

Medical Loss Ratio

The Affordable Care Act (the Act) includes a provision calling for fully insured health plans and issuers to annually calculate the medical loss ratio (MLR) to show the percentage of premium dollars spent on medical claims, clinical services and activities designed to improve health care quality. Insurers are required to spend a minimum percentage of premium dollars in these areas in a given calendar year, beginning January 1, 2011.

The Act specifies a target of an 80% MLR for individual and small group markets and 85% for large group markets. The Act defines "Small Group" as plans having one to 100 total average employees based on the preceding calendar year. However, if a state's current definition of Small Group for other purposes includes an upper limit of 50 employees, the state will have to affirmatively elect to use the Act's definition until 2016. After January 1, 2016, Small Group will be defined pursuant to the Act's provisions for all states. Large Group will be determined based on the upper limit established by the Small Group rules.

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The Interim Final Rule (IFR) defines a "plan year" as the calendar year, which will be the basis for MLR reporting. MLR is based on the aggregate experience of the issuer, by state, by insurance legal entity and by segment (individual, small and large).

Failure to achieve the designated MLR in a given year will result in payment of rebates to individual and group policyholders in most circumstances depending on the type of plan. The rebate will be based upon the percentage by which the insurer did not achieve the standard and the related amount of premium represented by that percentage.

In most cases, the group policyholders will have restrictions on how they can use the rebate, which are designed to assure that the subscribers receive an appropriate benefit. Rebates owed in the individual market will be paid to the individual policyholder.

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The MLR standard applies to health insurance plans offering group or individual coverage, including those designated "grandfathered plans." It does not apply to self-insured plans. In order to avoid market destabilization, special considerations for individual plans, small blocks, new plans, mini-med and expatriate plans are accounted for in the program.

For each state in which health insurers write coverage, they must submit data on aggregate premiums, claims experience, quality-improvement expenditures and non-claims costs incurred in the large group, small group and individual markets.

Part of the MLR provision calls for health insurers to report annually to HHS on the percent of total premium revenue spent on activities that improve health care quality. These activities must meet the following requirements:

- Be designed to improve health quality;
- Be designed to increase the likelihood of desired health outcomes in ways that can be objectively measured and produce verifiable results;
- Be directed toward individual health plan members, incurred for the benefit of specified member segments or provide health improvements to the general population;
- Be grounded in evidence-based medicine, widely accepted best clinical practice or criteria established by recognized health care quality organizations.

HHS has worked with the National Association of Insurance Commissioners (NAIC) to establish uniform definitions of activities reported in calculating the MLR, as well as methodologies for the calculation.

The MLR calculation is defined as the medical numerator divided by the premium denominator.

Medical numerator: Incurred claims and expenses for activities that improve health care quality;

Premium denominator: Premium revenue less federal and state taxes, licensing and regulatory fees, with adjustments for risks, risk corridors and reinsurance.

As part of the calculation, the NAIC developed a "credibility adjustment," designed to allow smaller plans to adjust their MLR to take into account the special circumstances of smaller plans, different types of plans and newer plans. The intent of the adjustment is to address the impact of claims variability that smaller plans can experience.

State insurance commissioners can request a waiver from the 80% MLR requirement for the individual market if the insurance commissioner determines there is a "reasonable likelihood" that destabilization may occur in the individual market without the adjustment.