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## How to Handle Medical Loss Ratio Rebates

For the most part, employers have probably ignored the Affordable Care Act (ACA) requirements that insurers maintain specific "medical loss ratios" (MLR), or be required to rebate a portion of the premiums charged in the individual, small group and large group markets. Under the ACA, insurers in the individual and small group markets (generally, employers with 100 employees or less) will have to maintain MLRs of 80% or more, while insurers in the large group market will have to maintain MLRs at 85% or more. An MLR is the percentage of the insurance premium that is spent on actual medical services or activities that improve health care quality, and not on administrative expenses or profit. The MLR rules do not apply to self-funded plans. Insurers who do not meet these criteria will have to rebate part of the premiums they charged.

As these rules affect how insurers will manage their business practices, and the Interim Final Regulations (IFR), issued in 2010, imposed no direct obligations on employer/plan sponsors, this lack of interest was understandable. Under the IFR, it was the insurer's obligation to pay the rebates directly to the covered individuals, or to the employer with the assurance that the employer would simply pass the rebate along to the participants. Under the IFR, the employer, in short, was simply a conduit. Insurers complained bitterly, however, that this scheme was administratively unworkable for them, and the IRS indicated that the rebates paid in this manner would represent additional taxable income to the employees.

The final regulations, issued in December of 2011, directly addressed these issues by requiring that rebates were to be paid to the policyholder, which for group health plans usually means the employer/plan sponsor. The final regulations then went on to establish requirements about how the group policyholder must administer the rebate distribution. For ERISA plans, the Department of Labor (DOL) also issued Technical Release 2011-04 that explained how these rebates were to be administered for ERISA plans.

### Calculating the MLR – The Insurer's Obligation

Insurers will be required to report 2011 MLR data for each state in which they do business. Insurers that fail to meet the MLR standards for their 2011 policies will have to provide a rebate to enrollees in August of 2012. The data is to be based on a calendar year. The general formula for determining rebates is to multiply the percentage by which the insurer's MLR failed to meet the required percentages times the amount of premium revenue, less state and federal taxes and certain accounting risk adjustments. For example, if the insurer missed the MLR standard by 5% and the annual premium paid by an enrollee was \$2,000,

and the tax/risk adjustments came to \$150, the rebate would be 5% times (\$2,000 minus \$150) or 5% times \$1,850 or \$92.50 payable to that enrollee. The final regulation also provided that if the rebates were *de minimus*, i.e., below \$20 per group, the insurer would not have to make a rebate payment.

When reporting data, insurers are to aggregate premiums, amounts paid for medical services, quality improvement expenses and non-claim administrative costs for the individual, small group and large group markets in each state in which they do business. For group coverage in multiple states, the data will be attributed to the state that regulates the insurance contract with the group health plan. Thus, **the MLR for each insurer will reflect its book of business within a state and will not be based on the actual claims experience of any single group health plan.**

### Notice of Rebates

Insurers must provide notices of rebates, if any, to current group health plan participants, and group policyholders. The notice must include (i) a description of the MLR concept generally, (ii) the purpose of setting an MLR standard, (iii) the applicable MLR standard, (iv) the insurer's MLR for the calendar year being reported, (v) the insurer's aggregate premium revenue as adjusted for the relevant tax and risk factors, (vi) the rebate percentage for the involved group, (vii) a statement that the aggregate group rebate is being provided to the group policyholder, and (viii) a statement about the policyholder's obligations with respect to administering the rebate distribution, the content of which will depend on whether the policyholder is a sponsor of an ERISA plan, a non-federal governmental plan or a non-governmental, non-ERISA plan.

### For ERISA Plans -- Are the Rebates Plan Assets?

For ERISA plans, the key question that must be answered for employers to know how to administer the rebates is whether, and to what extent, are the rebates plan assets? To the extent the rebates are plan assets, the plan's fiduciaries must act prudently and in the sole interest of the participants and beneficiaries. First, if the group health plan itself is the policyholder, then the DOL has indicated that all of the rebate must be treated as plan assets. Second, if the policyholder is the employer/plan sponsor, then one must look to the plan's governing documents to determine what portion, if any, must be treated as plan assets. Third, if the documents are not clear, then generally the DOL will look to what portion of the premium has been paid by the employer and what part by the employees.

- The portion paid by the employees must be treated as plan assets.
- If the employer pays the entire premium, no part of the rebate is a plan asset and the employer can keep the entire rebate.
- If the employees pay a percentage of the premium, that percentage is to be treated as a plan asset. For example, if a group's rebate is \$20,000 and participants paid in the aggregate 40% of the premium, then \$8,000 of that \$20,000 would be plan assets that would have to be used exclusively to benefit participants.

- If the employees pay a fixed amount and the employer pays the rest, the amount paid by the employees is a plan asset and the excess is not; whereas if the employer pays a fixed amount and the employees pay the rest, it is the excess of the employer payment that is the plan asset.
- The DOL has emphasized that employer/plan sponsors are prohibited under ERISA from receiving a rebate amount greater than the total amount of premiums and other plan expenses paid by the employer.

**Note** -- Because the MLR must be determined on a calendar year basis, these proportions should probably be determined based on the calendar year for which the rebates relate, and not on the plan or policy year.

#### **For ERISA Plans -- Must the Rebates That Are Plan Assets Be Kept In Trust?**

To the extent the rebates are plan assets, ERISA would generally require they be held in trust. Technical Release 2011-04, however, provides a safe harbor -- if the rebate is used to "pay premiums or refunds" within three months, then no trust is required. In addition, there is no trust requirement if the plan assets are held by the insurance company. If employers could negotiate with their insurer to retain the premium to be used as an offset for future premiums that would avoid the trust issue. Whether insurers would be amenable to this alternative or resist it, may depend on how the retained premiums would be classified when calculating the insurer's MLR for the calendar year in which they are received if they are not to be applied to premiums until the following calendar year.

#### **For ERISA Plans -- Administering the Distribution of the Rebates**

To avoid negative tax consequences to plan participants by making a cash payment to them of the rebates owed, the plan fiduciary could apply the rebate towards future premiums (*i.e.*, a premium discount) or by putting it toward enhancing plan benefits. The DOL allows for cash refunds to participants, though the decision to distribute the rebates in that manner is subject to fiduciary considerations.

The DOL has saved employers a lot of grief by allowing that the distributions need only be made to those who are plan participants in the year the rebates are received. Employers need not track down those who were participants in the year to which the rebates relate (*i.e.*, the year for which the MLR was calculated), but are no longer in the plan.

The DOL has outlined three permissible distribution methods:

- Reduce premiums for the subsequent year for all participants in the plan, even if they were not covered under the option that generated the rebate.
- Reduce premiums only for those in the plan's option that generated the rebate.
- Pay a taxable cash refund to those enrolled in the plan option that generated the rebate.

The DOL did not provide any explicit guidance with respect to using the rebate to enhance benefits, though presumably if the rebate were used to discount premiums for an enhanced benefits policy, even if the resulting premium were the same or higher than the premium for the existing benefits policy, that would be acceptable.

### **For Non-ERISA Plans -- Administering the Distribution of the Rebates**

For non-federal government plans to which ERISA's fiduciary duties do not apply, the Department of Health and Human Services (DHHS) provided regulations that require those employer/plan sponsors to treat the rebates in a manner very similar to that imposed by ERISA. For plans that are neither ERISA plans nor government plans (*i.e.*, church plans), insurers can pay the rebate to the group policyholder only if the policyholder agrees in writing that the rebate will be paid to subscribers in the same manner as the DHHS requires for non-federal government plans. If no agreement is obtained, the insurer must pay the full amount of the rebate, including the amount based on the portion of the premium paid by the policyholder, to the participants in equal amounts. Finally, if a plan has terminated and the insurer cannot locate the policyholder, the insurer must distribute the full amount of the rebate directly to the plan participants in equal amounts.

### **Action Steps**

Employers who sponsor insured group health plans should familiarize themselves with these MLR requirements and what will be required of them should rebates be forthcoming from their insurer. Specifically, they should begin planning for how they might want to administer the distributions of a possible rebate, consistent with their fiduciary obligations. In connection with this, employers may want to contact their insurers and inquire about (i) whether the insurer is likely to meet the applicable MLR standard for 2011, and (ii) if not, how best to coordinate and establish a process for receiving and distributing the rebates. Since premium reductions of some variety may prove to be an attractive, if not the most attractive, alternative, it would be best to work out procedures with the insurer before August of 2012. If there are no rebates to be paid in 2012, there should be an understanding in place should rebate distributions be paid in 2013 or in subsequent years.

If you have any questions about these MLR rebates, about how any other feature of the health care reform law will impact your employee benefit program, or about any other employee benefits issue, please contact any one of the Honigman attorneys listed on this Alert.