

MEDICAL LOSS RATIO: RULES ON REBATES

INTRODUCTION

The Patient Protection and Affordable Care Act's (PPACA) minimum Medical Loss Ratio (MLR) provisions require insurance issuers to provide rebates to group health plans purchasing insurance if the issuer does not spend a minimum percentage of the premium on medical claims and certain quality improvement initiatives. While the MLR provisions relate primarily to insurers, employers that sponsor fully insured group health plans must follow specific rules with respect to any rebates received from an insurer.

This white paper focuses on:

- The background of PPACA's MLR provisions
- The effective date of the provisions
- The MLR percentage standards and reporting requirements for insurers
- The employer's responsibilities and restrictions with respect to use of a rebate
- The federal tax consequences relating to MLR rebates
- Frequently asked questions relating to the MLR provisions

For employers that receive an MLR rebate, there is a four-step process to determine the proper use of that rebate.

I. MEDICAL LOSS RATIOS: AN OVERVIEW

PPACA's MLR provisions require all health plans to meet minimum MLRs, a concept that refers to the ratio of medical expenses (and quality improvement initiatives) paid by a plan as compared to the premiums collected by the plan. In general terms, a health insurance company's MLR is the percentage of premium revenue (excluding certain taxes and licensing fees) the company spends on direct care for patients and efforts to improve care quality.

Example: Health insurance company X insures 100 consumers in the individual market, and each consumer pays the company \$10,000 per year for coverage. It follows that company X's premium revenue for the year totals \$1 million. If company X pays out \$700,000 to cover its 100 consumers' annual medical expenses (and certain quality initiatives), then the company's MLR equals 70 percent.

Under PPACA's MLR rules, health insurers must calculate and report MLR percentages to the U.S. Department of Health and Human Services (HHS). In addition, insurers that do not meet specified MLR percentage standards must provide rebates to policyholders, usually the employer in an employer-sponsored group health plan. The employer is then tasked with determining the proper use of those rebates.



A. An Insurer Must Calculate and Report Its MLR

PPACA requires each health insurance issuer to submit an annual report to HHS detailing how the issuer spends its money.

Specifically, the report must include the percentage of total premium revenue the issuer spends:

- On reimbursement for clinical services provided to enrollees under such coverage
- For activities that improve health care quality
- 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

When reporting data, the insurer reports aggregate premium, claims experience, quality-improvement expenditures and non-claims costs it incurs in connection with the policies issued in the large-group, small-group and individual markets in each state. Experience is not broken down among products offered in the state, nor is it reported for each policy. Rather, the experience for group coverage of employees in multiple states will be attributed to the state regulating the insurance contract between the insurer and the group health plan.

Consequently, insurers will calculate MLR based on their entire business in the large-group or small-group market, not on a particular group health plan's experience. Moreover, whether an MLR rebate is due to a particular plan sponsor will not be affected by the experience of its actual group or a particular participant's claims.

B. An Insurer Failing to Meet MLR Benchmarks Must Issue Rebates

Prior to PPACA, 34 states had some form of MLR requirement for health insurance issuers, mainly in the individual and small-group market. However, there are some differences in the manner that MLR is calculated under PPACA as compared to traditional calculations under state law. A full explanation of MLR calculations is outside the scope of this white paper.

As stated above, under PPACA, a health insurance company's MLR is the percentage of premium revenue the company spends on direct care for patients and efforts to improve care quality. PPACA mandates that every health insurance issuer maintain its MLR above a certain benchmark: 85 percent in the large-group market and 80 percent in the small-group and individual markets.

It should be noted that PPACA's thresholds are a benchmark that may be altered by the states. Specifically, PPACA directs the states to 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 when determining the appropriate MLR.

If an insurer's MLR falls below the 80 percent or 85 percent threshold, the company must send a rebate to the policyholder, which is generally the employer in the context of an employer-sponsored group health plan. The rebate generally must be in the form of cash or a premium reduction (which could be a so-called "premium holiday").* Before discussing the employer's obligations with respect to a received rebate, it is helpful to determine which types of plans may be affected by the MLR provisions.

C. Not All Insurers Will Issue Rebates

Not all insurers are subject to PPACA's MLR provisions. For example, the MLR provisions do not apply to self-insured plans.

Generally, insurer rebates must be issued by September 30 following the end of the MLR reporting year. Should an insurer issue rebates, the insurer must provide notice of such action to current group health plan participants, as well as group policyholders. The notice must include general information about MLR, the issuer's MLR and the rebate, as well as other prescribed information that will vary depending on whether the plan is subject to ERISA and to HHS rules. An additional new notice for insurers that do not owe a rebate has not been required, but HHS indicates it intends to amend the rule in the future to provide such a requirement.

II. REBATES TO ENROLLEES IN THE GROUP MARKET

Generally, insurers that do not meet PPACA's MLR standards must provide an annual rebate to group policyholders (or in some instances, to enrollees). The rebate can be in the form of a premium credit, lump-sum check or lump-sum reimbursement to the same account that the enrollee used to pay the premium. However, to ensure the rebate does not represent taxable income to participants in a group health plan, HHS directed insurers in the group market to provide rebates to the group policyholder and to include protections designed to satisfy the objective of benefitting participants. So, in the group market, the insurer will generally provide rebates to the employer as the group policyholder. It is then up to the employer to determine the appropriate use of the rebate.

In December 2011, HHS issued final rules on MLR requirements that explained how rebates were to be distributed when a group health plan was not subject to ERISA. At the same time, the U.S. Department of Labor (DOL) issued guidance in Technical Release 2011-04 (T.R. 2011-04) with respect to how rebates from ERISA-governed group health plans can be allocated. Thus, what policyholders can do with the money depends largely on whether the health plan is subject to ERISA.

A. ERISA-covered Plans

1. Is the Rebate a Plan Asset?

In considering the appropriate use of a rebate, the first step for an ERISA plan is determining whether the rebate constitutes a plan asset. This determination is important since ERISA, through its fiduciary requirements, places restrictions on the use of ERISA plan assets.

In T.R. 2011-04, the DOL concludes that rebates paid pursuant to the MLR provisions may constitute ERISA plan assets if a plan has a beneficial interest in the distribution under ordinary notions of property rights. To determine property rights, it is helpful to determine which entity is the actual policyholder. If the plan or its trust is the policyholder, in the absence of specific plan or policy language to the contrary, the entire rebate would constitute plan assets, and the policyholder would be required to comply with ERISA's fiduciary provisions regarding the handling and use of any rebates it receives. This would be the case, for example, where the premiums are paid entirely out of trust assets. In contrast, if the employer is the policyholder, the determination of the portion of the rebate that constitutes plan assets, if any, may depend on language in the plan or policy, or on the manner in which the plan sponsor and plan participants have shared in the cost of the policy.

The general rule, as described in T.R. 2011-04, is that if the plan documents and other extrinsic evidence do not resolve the allocation issue, the portion of a rebate that is attributable to participant contributions would be considered plan assets. For example, if the employer paid the entire cost of the insurance coverage, out of the general assets of the company, then no part of the rebate would be attributable to participant contributions, and therefore no part of the rebate would constitute plan assets. However, if participants paid the entire premium cost, then the entire amount of the rebate would be attributable to participant contributions and therefore would be considered plan assets.

There are other considerations if there are fixed percentage costs associated with employer and employee contributions. If the participants and the employer each paid a fixed percentage of the cost, the percentage of the rebate that equals the percentage of the cost paid by participants would be considered attributable to participant contributions, and would thus constitute plan assets. If the employer was required to pay a fixed amount and participants were responsible for paying any additional costs, then the portion of the rebate that does not exceed the participants' total amount of prior contributions during the relevant period would be attributable to participant contributions. Finally, if participants paid a fixed amount and the employer was responsible for paying any additional costs, then the portion of the rebate that did not exceed the employer's total amount of prior contributions during the relevant period would not be attributable to participant contributions.

Plan Asset Rules

Factors	Rebate as Plan Assets?
Policy issued to plan or trust; no specific plan or policy language	Yes, 100 percent
Specific plan or policy language addressing ownership or division of rebates or refunds	Yes, to extent provided by plan or policy language
Policy issued to employer; plan or policy language can fairly be read to give employer ownership in some or all of a refund or rebate	No, to extent plan or policy language gives employer ownership
Premiums paid entirely from plan assets; no specific plan or policy language	Yes, 100 percent
Policy issued to employer; no specific plan or policy language, and:	
• Premiums paid 100 percent by employer	No
• Premiums paid 100 percent by participants	Yes, 100 percent
• Premiums shared by employer and participants by fixed percentage (e.g., employer pays 60 percent, participant pays 40 percent)	Yes, for percentage equal to percentage of premiums paid by participants
• Employer pays fixed amount of premiums, participants pay balance (e.g., employer pays \$5,000/year toward coverage; participant pays any balance)	Yes, up to total amount paid by participants; balance not plan assets
• Participants pay fixed amount of premiums, employer pays balance (e.g., participant pays \$5,000/year toward coverage; employer pays any balance)	No, up to total amount paid by employer; balance is plan assets

2. How Should the Rebate Be Used?

As described above, the appropriate use of an MLR rebate depends on whether the rebate (or a portion of the rebate) constitutes plan assets. If so, then under ERISA, plan assets must be held for the exclusive purpose of providing benefits to plan participants and beneficiaries, and/or offsetting reasonable administrative expenses of the plan. Thus, plan assets cannot be used for the benefit of the plan-sponsoring employer (e.g., the rebate could not be absorbed into the employer's general assets). Rather, the employer must decide how to use the rebate for the exclusive benefit of the plan's participants and beneficiaries.

T.R. 2011-04 identifies the following guidelines for applying the rebates:

- The rebate can be distributed to participants under a reasonable, fair and objective allocation method, including premium reductions, benefit enhancements or cash back to each participant.
- If the employer finds the cost of distributing shares of a rebate to former participants approximates the amount of the proceeds, the fiduciary may decide to limit rebates to current participants.
- If distributing payments to participants is not cost-effective because the amounts are small or would give rise to tax consequences to the participants, the employer may utilize the rebate for other permissible plan purposes, such as applying the rebate toward future participant premium payments or toward benefit enhancements.

Employers should use those three guidelines in following several different methods for using the rebates. Those methods include providing:

- Premium reductions for plan participants
- Benefit enhancements to the plan
- A refund back to plan participants either through cash or a check
- A so-called premium holiday

With respect to the option of a premium holiday, from an employer's perspective, an employer may pass on an insurer's premium holiday or create its own premium holiday, so long as the employer does so in accordance with the guidelines for ERISA plans and non-ERISA plans, as applicable.

Regardless of the method used, employers whose plans provide benefits under multiple policies must be careful to allocate the rebate for a particular policy only to the participants who were covered by that policy. According to the DOL, using a rebate generated by one plan to benefit another plan's participants would be a breach of fiduciary duty.

Finally, a rebate (or a portion of a rebate) that does not constitute plan assets is not subject to the same ERISA plan asset rules. Thus, in the case of a rebate that does not constitute plan assets, the employer may use the rebate (or a portion of it) as it sees fit. Normally, the rebate would simply be a return of cash into the employer's general assets, representing a refund of previously paid employer contributions toward the plan.

3. Is There a Time Limit for Using Rebates?

To the extent a rebate qualifies as a plan asset, ERISA would generally require the amount to be held in trust. Most group health plans receiving rebates do not maintain trusts, however, because their premiums are paid from the employer's general assets. As expressed in T.R. 2011-04, the DOL provides relief from the trust requirement for premium rebates used within three months of their receipt. In addition, directing an issuer to apply the rebate toward future participant premium payments or toward benefit enhancements adopted by the plan sponsor would avoid the need for a trust and, in some circumstances, may be consistent with the employer's fiduciary duties. Employers who decide to take this approach should coordinate with their insurance issuers to establish the process for handling rebates.

B. Non-ERISA Plan

1. Non-federal Governmental Plans

In separate interim final regulations also issued by HHS, issuers of policies to non-federal governmental plans are directed to distribute the entire rebate to the group policyholder. The group policyholder is required to use the amount of rebates proportionate to the total amount of premium paid by subscribers for the benefit of the subscribers. For example, if an insurer pays a \$50,000 rebate to the policyholder of a non-federal governmental plan, and subscribers paid 50 percent of the total premium, then the policyholder must use 50 percent of the rebate (\$25,000) for the benefit of the subscribers.

The interim final rules also state the subscriber portion of the rebate must be used, at the option of the policyholder, in one of the following ways:

- To reduce the subscribers' portion of the annual premium for the subsequent policy year for all enrollees covered under any group health policy offered by the plan
- To reduce the subscribers' portion of the annual premium for the subsequent policy year for only those enrollees covered by the group health policy on which the rebate was based
- To provide a cash refund only to subscribers that were covered by the group health policy on which the rebate is based

In all three options, the rebate is used to reduce premiums or is paid to subscribers enrolled during the year in which the rebate is actually paid, rather than the MLR reporting year on which the rebate was calculated.

2. Other Nongovernmental Plans Not Subject to ERISA

According to the final regulations, if the policyholder is a group health plan that is not a government plan and not subjected to ERISA, rebates may only be paid to the policyholder if the insurer receives a written assurance from the policyholder that the rebates will be used to benefit enrollees. Otherwise, the insurer must distribute the rebates directly to the enrollees of the group health plan covered by the policy during the MLR reporting year on which the rebate is based. The insurer must do this by dividing the entire rebate, including the amount proportionate to the premium paid by the policyholder, in equal amounts to all subscribers entitled to a rebate (without regard to how much each enrollee actually paid toward premiums).

III. TAX TREATMENT OF REBATES

The Internal Revenue Service (IRS) issued a set of FAQs with information on the federal tax consequences to employees when an MLR rebate stems from a group health insurance plan. The consequences will depend on whether the employee's share of the premiums was paid on a pre-tax or after-tax basis.

A. Pre-tax Premium Payments

When employees pay their portion of the premiums for employer-sponsored health coverage on a pre-tax basis under a cafeteria plan, MLR rebates that are distributed as a reduction of the employee premium cost or in cash to employees will be subject to federal income tax in the year of distribution. This is because employees who receive a rebate in either of these forms will have an increase in their taxable salary equal to the amount of the rebate.

The rebate will also be wages subject to employment taxes. The result would be the same whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (i.e., regardless of whether they participated in the plan during the plan year covered by the rebate).

B. After-tax Premium Payments

When employees pay their portion of the premiums on an after-tax basis, MLR rebates that are distributed as a reduction of the employee premium cost or in cash to employees will generally not be subject to federal income tax. But rebates relating to premium payments deducted on a self-employed individual's federal income tax return are subject to federal income tax.

In either case, because the MLR rebate is a return of amounts that have already been subject to federal employment taxes, it will not be subject to federal employment taxes. The result would be the same whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (i.e., regardless of whether they participated in the plan during the plan year covered by the rebate).

CONCLUSION

Under PPACA's MLR provisions, insurers are required to satisfy certain MLR percentages. Insurers that do not satisfy those percentages must issue a rebate to policyholders, which, for an employer-sponsored group health plan, is the employer. The employer is then tasked with determining the appropriate use of that MLR rebate. In making that determination, the employer will have to consider ERISA, state law and T.R. 2011-04 guidelines and methods for distributing the rebate to plan participants.

Generally, the employer may use the rebate for premium reductions (including premium holidays) for participants, plan benefit enhancements, or cash or check refunds to participants. However, because the appropriate use depends on the structure of the plan and the specific facts and circumstances surrounding the employer's situation, and because of the potential for liability, outside counsel should be engaged to assist with making the determination and amending plan documents to reflect the employer's policy with respect to MLR rebates.

FAQS

Q1. Are self-insured plans subject to MLR reporting and rebate requirements?

A. No. PPACA's MLR provisions do not apply to self-insured plans.

Q2. Based on the cost, must an employer distribute the rebate to former plan participants or COBRA beneficiaries?

A. The answer depends on the type of plan. A non-federal governmental entity whose plan is contributory must use the rebate for the benefit of current participants. "Current participants" is defined in regulations as those subscribers enrolled in the group health plan at the time the rebate is received by the policyholder. A COBRA participant is generally considered a subscriber enrolled in the group health plan. Thus, the employer should distribute the rebate to any former plan participant that has elected COBRA.

For non-federal, non-ERISA plans (e.g., a church plan), an insurer will only pay the rebate to the employer if the employer gives the insurer written assurances that the rebate will be used in the same manner that applies to non-federal governmental plans. This means that the rebate must be used for the benefit of current participants, as outlined in the previous paragraph. If the employer provides no written assurances, then the insurer must distribute the rebate in equal amounts to all subscribers who were participants during the year on which the MLR rebate is based.

Finally, for ERISA plans, the answer is less clear. Each plan should be reviewed based on its own facts and circumstances, and the employer should decide what is prudent for the plan. T.R. 2011-04 does provide that the employer can use any method that is reasonable, fair and objective. That guidance also states that if distributing payments to any participants is not cost-effective, then the employer may utilize the rebate for other permissible plan purposes. This would seem to indicate that the employer could choose to distribute payments to some participants (e.g., those who are still employed or those who are on COBRA) but not others (e.g., those who no longer participate in the plan). The answer would depend on whether the method is fair, reasonable and objective. Thus, no exact answer can be given without knowing the facts and circumstances of the situation.

Q3. May an employer use rebates to enhance a wellness program?

A. There is no clear answer on this question, particularly since wellness programs can be provided in so many different forms. In most cases, the wellness program does not have the exact same group of participants as the medical plan that received the MLR rebate. For example, some employees may waive the wellness program and participate only in the medical plan (or vice versa). Additionally, an employer may have multiple medical plans from different carriers and only one wellness program.

The mismatch of medical plan and wellness plan participants may create issues under ERISA. If the refund is determined to be ERISA plan assets, then the refund must be used for the exclusive purpose of providing benefits to plan participants (and defraying reasonable plan administrative expenses relating thereto). Using the rebate to pay for a wellness program that benefits employees other than plan participants would violate this rule. Therefore, if the plan is an ERISA plan, it is unlikely that the rebate could be used to enhance a wellness program.

For non-ERISA plans, the same issue may arise, since non-ERISA plans generally must use the rebate to benefit "enrollees." So again, unless the exact same set of employees is enrolled in the major medical plan as the wellness plan, using the rebate to enhance a wellness program would likely violate MLR rules. More importantly, non-ERISA plans generally must agree with the insurer to use the rebates to either reduce premiums or provide cash to plan participants. Since enhancing a wellness program would not accomplish either, a non-ERISA plan would not be able to use an MLR rebate to enhance a wellness program.

Q4. Is there a de minimis rebate amount that would excuse the employer from providing a rebate to plan participants?

A. There is clearly a de minimis exception for an insurer issuing a rebate; the exact amount depends on whether the insurer is providing the rebate directly to the policyholder or the plan participants. But there is no specific de minimis exception relating to the employer's provision of a rebate to its plan participants. That said, for an ERISA plan, the DOL notice clearly states that where distributions to participants are not cost effective, the fiduciary may utilize the rebate amounts for other permissible plan purposes (which would include benefit enhancements as an alternative to cash or premium reductions).

For a non-ERISA governmental plan, the answer is less clear. There is no specific discussion in the statute or regulation (or preamble) relating to the issue. In the absence of direct guidance, the most cautious approach would be to presume that there is no exception and that the plan must either provide a premium reduction or cash regardless of the related administrative expenses. But the employer would have to engage outside counsel for an exact answer or opinion.

Q5. May an employer sponsoring a plan subject to ERISA use rebates to fund a health flexible spending account (FSA), health reimbursement arrangement (HRA) or health savings account (HSA) for plan participants?

A. To begin with, the employer must determine whether the plan document addresses the situation and whether the rebate is attributable to participant or employer contributions. The employer can do so using the general concepts discussed earlier in this white paper. Once the employer makes those determinations, it can determine whether the rebate may be used to establish a health FSA, HRA or an HSA for plan participants.

With respect to an FSA, the portion of the rebate attributable to employer contributions can be used to make a non-elective employer contribution to the current participant's FSA. In addition, non-elective employer contributions do not count toward the \$2,500 annual contribution limit. Without further guidance from the federal agencies, the portion of the rebate attributable to participant or trust contributions cannot be used to fund the current participant's FSA for two reasons. First, FSAs can be funded only by employer contributions or by participant salary deferrals. Second, generally, FSA coverage can be elected (or increased) only at certain specified times — prior to the beginning of the year in which the contributions are actually made or if during the year, upon the occurrence of particular qualifying events. The return of a rebate does not constitute a qualifying event for purposes of electing (or increasing) coverage in an FSA. Thus, the rebate portion attributable to participant contributions may not be used to fund an FSA.

With respect to an HRA, in general, only employer contributions can be used to fund an HRA. In this instance, the established HRA would need to be a "carryover" HRA (i.e., HRAs in which funds are available in years subsequent to the year of funding), since the rebates would be considered HRA contributions from the previous year. Therefore, so long as the HRA plan document allows the HRA to carry over funds from year to year, the portion of the rebate attributable to employer contributions can be used to fund HRAs for current participants. On the other hand, the portion of the rebate attributable to trust or participant contributions cannot be used to fund HRAs for current participants, since that portion of the rebate is considered "employee contributions" (which may not be used to fund an HRA).

Finally, with respect to an HSA, it appears that the portion of the rate attributable to employer contributions can be used to make an employer contribution (subject to the HSA comparability requirements). The portion of the rate attributable to trust/participant contributions can be used to make a non-employer contribution to a participant's HSA subject to the following: (a) the participant must be participating in a high-deductible health plan (HDHP) in the year the rebate is made; (b) the HSA annual contribution limit (in 2014: \$3,300 for self-only HDHP coverage; \$6,550 for family HDHP coverage) in the year the rebate is made; and (c) the participant is not participating in a health FSA or HRA or is only participating in a limited-scope/post-deductible health FSA or HRA. (Unlike health FSAs, anyone may make a contribution to an HSA on behalf of an eligible individual, subject to conditions (a)-(c) above.) Although not specifically addressed in guidance, the fact that the rebate is attributable to a prior plan year and a different type of health care plan (e.g., PPO) should not preclude the rebate from being deposited into the HSA as a contribution for the current year, provided that conditions (a)-(c) above are met for the current year.

ADDITIONAL RESOURCES

[MLR Final Regulations](#)

[DOL Technical Release 2011-04](#)

[IRS MLR FAQs](#)

[CCIIO Technical Guidance \(CCIIO 2012—002\)](#)

[GAO Report on Private Health Insurance](#)

Endnote

*With respect to a premium holiday, there are state law restrictions on the insurer that must be considered. According to Technical Guidance CCIIO 2012-002: "Questions and Answers Regarding the Medical Loss Ratio Regulation," premiums are established and collected in accordance with state law. In addition, the terms of the policy or contract, where required, is filed with the applicable state regulatory agency. Thus, whether a premium "holiday" is permissible is a matter of state law. If a state allows insurers to provide a premium holiday, and the insurer chooses to do so, the premium holiday needs to be provided in a non-discriminatory and consistent manner to employees. The employer may then pass the premium holiday on to its plan participants.

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