001 of the PPACA as amended by §10101: new §2718 of the Public Health Service Act

Beginning not later than January 1, 2011, and subject to the definitions established through NAIC/HHS regulation, large-group plans (101 employees or more) that spend less than 85% of premium revenue and small-group (one to 100 employees) and individual plans that spend less than 80% of premium revenue on clinical services and activities to improve health care quality must provide a rebate to enrollees. Under certain conditions, states may increase small-group or individual percentages, or HHS may decrease these threshold percentages.[4]

Specifically carved out or excluded from premium ratios in the MLR standards are federal and state taxes and licensing or regulatory fees. The ratios must also account for insurance carrier payments or receipts for risk adjustment, risk corridors and reinsurance.[5]

Agent and Broker Community Looking Forward

While on the surface the MLR requirements might elicit concern from the agent/broker community in terms of downward pressures on services and compensation, there are a number of provisions of the new law that generally should bring down the administrative costs of insurance and mitigate adverse impact on professionally licensed producers:

- Administrative costs for carriers in the form of underwriting, outreach and enrollment, claims processing and coverage continuation are likely to be reduced through efficiencies of the individual and employer coverage mandate requirements, new consumer protections on pre-existing conditions, rescissions and annual/lifetime limits, and more uniform standards of coverage. Thus, in general, insurance carriers should be able to operate with less administrative overhead than before, making it easier to meet the new MLR requirements.

- In many ways, the services of professionally licensed benefit specialists will be in demand even more than they are today. The new law introduces a host of insurance and tax compliance issues for individuals and employers. Even with the new law, there will still be a need for professionals to design benefit plans, explain coordination issues of public and private benefits, assist with enrollments and terminations, resolve claims disputes and billing problems, advise on changes in family/child status, among other things. There are also new opportunities to create and expand on cutting-edge health promotion and wellness programs for employers. Moreover, professional benefit specialists will continue to be in demand to provide multifaceted value and services that extend far beyond health care. They help employers and others maximize options on a broad range of insurance and financial security instruments, including disability

[4] *Ibid.* States are permitted through regulation to set higher MLR standards, but are instructed to consider and ensure adequate participation by health insurance issuers, competition in the health insurance market in the state, and value for consumers so that premiums are used for clinical services and quality improvements. The HHS secretary may also adjust the MLR requirements in the individual market if the secretary determines it appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

[5] §1001 of the PPACA as amended by §10101

insurance, long-term care insurance, life insurance and other financial planning considerations.

- Professional agents and brokers have a long-standing and positive working relationship with state departments of insurance and the NAIC, and benefit specialists should look forward to working further with state insurance regulators in the development of workable standards and definitions as to what ought to be considered in MLR determination. For example, in specifically recognizing "activities to improve health care quality" as a sanctioned and legitimate use of premium revenues, the new law and ensuing regulations will rely on NAIC's broad experience and local market expertise in making appropriate distinctions between expenditures like wellness programs, disease management and health IT investments versus other administrative expenses like office space and salaries.

- The professional agent and broker community will continue to press policymakers on a very simple point of consistency. If the goal is to have government mandate caps on administrative expenses for health care dollars spent, it would only be sensible and equitable to apply similar requirements to all health care providers who will be involved in a reformed health care system. Similar administrative expense strictures ought to be imposed on doctors, hospitals, pharmaceutical companies, medical device manufacturers, nursing homes and the like. Any government initiatives to bring down the costs of medical treatments and health care generally should benefit American consumers and taxpayers universally across the health care spectrum.