



**Insurance Circular Letter No. 15 (2011)
December 22, 2011**

TO: All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, and Health Maintenance Organizations (“HMOs”) (collectively, “insurers”)

RE: Medical Loss Ratio Standards Applicable to Health Insurance Policies

STATUTORY AND REGULATORY REFERENCES: Public Law 111-148; Public Law 111-152; § 2718 of the Public Health Service Act; 45 C.F.R Part 158; N.Y. Ins. Law §§ 308, 3231 and 4308

Summary

The purpose of this Circular Letter is to provide guidance to insurers as to the Medical Loss Ratio (“MLR”) standards that are applicable to the calculation of refunds by insurers with respect to policies of hospital and/or medical expense insurance. As more fully explained below, insurers must use the federal standards for calculating refunds. Thus, insurers must meet a minimum MLR of 82% for small group and individual policies and 85% for all large groups. The Superintendent of Financial Services (“Superintendent”) will not apply those standards for rate review purposes, for which the expected loss ratio of individual, small group and community rated large group contract forms must be at least 82%, and the Superintendent may modify or disapprove a proposed premium increase if the Superintendent finds that it is unreasonable, excessive, inadequate or unfairly discriminatory.

Background

Chapter 107 of the Laws of 2010 amended New York Insurance Law §§ 3231 and 4308 to establish a process and time frame for the Superintendent to approve changes in health insurance premiums before they become effective. The statutes address rate review and, more generally, issuance of refunds. As to rate review, the statutes require that the expected loss ratio of individual, small group and community rated large group contract forms must be at least 82%. In reviewing a proposed premium rate increase, the Superintendent may modify or disapprove the proposed premium increases if the Superintendent finds that they are unreasonable, excessive, inadequate or unfairly discriminatory.

As to refunds, New York Insurance Law §§ 3231 and 4308 provide that “[n]o later than June thirtieth of each year, every insurer subject to this subparagraph shall annually report the actual loss ratio for the previous calendar year in a format acceptable to the Superintendent. If an expected loss ratio is not met, the Superintendent may direct the insurer to take corrective action, which may include the submission of a rate filing to reduce future premiums, or to issue

dividends, premium refunds or credits, or any combination of these.” The statutes do not specify how the MLR should be calculated. The Superintendent has broad discretion as to both the calculation of the MLR and the corrective actions to be taken where the MLR is not met. The Superintendent has considered MLR to be the ratio of claims to premiums.

In addition, President Obama signed into law the Patient Protection and Affordable Care Act (Pub. L. 111-148) on March 23, 2010 and the Health Care and Education Reconciliation Act (Pub. L. 111-152) on March 30, 2010. These two statutes are collectively referred to as the Affordable Care Act (“ACA”).

Discussion

In light of the ACA, the Superintendent has determined that in calculating an insurer’s MLR to determine whether corrective action needs to be taken, the Superintendent will apply the federal standards as established in the Affordable Care Act and the implementing regulation, 45 CFR Part 158.

The ACA reorganizes, amends, and adds to the provisions of the federal Public Health Service Act (“PHSA”) relating to health insurance in the group and individual markets. PHSA § 2718 establishes federal MLR reporting and rebate rules that are applicable to insurers in the individual, small group and large group markets. PHSA § 2718(a) and (b) provide that insurers must file annual MLR reports with the federal Secretary of Health and Human Services (“HHS”) and must issue annual rebates to policyholders if the insurers’ respective MLRs in the reporting year are not at least 80 percent in the individual and small group markets and 85 percent in the large group market.

HHS has issued an interim final regulation (“IFR”) implementing the Affordable Care Act’s MLR provision. See 75 Fed. Reg. 74864 (December 1, 2010). The IFR establishes detailed rules governing the calculation of the MLR and requires insurers to file annual MLR reports with HHS by no later than June 1st following the close of the MLR reporting year, and to pay any rebates to policyholders by August 1st following the close of the MLR reporting year.

Among other things, the IFR defines the methodology for calculating MLR as the ratio of an insurer’s incurred claims plus the insurer’s expenditures for “activities that improve health care quality” (the numerator) to the insurer’s “premium revenue” minus the federal and state taxes and licensing and regulatory fees paid by the insurer during the MLR reporting year (the denominator). See 45 CFR §158.221(a)-(c). The MLR calculation is subject to the applicable credibility adjustment, if any, as provided in 45 CFR §§ 158.230 and 158.232.

The IFR, in 45 CFR § 158.120, also requires an insurer to submit, for each state in which it writes health insurance coverage, data on the aggregate premiums, claims experience, quality improvement expenditures, and non-claims costs that it incurs in connection with the policies it issues in three separate markets: the individual, small group, and large group markets. As described by HHS, “[r]eporting by health insurance market – i.e., by large group, small group, and individual markets is . . . required by section 2718 of the PHS Act, which requires that MLR standards be met for each such market.” See 75 Fed. Reg. at 74869. In determining whether an

employer group is assigned to the small or large group market for MLR refund purposes, HHS requires insurers to count “any individual employed by an employer. This includes all full-time and part-time employees.” CCIIO Technical Guidance 2011-04, Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule (July 18, 2011), Q&A-18 (citing PHSA § 2791(d)(5)).

A State can require an MLR percentage higher than the 80% (for small group and individual policies) and 85% (for large groups) specified in the ACA: “For coverage offered in a State whose law provides that issuers in the State must meet a higher MLR than that set forth in [the ACA], the State’s higher percentage must be substituted for the percentage stated in [the ACA].” See 75 CFR § 158.211(a).

PHSA § 2718 and the applicable regulations by their terms apply only to the calculation of MLRs for the purposes of determining whether rebates are required. The MLR requirements of the statute and the applicable regulations do not address or apply to review of premium rates. Rate review is addressed under a separate section of the PHSA (See PHSA § 2794 and 45 CFR Part 154).

With the adoption of the federal MLR standard in New York, insurers thus must meet a minimum MLR of 82% for small group and individual policies and 85% for all large groups. Accordingly, if an insurer’s MLR is below 82% for the small group and individual markets or 85% for the large group market, based on all of the standards set forth in the ACA and 45 CFR Part 158, including the calculation methodology, aggregation by market segment, determination of group size and other applicable standards, the insurer must issue rebates as set forth in the ACA and 45 CFR Part 158. Insurers also must comply with the reporting requirements to the Secretary of HHS (the “Secretary”) as set forth in 45 CFR Part 158. Pursuant to New York Insurance Law §§ 3231 and 4308, insurers must make MLR reports to the Superintendent no later than June 30th of each year. By following the federal standards for reporting and rebate distribution and providing the Superintendent with a copy of the same report provided to the Secretary, insurers will satisfy their state MLR rebate reporting obligations under New York Insurance Law §§ 3231 and 4308. In addition, every insurer also must report to the Superintendent by August 1st whether, in accordance with the federal requirements, it has paid any rebates to policyholders.

For the purposes of rate review (as opposed to the calculation of rebates), the Superintendent will not apply the federal standards set forth in PHSA § 2718 or 45 CFR Part 158. Neither PHSA § 2718 nor 45 CFR Part 158, on their face, applies to rate review. Also, using the federal standards will generally result in a higher MLR than calculating the MLR as simply the ratio of claims to premiums. The higher MLR calculation could result in premiums meeting the minimum standards set forth in New York Insurance Law §§ 3231 and 4308 that would have otherwise not met those minimum standards. Accordingly, in order to retain the Superintendent’s maximum discretion to determine whether proposed premiums are unreasonable, excessive, inadequate or unfairly discriminatory, the Superintendent will not adopt the federal MLR calculation standards for the purposes of rate review.

Conclusion

In sum, when insurers report and, where applicable, pay MLR rebates with respect to policies of hospital and/or medical expense insurance, they must do so in accordance with federal standards. This results in a minimum MLR of 82% for the individual market, 82% for the small group market and 85% for the large group market. The Superintendent, however, will not apply the federal standards for rate review purposes, but will apply the state standards, for which the expected loss ratio of individual, small group and community rated large group contract forms must be at least 82%. Further, the Superintendent may modify or disapprove a proposed premium increase if the Superintendent finds that it is unreasonable, excessive, inadequate or unfairly discriminatory.

Please direct any questions regarding this circular letter to Gary Teitel, Assistant Chief Actuary, Health Bureau, New York State Department of Financial Services, 25 Beaver Street, New York, NY 10004, or by e-mail to Gary.Teitel@dfs.ny.gov.

Very truly yours,

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