Medical Loss Ratio

Frequently Asked Questions

General Questions

What does the Medical Loss Ratio (MLR) provision address?
The MLR provision of the Affordable Care Act (the Act) requires all health insurance companies to spend a certain portion of fully insured individual and group insurance premium dollars on health care claims and programs to improve health care quality. If these thresholds are not met, the insurer may have the obligation to rebate certain amounts back to the applicable policyholders. The law provides guidance regarding the calculation and reporting of the Medical Loss Ratio as well as, where applicable, the criteria for when rebates to policyholders must be paid.

What is the required Medical Loss Ratio as outlined under the regulation?

- Individual and Small Group Market - 80 percent
- Large Group – 85 percent

What defines the small and large group markets?
The Act defines "Small Group" as plans having 1-50 total average employees based on the preceding calendar year. However, with the passing of the PACE Act in early October 2015, states remain at 1-50 Small Business definition or allows a transition for those states that chose an upper limit of 100 prior to January 1, 2016.

Are there special considerations to prevent disruption to the market?
Yes. Special considerations are in place for the regulations of small plans, new plans, mini-med, expatriate and student plans. Each of these types of plan has a separate process and criteria by which a change to the standard MLR may be accommodated, if they qualify, for a period of time as outlined under the regulations.

Does the MLR provision apply to both fully insured and ERISA self-funded plans?
No, it applies just to fully insured health plans. ERISA self-funded plans are not a health insurance issuer, as defined by the regulation.

When did the MLR interim final regulation go in effect?
January 1, 2011. Any rebates applicable to 2011 were paid out by August 1, 2012.

Calculation

How is the MLR calculated?
The calculation is based on the incurred claims and the expenses for activities that improve health care quality divided by earned premium minus federal and state taxes, licensing and regulatory fees, adjusted for risk adjustment, risk corridor, and reinsurance under the Act. Calculations are conducted on a calendar year basis.

For purposes of calculating the MLR, policies are grouped together based on the health plan that issued the coverage, the state where issued and the market segment (Individual, Small Group or Large Group). The MLR is then computed for the entire group of policies in the aggregate.

What is considered an activity that improves health care quality?
Activities that improve health care quality increase the likelihood of desired health outcomes and are grounded in evidence-based medicine. Quality improvement programs are designed to achieve the following goals:

- Improve health outcomes, including an increased likelihood of desired outcomes compared to a baseline and reduced health disparities among specified populations
- Prevent hospital readmissions
- Improve patient safety and reduce medical errors, lower infection and mortality rates
- Increase wellness and promote health activities
- Enhance the use of health care data to improve quality, transparency and outcomes

What activities are not considered quality improvement activities in the MLR calculation?
Activities designed primarily to control or contain costs are not to be reported as quality improvement. Specifically identified examples of activities that may not be counted as quality improvement include:

- HIPAA and certain ICD-10 implementation and administration costs. However, insurers are to report the costs of implementation to document these costs.
- Retrospective and concurrent utilization review
- Most fraud prevention activities (other than to the extent they recover incurred claims)
- Provider network contracting costs and fees
- Provider credentialing
- Costs associated with calculating and administering enrollee/employee incentives

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Reporting

What are insurance company reporting requirements to HHS?

Each health insurer must report to the Department of Health and Human Services (HHS) for each calendar year. Issuers will report, among other things, the premium earned, claims, quality improvement expenses and other non-claims costs incurred under health insurance that is in force during the calendar year.

Rebates

What is the general requirement for distribution of MLR rebates?

In most circumstances, an issuer must provide any owed premium rebate to each applicable group policyholder if the issuer's relevant MLR does not meet or exceed the minimum MLR percentage required for that calendar year. Some rebates will be required to be sent to group policy subscribers in very limited circumstances. For policies in the individual market, rebates are paid directly to the individual policyholder.

Who is eligible for a rebate?

The MLR is calculated for all policies included in a specific block as categorized by the issuing insurer, state where issued and line of business (Individual, Small Group or Large Group). All policies in such block will either receive a rebate or not based on the computed MLR for the entire block. Eligibility for MLR premium rebates does not depend upon the usage of health plan services by the group or individual policyholder.

Will customers be notified if they become eligible for rebates?

Once the MLR has been calculated and eligible policyholders are verified, the policyholder will receive the rebate and the relevant group plan subscribers will receive written notice of the rebate.

How are specific group policy rebates distributed?

For most **ERISA plans** (i.e., employment-based coverage), the rebate will be paid to the group policyholder and the policyholder must use the rebate to benefit the subscribers of the relevant plan consistent with Department of Labor requirements (see below).

Federal governmental plan rebates will be paid to the group policyholder.

Non-federal governmental plan rebates will be paid to the group policyholder, with the policyholder having an obligation to use the portion of the rebate attributable to the premium paid by subscribers in one of the following three ways:

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

For those plans that are **neither governed by ERISA nor governmental plans** (e.g., church plans), the rebate will be paid to the group policyholder only if the policyholder provides written assurance that it will use the rebate according to standards applicable to non-federal governmental plans. If no such assurance is received, the issuer will divide the entire rebate equally among all applicable subscribers.

When would the rebates go out?

The insurer must provide all rebates by September 30 following the end of the MLR reporting year.

What guidelines are there for ERISA customers to follow in terms of the requirement to use the rebate to benefit their subscribers?

ERISA plans must check their plan documents to determine how they may use a premium rebate, including whether there are any timeframes in which a rebate must be used and to which uses a rebate may be put. Some plan sponsors may also have a more formalized trust document that should be consulted.

The Department of Labor (DOL) may also be able to assist ERISA plans on this issue. The Department of Labor's Employee Benefits Security Administration may be reached at 1-866-444-EBSA (3272) or on its website at **http://dol.gov/ebsa/newsroom/tr11-04.html**.

Unfortunately, there is no one answer to every situation. Each ERISA group health plan sponsor needs to review the terms of its plan and its specific situation to determine how to utilize rebate proceeds.

Whatever the type of plan, we recommend that customers consult with their legal counsel if they have questions on how to handle any premium rebate received.

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