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Medical Loss Ratio (MLR) Rules

Effective Jan. 1, 2011, the Affordable Care Act (ACA) established medical loss ratio (MLR) rules to help control health care coverage costs and ensure that enrollees receive value for their premium dollars. The MLR rules require health insurance issuers to spend **80—85 percent** of premium dollars on medical care and health care quality improvement, rather than administrative costs. Issuers that do not meet these requirements must provide **rebates to consumers**.

In each state where an issuer does business, it is required to report information to HHS on how it spent its premium dollars for the year by **July 31** of the following year. Issuers that do not meet the applicable MLR standard must provide rebates to consumers. Rebates must be paid by **Sept. 30** of each year, and are based upon aggregated market data in each state, not upon a particular group health plan's experience.

This ACA Overview provides a summary of the ACA's MLR requirements.

LINKS AND RESOURCES

- On Dec. 1, 2010, the Department of Health and Human Services (HHS) issued interim final regulations implementing the ACA's MLR requirements.
- HHS posts MLR data on its website to help educate consumers on the value of insurance coverage offered in their state.
- The Department of Labor (DOL) issued Technical Release 2011-4 (TR 11-4) to explain how ERISA's fiduciary duty and plan asset rules apply to MLR rebates.

HIGHLIGHTS

MLR STANDARDS

- Issuers in the **large group market** must spend at least **85 percent** of premiums on medical care and health care quality improvement activities.
- Issuers in the **small group and individual markets** must spend at least **80 percent** of premiums on those items.
- **Note**: States may set higher MLR standards than the federal 80/85 percent thresholds.

WHO IS AFFECTED?

- The MLR requirements apply to grandfathered and non-grandfathered health insurance issuers offering group or individual health coverage.
- However, these rules do not apply to self-insured plans.

CALCULATING THE MLR

An issuer's MLR is calculated as a fraction, where:

- The numerator is the amount of incurred claims paid, plus expenses for health care quality improvement activities; and
- The denominator is the issuer's premium revenue (excluding federal or state taxes and licensing and regulatory fees), and after accounting for payments or receipts related to the ACA's risk adjustment, risk corridors or reinsurance programs.

An issuer may deduct from earned premiums the higher of either:

1. The amount paid in state premium tax; or
2. Actual community benefit expenditures up to the highest premium tax rate in the state.

"Community benefit expenditures" are expenditures for activities or programs that aim to improve access to health services, enhance public health and relieve government burden.

Also, ACA assessments or fees are a state or federal assessment and may be excluded from the MLR calculation for the reporting year that they were incurred. For example, these include:

- The fees required by the risk adjustment program;
- The fees for funding the Patient Centered Outcomes Research Institute (PCORI); and
- The annual fee on health insurers.

An issuer may also include user fees paid to an Exchange as part of the licensing and regulatory fees that are subtracted from the premium in calculating the MLR.

However, an issuer's operating costs or any administrative costs associated with taxes or fees (such as those related to implementing and operating data submission and validation systems for the risk adjustment program) may not be deducted from premium for purposes of the MLR calculation.

Health Care Quality Improvement Activities

In determining whether the issuer meets the MLR requirements, amounts paid toward medical care include direct claims (including incentive and bonus payments) paid to providers and activities to improve health care quality. To be considered a "health care quality improvement activity," the activity must be designed to improve health quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

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The following chart provides examples of qualifying and non-qualifying activities:

QUALIFYING ACTIVITIES	NON-QUALIFYING ACTIVITIES
Health care quality improvement activities include: • Case management; • Care coordination; • Chronic disease management; • Wellness programs; • Supporting health information technology; • Hospital discharge programs; • Measures to improve patient safety and reduce medical errors; and • Fees charged by accrediting entities for certification of qualified health plans (QHPs).	Items that are *not* considered health care quality improvement activities include: • Activities primarily to control or contain costs; • Establishing or maintaining a claims adjudication system; • Retrospective and concurrent utilization review; • Fraud prevention activities;* • Costs of executing provider contracts or developing a provider network; • Provider credentialing; and • Marketing.

NOTE: The amount of claims payments recovered through fraud reduction efforts, up to the amount of fraud reduction expenses, can be included in incurred claims when calculating the MLR. In addition, HHS requested comments in its proposed Notice of Benefit and Payment Parameters for 2017 on whether an issuer's* ***investments in fraud prevention activities generally should be included as incurred claims* *for MLR reporting purposes.*

An issuer may also count a vendor's expenses as activities that improve health care quality, to the extent that the issuer and vendor can show that these expenses were incurred for performing allowable quality improving activities on behalf of the issuer. For example, to the extent that a pharmacy benefits manager (PBM) performs functions that are designed primarily to identify quality concerns (such as potential adverse drug interactions) those costs may be reported, in aggregate, as expenditures for activities that improve health care quality.

Administrative Expenses

An issuer's administrative expenses do not count toward medical care spending. Examples of administrative expenses that cannot be taken into account when calculating the MLR include:

- Amounts paid to third party vendors for secondary network savings, network development, administrative fees, claims processing and utilization management;
- Amounts paid (including amounts paid to a provider) for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee (such as medical records copying costs, attorneys' fees and compensation to administrative personnel);
- Cost containment and loss adjustment expenses;

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- Workforce salaries and benefits (including sales personnel);
- Agents' and brokers' fees and commissions;
- General administrative expenses; and
- Community benefit expenditures.

However, HHS requested comments in its proposed 2017 Notice of Benefit and Payment Parameters on whether an issuer's **investments in fraud prevention activities should be included as incurred claims** for MLR reporting. Currently, issuers may only include amounts recovered through fraud reduction efforts, up to the amount of fraud reduction expenses, in incurred claims when calculating the MLR.

DISCLOSURE AND REPORTING

Under the MLR rules, issuers must submit a report to HHS concerning premium revenue and expenses related to the group and individual health insurance coverage that it issued for each MLR reporting year. In general, the report must be submitted to HHS by **July 31** of the following year (June 1 for MLR reporting years prior to 2014), in the form and manner required by HHS.

REBATES

For each MLR reporting year, the issuer must provide a proportionate rebate if the MLR does not meet the minimum requirements. The amount of the rebate is based on the premium received (less appropriate taxes and fees), which is then multiplied by the difference between the required MLR and the issuer's actual MLR for the year.

Payment of Rebates

Issuers are generally required to provide rebates directly to policyholders. Policyholders must use the rebates for the benefit of enrollees. Policyholders may use the rebates for the benefit of enrollees in ways that are not taxable, such as through lowered premiums. This process varies according to the type of plan. For plans subject to ERISA, for instance, the rebates may be considered plan assets that are subject to ERISA's fiduciary responsibility requirements. Any rebate amount that qualifies as a plan asset under ERISA must be used for the exclusive benefit of the plan's participants and beneficiaries. DOL TR 11-4 explains how ERISA's fiduciary duty and plan asset rules apply to MLR rebates.

Exception for Small Rebate Amounts

No rebate is required to be paid to a group policyholder if the total amount owed to the policyholder and enrollees combined is less than **$20** for an MLR reporting year. For rebates distributed directly to enrollees by issuers, such as when an issuer does not receive assurance that the policyholder will use the rebate for the benefit of enrollees, no rebate is required if it would be less than **$5** per subscriber covered by the policy.

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This exception for small rebate amounts applies to the rebates an issuer is required to pay. It does not apply to amounts that are received by a n employer for its group health plan. Thus, this exception does not apply when a group health plan is determining how to handle a rebate.

Timing of Rebates

An issuer must provide any rebate owed no later than **Sept. 30** following the end of the MLR reporting year (Aug. 1 for MLR reporting years prior to 2014). If the rebate payment is late, interest on the rebate amount must be paid as well. Also, if an issuer's solvency would be affected beyond certain levels, HHS may defer all or a portion of the required rebates. However, the issuer will be required to pay the rebates, with interest, in a future year.

NOTICES

When providing a rebate to a group policyholder, the issuer must provide the policyholder and subscribers with a notice describing the MLR requirements, including the following information:

- A general description of the concept of an MLR;
- The purpose of setting a MLR standard;
- The applicable MLR standard;
- The issuer's MLR;
- The issuer's aggregate premium revenue, minus any federal/state taxes, and licensing and regulatory fees that may be excluded;
- The rebate percentage and amount owed to enrollees based upon the difference between the issuer's MLR and the applicable MLR standard; and
- The fact that the total aggregated rebate for the group health plan is being provided to the policyholder and a description of how the rebate will be handled.

For each MLR reporting year, issuers must submit a report to HHS regarding their rebates.

ENFORCEMENT

HHS is responsible for enforcing the reporting and rebating requirements of the MLR rules. In order to enforce these rules, HHS can audit issuers for compliance. Issuers must provide HHS with access to records and must maintain records to demonstrate compliance for **six years**.

Issuers that do not comply with the MLR requirements may be subject to civil penalties **up to $100 per day** for each individual affected by the violation. HHS can also order an issuer to pay rebates if it has failed to do so.

Penalties will not be assessed for periods where the issuer did not know of the failure, or would not have known about it if it had exercised reasonable diligence. HHS may not issue a penalty for the period after the issuer discovered the failure (or would have discovered it if it had exercised reasonable diligence), if the failure was due to reasonable cause and not due to willful neglect and the failure was corrected within 30 days.

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