

STATE OF CALIFORNIA

Department of Insurance



Department of Managed
Health Care

AGENDA FOR PUBLIC DISCUSSION RE: SB 51

**Proposed Regulations re: Medical Loss Ratios and Rebates for Health Insurance
Policies and Health Care Service Plans**

Wednesday, November 16, 2011, 10:00am to 1:00pm

Limited call-in lines available at: 1-800-997-3085, Passcode: 5779140

- I. Welcome
- II. Introductions of Department staff, workshop participants
- III. Overview of SB 51 (*Bruce Hinze*)
- IV. Open Forum Discussion
 - a. IC §10112.1 / H&S §1367.001: Annual & Lifetime Limits
 - Is there a need for a regulation?
 - b. IC §10112.5 / H&S §1367.003: Rebate and MLR Requirements
 - What issues and concerns should the Departments have in mind when developing regulations for this section?

SENATE BILL 51 (Alquist) (Statutes 2011, Chapter 644)

Health and Safety Code § 1367.001 (Annual and Lifetime Limits)

(a) To the extent required by federal law, every health care service plan that issues, sells, renews, or offers contracts for health care coverage in this state shall comply with the requirements of Section 2711 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-11) and any rules or regulations issued under that section, in addition to any state laws or regulations that do not prevent the application of those requirements.

(b) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

Health and Safety Code § 1367.003 (Medical Loss Ratio and Rebates)

(a) Every health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, but not including specialized health care service plan contracts, shall provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health care service plan on the costs for reimbursement for clinical services provided to enrollees under such coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.

(b) Every health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, shall comply with the following minimum medical loss ratios:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.

(c) **(1)** The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the following:

(A) The amount by which the percentage described in paragraph (1) or (2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).

(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

(2) A health care service plan shall provide any rebate owing to an enrollee no later than August 1 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.

(d) **(1)** The director may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(2) The director may also adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) when it is necessary to implement the applicable provisions of this section and to address specific conflicts between state and

federal law that prevent implementation of federal law and guidance pursuant to Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial adoption of the emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

- (e) The department shall consult with the Department of Insurance in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.
- (f) This section shall be implemented to the extent required by federal law and shall comply with, and not exceed, the scope of Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections.
- (g) Nothing in this section shall be construed to apply to provisions of this chapter pertaining to financial statements, assets, liabilities, and other accounting items to which subdivision (s) of Section 1345 applies.
- (h) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

Insurance Code § 10112.1. (Annual and Lifetime Limits)

- (a) To the extent required by federal law, every health insurer that issues, sells, renews, or offers policies for health care coverage in this state shall comply with the requirements of Section 2711 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-11) and any rules or regulations issued under that section, in addition to any state laws or regulations that do not prevent the application of those requirements.
- (b) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5)), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

Insurance Code § 10112.25 (Medical Loss Ratio and Annual Rebate)

(a) Every health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including a grandfathered health plan, but not including specialized health insurance policies, shall provide an annual rebate to each insured under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health insurer on the costs for reimbursement for clinical services provided to insureds under such coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health insurer offering coverage in the large group market, 85 percent.

(2) With respect to a health insurer offering coverage in the small group market or in the individual market, 80 percent.

(b) Every health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including a grandfathered health plan, shall comply with the following minimum medical loss ratios:

(1) With respect to a health insurer offering coverage in the large group market, 85 percent.

(2) With respect to a health insurer offering coverage in the small group market or in the individual market, 80 percent.

(c) **(1)** The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the following:

(A) The amount by which the percentage described in paragraph (1) or (2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).

(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

(2) A health insurer shall provide any rebate owing to an insured no later than August 1 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.

(d) **(1)** The commissioner may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(2) The commissioner may also adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) when it is necessary to implement the applicable provisions of this section and to address specific conflicts between state and federal law that prevent implementation of federal law and guidance pursuant to Section

2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial adoption of the emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

(e) The department shall consult with the Department of Managed Health Care in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.

(f) This section shall be implemented to the extent required by federal law and shall comply with, and not exceed, the scope of Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections.

(g) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5)), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

42 USC § 300gg-18. Bringing down the cost of health care coverage

(a) **Clear accounting for costs.** A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends--

(1) on reimbursement for clinical services provided to enrollees under such coverage;

(2) for activities that improve health care quality; and

(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees. The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

(b) Ensuring that consumers receive value for their premium payments

(1) Requirement to provide value for premium payments.

(A) **Requirement.** Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue

(excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 18061, 18062, and 18063 of this title) for the plan year (except as provided in subparagraph (B)(ii)), is less than--

(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

(B) Rebate amount.

(i) **Calculation of amount.** The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of--

(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 18061, 18062, and 18063 of this title) for such plan year.

(ii) **Calculation based on average ratio.** Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

(2) Consideration in setting percentages. In determining the percentages under paragraph (1), a State shall seek to 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.

(3) Enforcement. The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

(c) Definitions. Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

(d) Adjustments. The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

(e) Standard hospital charges. Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title.

SELECTED FEDERAL REGULATIONS PERTAINING TO MEDICAL LOSS RATIO AND REBATES

45 CFR § 158.210. Minimum medical loss ratio.

Subject to the provisions of § 158.211 of this subpart:

(a) Large group market. For all policies issued in the large group market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 85 percent, as determined in accordance with this part.

(b) Small group market. For all policies issued in the small group market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80 percent, as determined in accordance with this part.

(c) Individual market. For all policies issued in the individual market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80 percent, as determined in accordance with this Part.

(d) Adjustment by the Secretary. If the Secretary has adjusted the percentage that issuers in the individual market in a specific State must meet, then the adjusted percentage determined by the Secretary in accordance with § 158.301 of this part et seq. must be substituted for 80 percent in paragraph (c) of this section.

45 CFR § 158.220. Aggregation of data in calculating an issuer's medical loss ratio.

(a) Aggregation by State and by market. In general, an issuer's MLR must be calculated separately for the large group market, small group market and individual market within each State. However, if, pursuant to section 1312(c)(3) of the Affordable Care Act, a State requires the small group market and individual market to be merged, then the data reported separately under subpart A for the small group and individual market in that State may be merged for purposes of calculating an issuer's MLR and any rebates owing.

(b) Years of data to include in calculating MLR. Subject to paragraph (c) of this section, an issuer's MLR for an MLR reporting year is calculated according to the formula in § 158.221 of this subpart and aggregating the data reported under this Part for the following 3-year period:

- (1) The data for the MLR reporting year whose MLR is being calculated; and
- (2) The data for the two prior MLR reporting years.

(c) Requirements for MLR reporting years 2011 and 2012.

(1) For the 2011 MLR reporting year, an issuer's MLR is calculated using the data reported under this Part for the 2011 MLR reporting year only.

(2) For the 2012 MLR reporting year--

(i) If an issuer's experience for the 2012 MLR reporting year is fully credible, as defined in § 158.230 of this subpart, an issuer's MLR is calculated using the data reported under this Part for the 2012 MLR reporting year.

(ii) If an issuer's experience for the 2012 MLR reporting year is partially credible or non-credible, as defined in § 158.230 of this subpart, an issuer's MLR is calculated using the data reported under this part for the 2011 MLR reporting year and the 2012 MLR reporting year.

45 CFR § 158.221. Formula for calculating an issuer's medical loss ratio.

(a) Medical loss ratio.

(1) An issuer's MLR is the ratio of the numerator, as defined in paragraph (b) of this section, to the denominator, as defined in paragraph (c) of this section, subject to the applicable credibility adjustment, if any, as provided in § 158.232 of this subpart.

(2) An issuer's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

(b) Numerator. The numerator of an issuer's MLR for an MLR reporting year must be the issuer's incurred claims, as defined in § 158.140 of this part, plus the issuer's expenditures for activities that improve health care quality, as defined in § 158.150 and § 158.151 of this part, that are reported for the years specified in § 158.220 of this subpart.

(1) The numerator of the MLR for the 2012 MLR reporting year may include any rebate paid under § 158.240 of this subpart for the 2011 MLR reporting year if the 2012 MLR reporting year experience is not fully credible as defined in § 158.230 of this subpart.

(2) The numerator of the MLR for the 2013 MLR reporting year may include any rebate paid under § 158.240 for the 2011 MLR reporting year or the 2012 MLR reporting year.

(3) The numerator of the MLR for policies that are reported separately under § 158.120(d)(3) of this part must be the amount specified in paragraph (b) of this section, except that for the 2011 MLR reporting year the total of the incurred claims and expenditures for activities that improve health care quality are then multiplied by a factor of two.

(4) The numerator of the MLR for policies that are reported separately under § 158.120(d)(4) of this part must be the amount specified in paragraph (b) of this section, except that for the 2011 MLR reporting year the total of the incurred claims and expenditures for activities that improve health care quality are then multiplied by a factor of two.

(c) Denominator. The denominator of an issuer's MLR must equal the issuer's premium revenue,

as defined in § 158.130, minus the issuer's Federal and State taxes and licensing and regulatory fees, described in §§ 158.161(a) and 158.162(a)(1) and (b)(1) of this part.

45 CFR § 158.240. Rebating premium if the applicable medical loss ratio standard is not met.

(a) General requirement. For each MLR reporting year, an issuer must provide a rebate to each enrollee if the issuer's MLR does not meet or exceed the minimum percentage required by §§ 158.210 and 158.211 of this subpart.

(b) Definition of enrollee for purposes of rebate. For the sole purpose of determining whom is entitled to receive a rebate pursuant to this part, the term “enrollee” means the subscriber, policyholder, and/or government entity that paid the premium for health care coverage received by an individual during the respective MLR reporting year.

(c) Amount of rebate to each enrollee.

(1) For each MLR reporting year, an issuer must rebate to the enrollee the total amount of premium revenue received by the issuer from the enrollee after subtracting Federal and State taxes and licensing and regulatory fees as provided in § 158.161(a), § 158.162(a)(1) and § 158.162(b)(1) of this part, multiplied by the difference between the MLR required by § 158.210 or § 158.211 of this subpart, and the issuer's MLR as calculated under § 158.221 of this subpart.

(2) For example, an issuer must rebate a pro rata portion of premium revenue if it does not meet an 80 percent MLR for the small group market in a State that has not set a higher MLR. If an issuer has a 75 percent MLR for the coverage it offers in the small group market in a State that has not set a higher MLR, the issuer must rebate 5 percent of the premium paid by or on behalf of the enrollee for the MLR reporting year after subtracting premium and subtracting taxes and fees as provided in paragraph (c) of this section. In this example, an enrollee may have paid \$2,000 in premiums for the MLR reporting year. If the Federal and State taxes and licensing and regulatory fees that may be excluded from premium revenue as described in § 158.161(a), § 158.161(a)(1) and § 158.162(b)(1) of this subpart are \$150 for a premium of \$2,000, then the issuer would subtract \$150 from premium revenue, for a base of \$1,850 in premium. The enrollee would be entitled to a rebate of 5 percent of \$1,850, or \$92.50.

(d) Timing of rebate. An issuer must provide any rebate owing to an enrollee no later than August 1 following the end of the MLR reporting year.

(e) Late payment interest. An issuer that fails to pay any rebate owing to an enrollee or subscriber in accordance with paragraph (d) of this section or to take other required action within the time periods set forth in this Part must, in addition to providing the required rebate to the enrollee, pay the enrollee interest at the current Federal Reserve Board lending rate or ten percent annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due under paragraph (d) of this section.

45 CFR § 158.241. Form of rebate.

(a) Current enrollees.

(1) An issuer may choose to provide any rebates owing to current enrollees in the form of a premium credit, lump-sum check, or, if an enrollee paid the premium using a credit card or direct debit, by lump-sum reimbursement to the account used to pay the premium.

(2) Any rebate provided in the form of a premium credit must be provided by applying the full amount due to the first month's premium that is due on or after August 1 following the MLR Reporting year. If the amount of the rebate exceeds the premium due for August, then any overage shall be applied to succeeding premium payments until the full amount of the rebate has been credited.

(b) Former enrollees. Rebates owing to former enrollees must be paid in the form of lump-sum check or lump-sum reimbursement using the same method that was used for payment, such as credit card or direct debit.

45 CFR § 158.242. Recipients of rebates.

(a) Individual market. An issuer must meet its obligation to provide any rebate due to an enrollee in the individual market by providing it to the enrollee. For individual policies that cover more than one person, one lump-sum rebate may be provided to the subscriber on behalf of all enrollees covered by the policy.

(b) Large group and small group markets. An issuer must meet its obligation to provide any rebate to persons covered under a group health plan by providing it to the enrollee, in amounts proportionate to the amount of premium the policyholder and each subscriber paid.

(1) Arrangement with policyholder to distribute rebates. An issuer may meet its obligation to provide any rebate owing to a large group or small group enrollee by entering into an agreement with the group policyholder to distribute the rebate on behalf of the issuer, subject to all of the following conditions:

(i) The issuer must remain liable for complying with all of its obligations under this part.

(ii) The issuer must obtain and retain records and documentation evidencing accurate distribution of any rebate owing, sufficient to demonstrate compliance with its obligations under this subpart, subpart D, and subpart E. Such records and documentation include:

- (A) The amount of the premium paid by each subscriber;
- (B) The amount of the premium paid by the group policyholder;
- (C) The amount of the rebate provided to each subscriber;
- (D) The amount of the rebate retained by the group policyholder; and
- (E) The amount of any unclaimed rebate and how and when it was distributed

Contact persons for further concerns:

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