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Title: Insurance Standards Bulletin Series--INFORMATION

Subject: CCIIO Technical Guidance (CCIIO 2011—004): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule

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 Affordable Care Act. The interim final rule 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 regulations published in the IFR are codified at 45 CFR Part 158.

This Bulletin provides guidance on the following topics regarding the MLR Interim Final Rule:

- Counting Employees for Determining Market Size
- Third Party Vendor Payments

Previous CCIIO Technical Guidance (CCIIO 2011—002) - Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule – dated May 13, 2011, contained Questions and Answers numbers 1-17 (http://cciio.cms.gov/resources/files/2011_05_13_mlr_q_and_a_guidance.pdf). This Bulletin begins with Question and Answer number 18.

II. Questions and Answers

COUNTING EMPLOYEES FOR DETERMINING MARKET SIZE (45 CFR §158.103, §158.120, §158.210)

Question #18:
When reporting experience related to MLR, what method should issuers use for counting "employees" in determining whether the data from a group policy should be reported as being

issued in the large group market or small group market, as required by 45 CFR §158.120, and for determining the minimum medical loss ratio required by 45 CFR §158.210?

Answer #18:
The large group and small group markets are defined as those where health insurance coverage is obtained through a large or small employer, respectively. A large employer and small employer are defined by the number of employees; a small employer has up to 100 employees, but a State may substitute "50" employees for "100" employees until 2016. (45 CFR §158.103.) (Question and Answer 1 addresses how a State makes this election; http://cciio.cms.gov/resources/files/2011_05_13_mlr_q_and_a_guidance.pdf.) An employer's number of employees is determined by averaging the total number of all employees employed on business days during the preceding calendar year. (Section PHS Act §2791(e)(2) and (4).) By way of example, this includes each full-time, part-time and seasonal employee.

An employee is "any individual employed by an employer." This includes all full-time and part-time employees. (PHS Act §2791(d)(5).)

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

Question #19:
How should an issuer report amounts paid to third party vendors who pay others to provide clinical services to enrollees and who perform network development, administrative functions, claims processing, and utilization management?

Answer #19:
In general, an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees. Where the third party vendor is performing an administrative function such as eligibility and coverage verification, claims processing, utilization review, or network development, expenditures and profits on these functions would be considered a non-claims administrative expense as provided in 45 CFR §158.140(b)(3)(ii).

Some third party vendors provide reimbursement for clinical services to enrollees and provide administrative functions such as claims processing and network development. Payments by an issuer to a third party vendor to provide clinical services directly to enrollees through its own employees are considered to be incurred claims. However, the amounts paid by the issuer to a third party vendor for the functions that are not direct clinical services to enrollees through its own employees are governed by §158.140(b)(3)(ii), and only the amounts the third party vendor pays to providers may be included in incurred claims. (Questions and Answers 8 and 9 address what is meant by the term "providers"; http://cciio.cms.gov/resources/files/2011_05_13_mlr_q_and_a_guidance.pdf.) The amounts attributable to network development, administrative fees, claims processing, and utilization management by the third party vendor and the third party vendor's profits on those activities must not be included by an issuer in its incurred claims.

For example, when a pharmacy benefit manager (PBM) pays a retail pharmacy one amount for prescription drugs covered by the plan and charges the issuer a higher amount (the retail spread), the issuer may only claim the amounts paid by the PBM to the retail pharmacy as incurred claims.

As stated in the May 13, 2011 guidance posted on the internet at http://cciio.cms.gov/resources/regulations/index.html#mlr), the third party vendor (in this example, the PBM) must report to the issuer only the aggregate amount it pays all providers (in this example, retail pharmacies) for clinical services to enrollees on behalf of the issuer, by market in each State. No claim by claim or provider by provider reporting is required.