Accordingly, 44 CFR 206.171 of the interim rule published on March 21, 1989 (54 FR 11610), with the amendment to 206.171(g)(4)(i) published on March 3, 2003 (68 FR 9899), is adopted as a final rule without change.

W. Craig Fugate,
Administrator, Federal Emergency Management Agency.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Part 158
[CMS–9996–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 Annual Reporting Form.”

DATES: Effective date: This document is effective on May 16, 2012.

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

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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 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 or more payments. 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 runoff 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 runoff 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 an 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 74922, 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.

3. 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.

4. 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.

5. 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.

6. 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 an individual market business sold through a trust.
§ 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.

§ 158.120 Aggregate reporting.

(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.

§ 158.130 [Amended]

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

§ 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.

§ 158.240 based upon prior MLR reporting year experience.

§ 158.150 [Amended]

6. Amend § 158.150 as follows:

§ 158.232 Calculating the credibility adjustment.