

Medical Loss Ratio Standards

For Certain Fully Insured Plans



Medical loss ratio standards explained.

Under the Affordable Care Act (the Act), fully insured health plans and issuers are subject to new standards requiring a minimum percentage of premium dollars to be spent on medical claims, clinical services and activities designed to improve health care quality.

As a result, on a calendar year basis, insurers must achieve a medical loss ratio (MLR) of 80 percent for individual and small group markets, and 85 percent for large group markets. Prior to January 1, 2016, the Act defined “Small Group” as plans having 1-50 total average employees based on the preceding calendar year, unless the state elected to use an upper limit of 100 for MLR purposes. With the passing of the PACE Act in early October 2015, effective January 1, 2016, the “Small Group” definition remains 1-50, unless a state specifically chooses a 1-100 definition. Federal guidance allows for states that chose to have an upper limit of 100 for MLR prior to January 1, 2016, to use a transition period before they move back to 1-50 definition.

Rules regarding the issuance of rebates vary depending on whether a group is a plan governed by ERISA, a governmental plan or neither. In most circumstances, an issuer must provide a rebate to each applicable group policyholder if the issuer’s relevant MLR does not meet or exceed the minimum MLR percentage required during the MLR reporting year.

How the rebate is used.

Most group policyholders have the obligation to use a portion of the rebate to benefit their subscribers. In very limited circumstances, rebates will be required to be sent to group policy subscribers. For policies in the individual market, rebates will be paid directly to individual policyholders.

How the MLR is calculated.

The MLR is calculated for each legal insurance entity broken down by state and line of business. Group customers are organized by employer situs (i.e., contract issuance state), and type (small or large), to determine eligibility for rebates.

MLR calculation defined.

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

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

Among the activities that improve health care quality are:

- case and disease management;
- nurse line;
- certain wellness expenses;
- prospective utilization review;
- medical home as defined in the Act.

Activities excluded from the health care quality component include:

- provider credentialing;
- provider contracting and network management;
- concurrent and retrospective utilization review;
- HIPAA and certain ICD-10 implementation costs.

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

In addition, the federal government has allowed for credibility adjustments or other accommodations to apply to small plans, new plans, mini-med plans and expatriate plans.

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