Medical Loss Ratio

Overview

The Affordable Care Act and medical loss ratio requirements.

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 have been required to spend a minimum percentage of premium dollars in these areas in a given calendar year since 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 50 total average employees based on the preceding calendar year.

Small group defined.

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.

Plan year defined.

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.

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.

MLR standard application.

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.

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HHS reporting requirements.

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.

MLR calculation defined.

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 and new market entrants can experience.

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