Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress

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Summary

The 2010 Patient Protection and Affordable Care Act (ACA, P.L. 111-148) requires certain health insurers to provide consumer rebates if they do not meet a set financial target known as a medical loss ratio (MLR). At its most basic, a MLR measures the share of health care premium dollars spent on medical benefits, as opposed to company expenses such as overhead or profits. For example, if an insurer collects $100,000 in premiums and spends $85,000 on medical care, the MLR is 85%. In general, the higher the MLR, the more value a policyholder receives for his or her premium dollar. The ACA requires an annual, minimum 80% MLR for individual and small group insurance plans, and an annual, minimum 85% MLR for large group plans. Congress imposed the MLR to provide "greater transparency and accountability around the expenditures made by health insurers and to help bring down the cost of health care."

The Department of Health and Human Services (HHS) issued rules to implement the MLR with input from state insurance commissioners, who are the main regulators of health insurance. The ACA statute and regulations allow companies to include both quality improvements and medical services when calculating total MLR medical spending. Insurers may subtract (i.e., disregard) state and local taxes and some licensing fees from total MLR expenses. The federal ACA requirements differ from many state MLR laws, which generally compare medical claims to premiums. The ACA MLR is now the national minimum standard that must be met by covered health insurers.

The ACA MLR is based on an insurer's annual aggregate performance, not on each individual's policy history. A consumer who paid health insurance premiums but did not file any medical claims during a plan year would not qualify for a rebate if his or her insurer met minimum MLR requirements. In addition, many Americans are enrolled in health plans that are not covered by the ACA MLR. The MLR provisions apply to fully funded health plans, which are plans where insurance companies assume full risk for incurred medical expenses. The MLR does not extend to self-funded plans, which are health care plans offered by businesses where the employer assumes the risk for, and pays for, medical care. Non-profit insurers and Medicare plans were not subject to the MLR during the first two years the ACA was in effect. These insurers must comply with MLR provisions beginning in calendar 2014. The HHS granted three-year MLR waivers to select states where it determined that MLR implementation could harm the individual insurance market.

For the 2013 plan year, insurers owe $332 million in MLR rebate payments to 6.8 million consumers. That is significantly less than the $1.1 billion in rebates to 12.8 million individuals in 2011, the first year the MLR was in effect. Insurers and employers may provide the rebates via a check, an electronic deposit in a bank account, a reduction in insurance premiums, or by spending the funds for the benefit of employees. Lawmakers have raised some concerns about the MLR provisions, including the fact that insurers are not allowed to deduct insurance agent and broker bonuses and commissions from their MLR expenses.

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Introduction

Health insurance provides protection against the financial risks associated with illness or injury. Consumers who enroll in health insurance plans pay premiums for a specified set of benefits. When insurers set premiums they include the cost of a set package of medical benefits as well as other costs such as overhead. In broad terms, a medical loss ratio (MLR) measures the share of enrollee premiums that health insurance companies spend on medical claims, as opposed to other non-claims expenses such as administration or profits. Many states, as the primary regulators of health insurance, have their own MLR requirements, which they use to evaluate companies and compare health plans. (See **Appendix B** for data on state MLRs.) Private entities, such as stock and bond analysts and lenders, also use various MLR data when assessing the financial performance of health insurers.

In general, the higher the MLR, the more value a consumer receives for each dollar of paid premium. For example, an 85% MLR means that 85% of premium dollars paid into a plan are paid out in the form of benefits. A 75% MLR means that just 75% of premium dollars are used for benefits. The MLR is an aggregate measure. Because the ratio is based on a health plan's overall performance, some enrollees may pay more in premiums during the course of a year than they receive in benefits, while others may receive benefits that far exceed their premium payments.

Section 1001 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended)[1] imposes a federal, minimum MLR requirement on fully funded health plans, which are plans where insurance companies assume the full risk for medical expenses incurred.[2] Beginning with calendar year 2011, covered insurers have been required to submit reports to the Department of Health and Human Services (HHS) detailing the share of premium dollars spent for medical benefits (which may include certain quality improvements), and the share allocated to administrative expenses and profits (minus certain taxes, fees, and other expenses).[3] The MLR

[1] HHS issued the following regulations to implement the ACA MLR provisions: "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register* 45 CFR 158, December 1, 2010, http://www.gpo.gov/fdsys/pkg/FR-2010-12-01/pdf/2010-29596.pdf; "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Corrections to the Medical Loss Ratio Interim Final Rule With Request for Comments," *Federal Register* 45 CFR 158, December 30, 2010, http://www.gpo.gov/fdsys/pkg/FR-2010-12-30/pdf/2010-32526.pdf; "Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans; Interim Final Rule," *Federal Register* 45 CFR 158, December 7, 2011, http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31291.pdf; "Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act, Final Rule," *Federal Register* 45 CFR 158, May 16, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-05-16/pdf/2012-11753.pdf; "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rules; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. Small Business Health Options Program, Proposed Rule," *Federal Register,* 45 CFR Parts 153, 155, 156, et al, March 11, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf; and "Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs; Final Rule," *Federal Register*, 42 CFR Parts 422 and 423, May 23, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf

[2] In fully funded insurance plans employers purchase health coverage from insurance underwriters that assume the full financial risk for claims made under the plan—that is, the risk that benefits paid out could exceed premiums paid in. In self-funded health plans, which are most often used by large employers, companies use their own assets to cover risk and may purchase stop-loss insurance from outside companies to limit their overall liability. Self-funded plans are not subject to the same insurance regulations as fully funded plans.

[3] See §2718(a) of the Public Health Service Act (PHS).

requirement is intended to provide "greater transparency and accountability around the expenditures made by health insurers and to help bring down the cost of health care."[4]

Insurance companies must issue rebates to policyholders each year that they do not meet ACA MLR standards for individual, small group, and large group policies. The HHS in July 2014 announced that, based on 2013 performance, insurers would be required to issue $332 million in rebates to 6.8 million consumers.[5] That compares to $504 million in rebates to 8.5 million individuals for 2012,[6] and $1.1 billion in rebates to 12.8 million individuals for 2011 plan performance. [7]

This report provides a detailed description of the ACA requirements for MLR reporting and rebates as specified in regulations, including

- MLR reporting requirements under ACA,
- components of the MLR formula,
- state flexibility and waivers, and
- the nature of rebates to policyholders.

The report also addresses issues that have been raised about the MLR provisions since the ACA was enacted, namely the treatment of insurance commissions paid to brokers and agents.

MLR Reporting Requirements Under the ACA

Minimum Standards Required

The ACA MLR standards require that covered insurers in the individual and small group markets meet a minimum MLR of 80%. For insurers that sell large group plans, the minimum MLR is 85%. The higher MLR requirement for the large group market accounts for economies of scale; in other words, it is more efficient to sell insurance to a large company that will offer coverage for many individuals and families than it is to have to market a product to one individual at a time, or to firms that cover a smaller group of individuals. Thus, the higher MLR standard for large companies reflects their assumed lower administrative costs.

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[4] Department of Health and Human Services, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register,* 45 CFR Part 158**,** December 1, 2010, p. 74864 -74934; https://www.federalregister.gov/articles/2010/12/01/2010-29596/health-insurance-issuers-implementing-medical-loss-ratio-mlr-requirements-under-the-patient. The rule states that the ACA MLR provisions have two purposes, "The first is the establishment of greater transparency and accountability around the expenditures made by health insurance issuers ... The second is the establishment of MLR standards for issuers, which are intended to help ensure policyholders receive value for their premium dollars."

[5] Department of Health and Human Services, "Consumers Benefited From 80/20 Rule in 2013," http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report_07-22-2014.pdf

[6] Department of Health and Human Services,"80/20 Rule Delivers More Value to Consumers in 2012," http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf.

[7] Department of Health and Human Services, "The 80/20 Rule: Providing Value and Rebates to Millions of Consumers," http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/mlr-rebates06212012a.html.

For purposes of calculating the MLR, the ACA defines large group policies as policies sold to employers with more than 100 workers, and small group policies as those of up to and including 100 workers.[8] Individual policies can be policies bought through an insurance agent or broker, or through an association that is not part of a larger group policy. An individual plan can also be purchased through a state health exchange established under the ACA.[9]

In addition, MLR reporting requirements exclude premiums and claims experience of newly introduced health insurance offerings, under certain circumstances.[10]

Timeline for Compliance

The ACA required health insurers to provide their first MLR reports to the HHS by June 1, 2012, detailing financial activity for 2011.[11] Likewise, MLR reports for 2012 and 2013 were due by June 1 of the following year. Beginning with the 2014 benefit year, insurers must provide MLR reports to HHS by the following July 31.[12]

Each insurer covered by the law must report aggregated activity within each state for the three market segments: large group, small group, and individual policies. If a group policy covers workers in more than one state, the activity is recorded in the state where the policy is issued.[13] HHS rules allow penalties to be imposed on companies that do not comply with reporting, auditing, rebate, or other requirements, equal to $100 per entity per affected individual each day the insurer is out of compliance.[14]

Who Must Comply

The ACA generally requires fully funded health insurers offering coverage (including grandfathered health plans)[15] to report their MLRs. For-profit, fully funded insurers provided their

[8] Prior to passage of the ACA, some states identified businesses with 51 or more workers as large group plans and those with 50 or less as small groups. Some states also regulate very small groups (one person) as small groups. The HHS regulations allow states, until 2016, to continue to define large groups as those with 51 or more workers. Other provisions of the ACA use different definitions of small and large group plans.

[9] CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach

[10] Under the regulation, an insurance company is allowed to defer, until the next MLR reporting year, activity from new policies issued after the first of the year, if the new policies make up more than half a company's overall premium revenue for a market segment in an individual state.

[11] Companies are required to report calendar year activity when calculating the MLR, rather than using plan year, corporate fiscal year, or other alternatives.

[12] 45 CFR Section 158.111.

[13] The rules apply unless the policy is offered through multiple subsidiaries in various states.

[14] Department of Health and Human Services, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, §158.606, December 1, 2010, p. 74890; https://www.federalregister.gov/articles/2010/12/01/2010-29596/health-insurance-issuers-implementing-medical-loss-ratio-mlr-requirements-under-the-patient.

[15] The ACA defines a grandfathered health plan as coverage provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under the rules of the ACA). A group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010, cease to be covered. A number of ACA provisions apply to all plans, including grandfathered plans, but some (continued...)

first MLR reports to HHS by June 1, 2012. Non-profit insurers are required to report their MLRs, beginning in 2014.[16]

The federal MLR requirements for not-for-profit insurers are specified in a different section of the ACA and essentially amend Section 833 of the Internal Revenue Code (IRC).[17] The ACA requires that non-profit insurers meet minimum MLR standards in order to keep their non-profit status. Under final IRS regulations, a non-profit insurer would lose its non-profit status for the taxable year or years in which the insurer did not meet the MLR standard.[18] The IRS regulations do not allow non-profit insurers to adjust medical claims for quality expenditures, as is the case with for-profit insurers.[19]

The ACA imposes separate MLR standards for Medicare Part D prescription drug plans and Medicare Advantage Plans (MA), which are plans that provide private insurance options, such as managed care, to Medicare beneficiaries who are enrolled in both Medicare Parts A and B.[20] Effective in 2014, the ACA requires coverage sold through these programs, with some exceptions, to achieve a minimum 85% MLR. MA and Part D contracts that do not meet this standard will have to pay HHS an amount equal to their total revenue multiplied by the difference between the 85% goal and their actual MLR. If MA and Part D contracts have an MLR below 85% for three consecutive years, enrollment will be restricted. If a contract is out of compliance for five consecutive years, the contract will be terminated. (See "Medicare Advantage and Part D Drug Plans.")

The HHS provides additional adjustments to the MLR formula for two less common types of health insurance: expatriate and mini-medical policies. Expatriate plans are group policies that can cover employees working outside their home country or non-U.S. citizens working for American firms in their home country. Mini-medical plans subject to the additional adjustments have total annual benefit limits of $250,000 or less. Because of the unique characteristics of these plans, HHS determined that insurers would have difficulty meeting minimum MLR requirements. (See **Appendix C**.)

The MLR requirement does not apply to self-funded plans,[21] which are health care plans offered by businesses in which the employer assumes the financial risk for medical care. During 2012, 58.6% of private sector insurance enrollees obtained health coverage through self-funded plans.[22]

(...continued)

provisions apply only to new plans.

[16] §9016(a) of ACA (P.L. 111-148) amends Internal Revenue Code §833(c) adding paragraph (5).

[17] §9016 of ACA.

[18] Internal Revenue Service (IRS), "Computation of, and Rules Relating to Medical Loss Ratio," *Federal Register*, 26 CFR Part 1, January 7, 2014, p. 757; http://www.gpo.gov/fdsys/pkg/FR-2014-01-07/pdf/2014-00092.pdf; and IRS Notice 2012-37, "Extension of Interim Guidance on Modification of Section 833 Treatment of Certain Health Organizations," June 11, 2012, http://www.irs.gov/irb/2012-24_IRB/ar07.html.

[19] Internal Revenue Service (IRS), "Computation of, and Rules Relating to Medical Loss Ratio," *Federal Register*, 26 CFR Part 1, January 7, 2014, p. 757; http://www.gpo.gov/fdsys/pkg/FR-2014-01-07/pdf/2014-00092.pdf.

[20] See §1103, Health Care Reconciliation Act (P.L. 111-152) and Centers for Medicare & Medicaid Services, "Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs: Final Rule," *Federal Register*, 42 CFR Parts 422 and 423, May 23, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf.

[21] Employers who offer self-funded plans are assuming the "risk" for paying for medical claims; it is in their own best interest to do so.

Medigap plans, which are supplemental policies that Medicare beneficiaries can purchase to fill gaps in Medicare coverage, are not covered by the ACA MLR provisions. Medigap plans are subject to their own separate MLR requirements, found in Title 18 of the Social Security Act; the MLR requirements are 65% in the individual marketplace and 75% in the group market.[23]

Finally, the ACA's MLR requirements do not apply to long-term care, dental, vision, or retiree health insurance.

Components of the MLR Formula

The federal MLR represents the percentage of premium dollars spent on medical claims and quality improvement activities. Mathematically, the formula for calculating the MLR is displayed in the text box below. The numerator is the sum of medical claims plus quality improvement expenditures. (This differs from the general approach of state insurance regulators, where the numerator is only medical claims.) The federal MLR denominator is earned premiums[24] minus taxes, licensing, and regulatory fees.

Formula for Calculating the MLR

NUMERATOR: Medical Claims + Quality Improvement Expenditures

Divided by:

DENOMINATOR: Earned Premiums - Taxes, Licensing and Regulatory Fees

Specific details about how each of these components is defined and measured are important in deriving the MLR for each insurer and, thus, the potential rebate to policyholders. The ACA directed the National Association of Insurance Commissioners (NAIC)[25] to recommend the factors that should go into each component of the MLR formula. In December 2010, HHS published interim final regulations to implement the MLR provisions, based largely on a model regulation drafted by the NAIC. Since then, HHS has issued corrections and amplifications to the rule, including a final regulation on May 16, 2012.[26] The following sections provide greater detail on each of the components of the MLR formula, as described in the HHS regulations.

(...continued)

[22] Beth Levin Crimmel, "Changes in Self-Insured Coverage for Employer-Sponsored Health Insurance: Private Sector, by Firm Size, 2001-2011," Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, Statistical Brief #412, June 2013, http://meps.ahrq.gov/mepsweb/data_files/publications/st412/stat412.pdf.

[23] CRS Report R42745, *Medigap: A Primer*, by Carol Rapaport.

[24] The amount of a premium that an insurer can consider earned is based on the time elapsed on a policy. In a simple example, if a person pays a $1,000 premium for a two-year policy and a year has elapsed with no claims paid, the insurer has earned 50% of $1,000, or $500.

[25] Most insurance regulation is carried out at the state level. The National Association of Insurance Commissioners (NAIC) is an organization of the chief insurance regulators of the 50 states, the District of Columbia and five U.S. territories. The NAIC, founded in 1871 to coordinate insurance regulation, sets standards and best practices for insurance products.

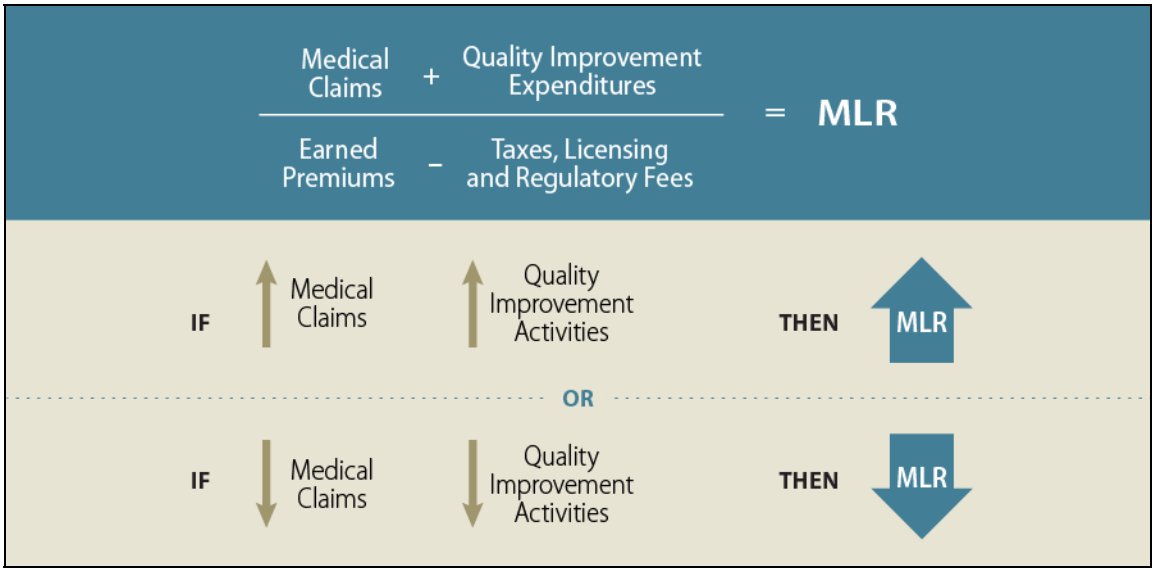
[26] See footnote **Error! Bookmark not defined.** for a listing of federal regulations relating to the MLR requirements.

Medical Claims and Quality Improvement Expenditures

As illustrated in **Figure 1**, increases in either medical claims or quality improvement expenditures (holding other factors constant) will increase the MLR and reduce the likelihood of premium rebates to policyholders. Conversely, reductions in medical claims and/or quality improvement expenditures (holding other factors constant) will decrease the MLR and increase the likelihood that insurers will have to provide rebates to policyholders.

Figure 1. Impact of Changes to Numerator on MLR

(Holding Other Factors Constant)



Source: Congressional Research Service.

Notes: There are a number of other combinations of changes in the numerator and the denominator that could affect the MLR. The chart is intended to be illustrative of some, not all, of the possibilities.

Medical Claims

The definition of medical claims (also called health care benefits or clinical services) is based on direct claims incurred (prior to reinsurance) during the applicable MLR reporting year, with adjustments for reserves. In addition, MLR rebates to policyholders are excluded from the medical claims measure. This prevents insurers from passing on the costs of any rebates to policyholders in subsequent years. The text box below shows the specific definition of medical claims as adopted by HHS per the NAIC recommendation.

Definition of Medical Claims

Incurred claims = direct claims incurred in MLR reporting year + unpaid claim reserves associated with claims incurred + change in contract reserves + claims-related portion of reserves for contingent benefits and lawsuits + experience-rated refunds (exclude rebates based on issuers MLR).

Medical claims are adjusted by three different reserve measures: (1) unpaid claims reserves, (2) contract reserves, and (3) claims-related reserves for contingent benefits and lawsuits. Unpaid claims reserves are premium funds that are set aside by insurers to cover claims that were incurred during a reporting period, but had not been paid by the date on which the required report

was prepared.[27] Similarly, contract reserves are established to account for the value of future benefit payments. As a policy matures, the reserves set aside at the introduction of the policy are used to cover claims that are submitted in the future. For example, an issuer may establish contract reserves to reduce the need to increase premiums for a newly introduced product as the policy matures and more claims are incurred.

The third reserve adjustment includes the claims-related portion of reserves for contingent benefits and lawsuits. These funds are set aside for a future event which may be beyond the control of the insurance company, such as deferred maternity benefits or potential outcome of a lawsuit.

There was concern from consumer groups when HHS regulations were initially promulgated that reserves could be manipulated and, in particular, overstated, which would lead to a reported MLR for a given year that was higher than the true MLR for that year. However, the NAIC and HHS concur that, over the long run, such over-reserving for one year necessarily results in a reduction or releasing of reserves in future years.

Prescription Drug Costs

The NAIC recommended, and HHS agreed, that prescription drug costs should be included in incurred claims, while prescription drug rebates should be deducted from incurred claims. Prescription drug rebates are rebates that pharmaceutical companies pay to insurers when enrollees fill their prescriptions at participating pharmacies.

Quality Improvement Expenditures

The ACA allows insurers (with some exceptions) to include spending for quality improvements in the numerator for calculating the MLR. In other words, companies can meet the federal MLR medical claims requirement, in part, by increasing activities designed to enhance the quality of their insurance products. Thus, the actual definition of what constitutes a quality expenditure is important to the MLR calculation.

Companies must submit annual data to the Secretary of HHS detailing the amount of premium revenue dedicated to quality improvements. To be classified as a quality initiative, spending must meet four specific criteria developed by the NAIC.

An allowable quality initiative must

- improve health outcomes by implementing activities such as quality reporting, effective case management, care coordination, chronic disease management, or medication and care compliance initiatives;
- implement activities to prevent hospital readmissions including a comprehensive program for hospital discharge that includes patient education and counseling, discharge planning, and post-discharge follow-up by an appropriate health care professional;

[27] Unpaid claims reserves are required to be calculated based on claims that have been processed within three months after the end of the MLR reporting year.

- implement activities to improve patient safety and reduce medical errors through the use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage; and
- implement wellness and health promotion activities.

In addition, the HHS rules state that a non-claims expense will be counted as a quality improvement only if it falls into one of the four categories above, and also meets *all* the following requirements. An expense must be

- designed to improve health care quality;
- designed to increase the likelihood of desired health outcomes in ways that can be objectively measured and that can produce verifiable results and achievements;
- directed toward individual enrollees or incurred for specific segments of enrollees or provide health improvements to the population beyond those enrolled in coverage, so long as no additional costs are incurred due to the non-enrollees; and
- grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations.

ICD-10 Implementation As Quality Improvement

HHS allowed insurers to count a certain percentage of their ICD-10 conversion costs as a quality improvement activity. ICD refers to the International Statistical Classification of Disease and are alphanumeric designations given to every diagnosis, description of symptoms, and cause of death. ICD codes are widely used in medical billing by insurers, as well as for research and other purposes.

HHS initially proposed that health insurers would have to convert their billing systems from ICD version 9 (ICD-9) to ICD version 10 (ICD-10) by October 1, 2013. However, HHS extended the deadline to October 1, 2014 and then to 2015.[28] For an insurer's MLR calculation, HHS stated that ICD-10 conversion costs that account for up to 0.3% of an insurer's premium revenue could be counted as quality improvement activities for the 2012 and 2013 reporting years, which could increase the insurer's MLR slightly. Any additional costs for ICD-10 maintenance and claims adjudication systems would count as administrative costs under the MLR rule. To the extent these additional costs exceed 0.3%, they would reduce the denominator and could reduce the MLR.

[28] CMS, "Deadline for ICD-10 Allows Health Care Industry Ample Time to Prepare for Change," July 31, 2014, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-07-31.html.

Treatment of Fraud Reduction and Prevention Activities Relative to Quality Expenditures

One issue that was raised when HHS was defining quality expenditures was the treatment of fraud reduction and prevention activities and whether these activities would be part of allowable quality improvement spending.[29] Final HHS rules let insurers count money recovered from fraud and abuse initiatives toward the MLR requirement for medical benefits spending, but do not allow companies to count broader fraud prevention activities.[30] In making this decision, HHS stated that:

> The current treatment of fraud reduction efforts under the MLR rule is consistent with the NAIC's position and adequately addresses the concerns of issuers, while still recognizing that many fraud prevention efforts are not directly targeted toward quality improvement.... Thus, allowing payments recovered through fraud reduction efforts as adjustments to incurred claims gives issuers the opportunity to recoup monies invested to deter fraud.[31]

To the extent that insurers can recover money from fraud and abuse initiatives, this can increase their MLR. However, expenses for broader fraud prevention activities (such as medical review or provider auditing) would be part of administrative expenses in the denominator. In this case, all other elements equal, increases in these expenditures could lower (and not raise) the MLR.

Premiums and Taxes, Licensing and Regulatory Fees

A key part of the MLR calculation is the definition of premiums, which is in the denominator of the MLR formula. Holding medical claims and quality improvement constant, an increase in premium revenues lowers the MLR, while a reduction in premium revenues raises the MLR. (See **Figure 1**.) The ACA also allows insurers to subtract certain taxes, licensing, and regulatory fees from premiums, which can further increase the MLR amount (and reduce the likelihood of paying rebates). The following provides greater detail on how premiums, taxes, and licensing and regulatory fees are defined in the MLR calculation.

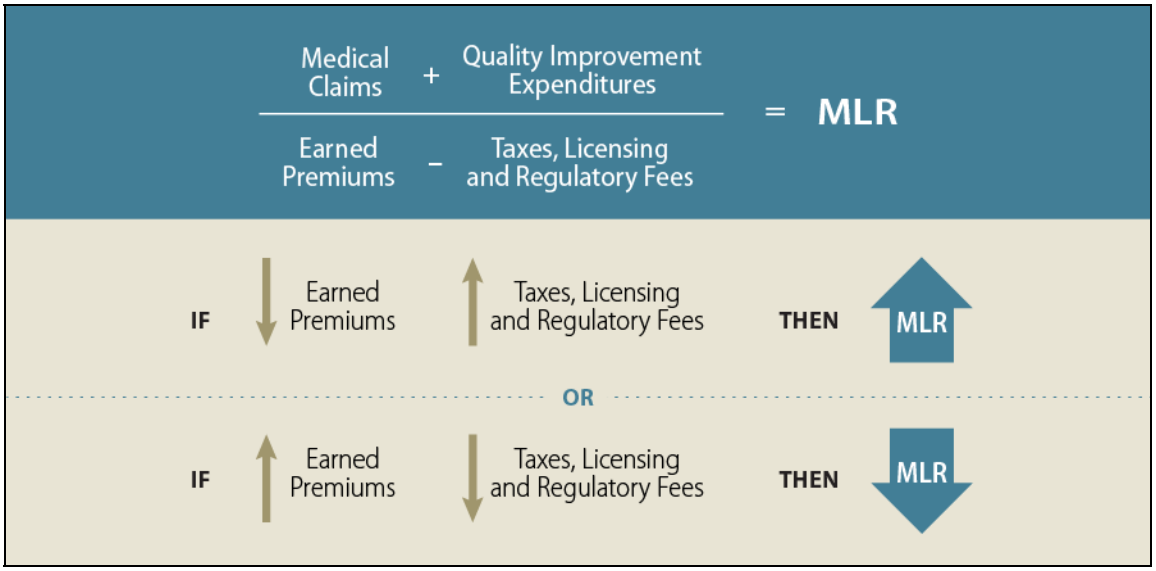
[29] America's Health Insurance Plans, "Interim Final Rule – Medical Loss Ratio Requirements," January 31, 2011, http://www.ahip.org/Issues/Medical-Loss-Ratio.aspx.

[30] Department of Health and Human Services, "Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans; Interim Final Rule," *Federal Register*, December 7, 2011, p. 76596-76600; and America's Health Insurance Plans, "Medical Loss Ratio," http://www.ahip.org/Issues/Medical-Loss-Ratio.aspx. The amount of claim payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses, can be included in incurred claims. Fraud reduction efforts include fraud prevention as well as fraud recovery. In addition, the interim final rule provides that fraud prevention activities are excluded from the quality improvement activities.

[31] Department of Health and Human Services, "Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans; Interim Final Rule," *Federal Register*, December 7, 2011, p. 76596-76600.

Figure 2. Impact of Changes to Denominator on MLR

(Holding Other Factors Constant)



Source: Congressional Research Service.

Premiums

Premiums are calculated based on earned premiums, and are defined as the sum of all monies paid by a policyholder in order to receive coverage from a health insurer. Thus, an earned premium is any fee or other contribution associated with a health plan, with some distinctions:

- Earned premiums exclude premium assessments paid to, or subsidies received from, federal and state high risk insurance pools created by the ACA.[32]
- Earned premiums exclude adjustments for retroactive rate reductions.[33]
- Earned premiums are to be reported before insurers deduct premium discounts for enrollees for health and wellness promotion.[34]
- Earned premiums should be direct (excluding reinsurance).[35]

[32] See Appendix B of CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach for more information about the risk programs in ACA.

[33] In retrospectively rated contracts, insurers charge an initial, estimated premium. The final premium is based in part on actual claims and other experience during the time the policy was in place.

[34] Since these discounts are considered quality improvements (and are included in the numerator), if they were also used to reduce premiums in the denominator, this would lead to double counting. Therefore, they are excluded from earned premiums in the denominator.

[35] Reinsurance is sometimes described as insurance for insurers. Under a reinsurance contract one insurance company (the reinsurer) charges a premium to compensate another insurance company for all or part of the losses that insurer could sustain under the policies it has issued. Reinsurance contracts can be written to cover a specific risk or a broad category of activity. Premiums for reinsurance do not represent premiums for active claims behavior under the MLR.

- Earned premiums are to account for net payments or receipts related to risk adjustment, risk corridor, and reinsurance programs for policies sold under the ACA.[36]

Taxes, Licensing, and Regulatory Fees

Taxes, licenses, and regulatory fees are subtracted from premiums under the MLR formula.[37] Since they reduce premium revenue, higher taxes and fees can raise the MLR (assuming all other components hold steady). See **Figure 1**.

Federal taxes are defined by HHS as all federal taxes and assessments allocated to health insurance coverage that are subject to the MLR reporting requirements under ACA. Federal income taxes on investment income and capital gains are excluded from this component as they are not considered taxes on premium revenues and, thus, should not be used to adjust premium revenues.

HHS also requires insurers to report state taxes and assessments separately, including any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to a state directly, or any premium subsidies designed to cover the cost of providing indigent care, or other access to care, throughout a state.

Licensing and regulatory fees that must be reported as an adjustment to premium revenue include statutory assessments and examination fees in lieu of premium taxes. However, fines and penalties of regulatory authorities, and fees for examinations by state and federal departments other than those referenced above, must be separately reported, but may not be used as an adjustment to premium revenue.

Adjustments for Plan Size and Deductible

The ACA requires that the MLR calculation include methodologies to account for the special circumstances of smaller plans, different types of plans, and newer plans. To that end, the NAIC recommended, and HHS adopted, two "credibility adjustments" designed to address issues associated with random variation in claims data.

The first credibility adjustment is intended to address health insurance plans with low enrollment. The rationale for the credibility adjustments is that smaller plans may have more variability in annual claims, making it harder for them to plan for the MLR.

Table 1 specifies the credibility adjustments based on life years[38] that insurers are permitted to use to adjust their MLR upward. For example, an insurer with an MLR of 79% would be below the MLR standard of 80% for a small group. However, if the insurer covered 50,000 life years, it

[36] Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rules; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. Small Business Health Options Program, Proposed Rule," *Federal Register*, March 11, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf; and 45 CFR Section 158.130(b)(5).

[37] §2718(a) of PHS Act.

[38] A life year is equal to the number of months of enrollee coverage divided by 12.

could increase its MLR calculation by the adjustment factor shown in **Table 1** of 1.2%. The adjustment calculation would be 79% times 1.012, resulting in an adjusted MLR of 80%, which would then meet the minimum standard required for small group plans.

Table 1. Base Credibility Factors for Calculating MLR

Life Years	Base Credibility Factor
<1,000	Not Credible
1,000	8.3%
2,500	5.2%
5,000	3.7%
10,000	2.6%
25,000	1.6%
50,000	1.2%
75,000	0.0%

Source: Department of Health and Human Services, December 1, 2010, MLR Interim Rule.

Notes: A life year is equal to the number of months of enrollee coverage divided by 12. The credibility factor is a multiplier.

A second credibility adjustment is available to insurers that have a large share of high deductible health plans (HDHPs).[39] HDHPs tend to have a more variable (and uncertain) claims experience than other plans. Specifically, in high deductible health plans a smaller share of policyholders may end up filing medical claims during a year, but the claims that are filed are generally higher than is the case in lower-deductible insurance plans.

To address this variability there is a deductible adjustment to the MLR calculation, which is based on the average deductible of all policies for which experience is included in the reported MLR (see **Table 2**). This potentially increases the credibility adjustments by a multiplier of 1.0 to 1.736. This deductible factor is multiplied by the base credibility adjustment factors in **Table 1** above.

As an example, suppose a small group plan (with only 50,000 lives) that sold a large share of HDHPs initially had an unadjusted MLR of 61%. This unadjusted MLR would not meet the minimum standard of 80%. However, in this case the insurer is allowed to apply two adjustments. Because it has only 50,000 lives, it can use the base credibility factor of a 1.012 adjustment. Next, because it has an average deductible of $5,000, it can use the deductible factor of 1.402 as shown in **Table 2**. The combination would lead to a final, adjusted MLR of 1.012 times 1.402, which is equal to 1.4188. This adjustment would raise their MLR to 86.5% and the insurer would more than meet the minimum MLR requirement. It is important to note that the deductible factor would not apply to insurers with more than 75,000 life years (e.g., 0.0 times 1.402= 0).

[39] A high deductible health plan (HDHP) is a plan with lower premiums and higher deductibles than traditional health insurance. Consumers may face larger out-of pocket costs under such HDHPs, depending on their health needs. An individual with a HDHP may set up a health savings account. See CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2012*, by Janemarie Mulvey.

Table 2. Deductible Factors to Adjust MLR

Deductible	Deductible Factor
$0	1.000
$2,500	1.164
$5,000	1.402
$10,000	1.736

Source: *Federal Register*, Vol. 75, No. 230, December 1, 2010, p. 74882

Notes: If the average deductible falls within the categories, the insurer is to calculate the deductible adjustment based on linear interpolation. The factor is a multiplier.

Beginning with the 2013 MLR reporting year, the credibility adjustment for an MLR, based on partially credible experience, is zero if

- the issuer during the current MLR reporting year and each of the two previous MLR reporting years included experience of at least 1,000 life-years; and
- without applying any credibility adjustment, the issuer's MLR for the current MLR reporting year and each of the two previous MLR reporting years was below the applicable MLR standard for each year.[40]

State Flexibility and Waivers

The ACA gave the HHS Secretary the authority to adjust the 80% MLR standard for the individual health insurance market if the Secretary determined that applying the standard could destabilize the individual market in a given state.[41] States were allowed to request a temporary adjustment in the MLR ratio for up to three years, to avoid coverage disruptions in their individual markets. ACA regulations allowed the HHS to consider a set of factors regarding such waivers, including (1) the number of insurers likely to exit a state or to cease offering coverage absent an adjustment to the MLR; (2) the number of individual market enrollees covered by insurers reasonably likely to exit the state; (3) the impact of the MLR standard on consumer access to insurance agents and brokers; (4) alternate coverage options in a state; (5) the impact on premiums and benefits to remaining consumers if insurers withdrew from the market; and (6) any other relevant information submitted by a state's insurance commissioner.[42] HHS issued decisions on waivers in early 2012.[43]

According to HHS, 17 states and a territory requested adjustments to the federal MLR for the individual market.[44] Seven states were granted an adjustment: Georgia, Iowa, Kentucky, Maine,

[40] 45 CFR §158.232(d).

[41] See §2718(b)(1)(A)(ii) of the PHS Act. The ACA did not provide authority to provide waivers of the MLR standard for the small and large group markets.

[42] Department of Health and Human Services, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register*, December 1, 2010, (§158.310-158.311); https://www.federalregister.gov/articles/2010/12/01/2010-29596/health-insurance-issuers-implementing-medical-loss-ratio-mlr-requirements-under-the-patient.

[43] Centers for Medicare & Medicaid Services, "State Requests for MLR Adjustment," http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state_mlr_adj_requests.html.

[44] Ibid.

Nevada, New Hampshire, and North Carolina. Ten states and a territory were denied an adjustment: Delaware, Florida, Guam, Indiana, Kansas, Louisiana, Michigan, North Dakota, Oklahoma, Texas, and Wisconsin.[45] See **Table 3** for information on the alternative MLR rates in effect in states that were granted a waiver.

Table 3. HHS Individual Insurance Market Waivers

Alternative MLRs for states that received waivers from 2011-2013.

State	2011	2012	2013
Georgia	70%	75%	80%
Iowa	67%	75%	80%
Kentucky	75%	80%	80%
Maine	65%	65%	65%
Nevada	75%	NA	NA
New Hampshire	72%	75%	80%
North Carolina	75%	80%	80%

Source: HHS. For more detail on individual state waivers and applications, see http://cciio.cms.gov/programs/marketreforms/mlr/state-mlr-adj-requests.html. Nevada asked for only a one-year waiver.

Medicare Advantage and Part D Drug Plans

Effective in 2014, most MA plans, stand-alone Medicare Part D prescription drug plans, and MA plans that include a Part D drug benefit (MA-PD) must meet an 85% MLR standard.[46] In May 2013, CMS issued final rules for calculating the MLR for such plans.[47]

In general, the MLR is based on the percentage of Medicare contract revenue spent on clinical services, prescription drugs, quality improvement activities, and direct benefits to beneficiaries in the form of reduced Medicare Part B premiums.[48] Insurers that cannot meet the 85% threshold must pay HHS an amount equal to the total revenue for the MA or Part D contract in question, multiplied by the difference between the target MLR and their actual MLR.[49] For example, if total

[45] Department of Health and Human Services, "2011 Issuer MLR Rebate Estimates in States that Applied for an MLR Adjustment," Table of States Requesting Rebates, http://cciio.cms.gov/programs/marketreforms/mlr/rebate-estimates.html.

[46] See §1103, Health Care Reconciliation Act (P.L. 111-152). CMS has determined that the MLR rules will apply only to the Part D portions of Medicare Cost-Based Health Maintenance Organization and Competitive Medical Plans (HMO/CMPs) and employers/unions offering Health Care Prepayment Plans (HCPP). In addition, CMS waived the MLR requirements for the Part D offerings of PACE plans, (Program of All-inclusive Care for the Elderly), which are offered under a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility.

[47] Centers for Medicare & Medicaid Services, "Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs: Final Rule," *Federal Register*, 45 CFR Parts 422 and 423, May 23, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf.

[48] Medicare Part B covers physician services, skilled nursing care and other select services. In general, the MLR is based on actual costs and revenues for MA and Part D plans, including both federal payments and enrollee premiums.

[49] Department of Health and Human Services, "Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs: Final Rule," *Federal Register*, May 23, 2013, (continued...)

contract revenue was $1,000, and the MLR was 82%, the plan would remit $30 to HHS (0.85-0.82 X $1,000 = $30).

Contract Level Calculation

CMS rules require insurers to calculate the MLR for Part D and MA plans at the contract level. HHS enters into contracts with MA and Part D insurers to provide coverage to beneficiaries. Insurers offering standalone Part D drug plans enter into one-year, renewable contracts to provide services, region-wide, in one of the 34 designated U.S. regions. Many single states are designated as Part D regions, but a number of regions encompass two or more states. Insurers may sponsor Part D plans in more than one region or nationwide, but must submit separate contracts for each region.

Most MA beneficiaries are enrolled in local HMOs or PPOs offered in a county or group of counties. Since 2006, the MA program has also allowed MA sponsors to offer regional plans serving the 26 U.S. regions designated by the Secretary of HHS. Some regions are single states; others are groups of states. A single MA contract may cover more than one MA plan.[50] Under CMS rules, sponsors that offer MA plans will report a single MLR for each contract that includes MA–PD plans, rather than one MLR for non-drug benefits and another MLR for prescription drug benefits.

Enrollment Ban and Contract Termination

If an MA or Part D contract fails to meet the 85% MLR for three or more consecutive years, plans offered under that contract will be closed to new enrollees. CMS will bar new enrollment starting in the second contract year after the three-year threshold is reached. For example, MLR data for Part D plans for contract years 2014 through 2016 will be reported during calendar years 2015 through 2017. If the 2017 data show that a contract has been out of compliance for three consecutive years, a ban on new enrollment would take effect in 2018.

If a MA or Part D contract is out of compliance for five consecutive years, the contract would be terminated. Termination, like the ban on new enrollment, would take place in the second, succeeding contract year after the threshold has been met. For example, an MA or Part D insurer that failed to meet the MLR requirement from 2014 through 2018 would have the contract terminated in 2020.

CMS will require the Medicare plans to report their MLR data in December following a contract year. However, in the case of contracts that fail to meet the MLR threshold for two consecutive years, MLR reporting will be required prior to December, in a month to be specified by CMS. Earlier reporting will give CMS time to implement enrollment sanctions or contract terminations before annual Medicare open enrollment,[51] when beneficiaries are allowed to change plans.

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http://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf.

[50] Centers for Medicare & Medicaid Services, *Medicare Managed Care Manual*, Chapter 11, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c11.pdf.

[51] For more information about Medicare enrollment periods, see Centers for Medicare & Medicaid Services, "Understanding Medicare Part C & D Enrollment Periods," October 2012, http://www.medicare.gov/Pubs/pdf/
(continued...)

The CMS rules also include credibility adjustments for MA-PD and Part D standalone plans. (See **Table D-1** and **Table D-2**.)

Rebates to Policyholders

Health insurers that fail to meet the minimum MLR requirements must provide rebates to policyholders. For 2011, 2012, and 2013 insurers were required to issue rebates by August 1 each year following the calendar year used in calculating the MLR. For example, insurers were required to issue rebates for calendar year 2012 by August 1, 2013. Beginning with reporting of the 2014 information in 2015, issuers must provide rebates no later than September 30 of the following year.[52]

Policyholders include both employers and individuals, and there are slightly different rebate procedures for employer-sponsored plans and those in the individual market, as discussed below.

Calculation of the Rebate

Rebates are based on aggregate data from all insurer plans in each of the three market categories (large market, small market, and individual market) in each state. HHS does not distinguish between the relative efficiency of different plans offered by the same insurer in the same market. For example, if the aggregate data from the large group plans offered by an insurer in a state indicate that the insurer has reached an 82% MLR, rather than the required 85% MLR, all enrollees in the large group plans are eligible for a 3% of premium rebate—even if they are in a plan that is less, or more, efficient than the average. Rebates will eventually be based on cumulative data for a three-year period.

Who Is Eligible for a Rebate?

For the purpose of determining who is entitled to a rebate, HHS has defined the term "enrollee" to mean the subscriber, policyholder, and/or government entity that paid the premium for the health care coverage received by an individual during a respective calendar year.

In the case of individual insurance, the insurer pays the rebate to the enrollee. In the case of employer-sponsored coverage, a rebate would be paid by the insurer to the employer, which would then distribute a portion of the rebate to the enrollee (employee). The amount of the rebate due to the employer and the employee is based on their relative shares of the original premium payment. Thus, if the employer paid 75% of the premium and the employee paid 25%, the rebate would be split 75%/25% accordingly. In addition, enrollees who were covered by insurance for only part of a calendar year would have their share of any rebate adjusted to partial year coverage.

Enrollees who paid premiums to an insurance plan that did not meet its required MLR are entitled to a rebate, even those who are no longer covered by the specific insurance plan (with certain

(...continued)

11219.pdf.

[52] 45 CFR Section 158.240

exceptions). For example, if an employer finds that the cost of distributing a rebate to a former plan enrollee is approximately equal to the value of the rebate, the employer may instead allocate the rebate to current enrollees based upon a reasonable, fair, and objective allocation method.[53] (Also see the "De Minimis Rebates" section.)

Group Policy Rebates

Many Americans do not pay the full insurance premium because they obtain coverage through an employer that assumes a part of the cost. Thus, rebates under group policies must be coordinated through the employer. Under ACA, an insurer can enter into an agreement with the group policyholder (employer) to distribute rebates on behalf of the insurer.

Rebates provided to workers from employers in the form of a lump-sum payment will be treated as regular income and therefore may be taxed. Thus, there is an incentive for employers to provide rebates in the form of premium credits for the upcoming enrollment period.

Form of Rebates to Current and Former Employees

The NAIC recommended, and HHS agreed, that the entity distributing the rebates may choose whether to disburse payments to current enrollees as a lump-sum check or a deposit to a credit or debit card.[54] Current enrollees can also receive refunds in the form of a credit against future premium payments. For the 2011, 2012, and 2013 MLR reporting years, the rules required that the full amount of the rebate be applied to the first plan premium due on, or after, August 1. If the amount of the rebate was greater than the first premium payment, any remaining money would be applied to future premium payments until the rebate was used up. Starting with the 2014 MLR reporting year, rebates provided as premium credits must be applied to the first month's premium due on or after September 30. If the amount of the rebate exceeds the premium due for October, any overage shall be applied to succeeding payments until the full amount of the rebate has been credited.[55]Rebates to former enrollees can take the form of a check or a transfer to a debit or credit card.

De Minimis Rebates

There are special rules for de minimis, or minor, rebates defined as

- group policies where the insurer distributes the rebate to the policyholder (generally an employer), and the total rebate owed to the policyholder and the enrollees combined is less than $20 for a given year; or

[53] Department of Labor, "Guidance On Rebates For Group Health Plans Paid Pursuant To The Medical Loss Ratio Requirements Of The Public Health Service Act," Technical Release 2011-04, December 2, 2011, http://www.dol.gov/ebsa/pdf/tr11-04.pdf

[54] Department of Health and Human Services, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register***,** December 1, 2010, (§158.241); https://www.federalregister.gov/articles/2010/12/01/2010-29596/health-insurance-issuers-implementing-medical-loss-ratio-mlr-requirements-under-the-patient.

[55] 45 CFR Section 158.241.

- group policies where the insurer issues the rebate directly to the enrollee and the enrollee rebate is less than $5 for a given year; or
- individual policies, where total rebate owed by the insurer to each subscriber is less than $5 for a given MLR reporting year.[56]

Under these scenarios, direct rebates are not required, given that the cost of administering such small benefits may exceed their value. Insurers issuing the rebates do not get to keep these de minimis amounts, but must aggregate the money and distribute it to other enrollees in the state who are due a rebate.[57] In addition, employers, rather than insurers, that oversee plans are not required to issue rebates if the cost of doing so would exceed the cost of the rebates, but they must use the de minimis amounts for allowable activities to benefit enrollees.

Notification Requirements

Under HHS rules, all insurers subject to the MLR reporting requirement, regardless of whether they were required to provide a rebate, were required in 2012 to notify enrollees of their MLR results. This was a one-time requirement; companies that do not owe refunds do not have to notify their customers in 2013 and future years.[58]

Insurers that do not meet annual MLR requirements must notify enrollees about the federal MLR, its purpose, and the amount of the rebate being provided. The notice must include about how the insurance company uses premium dollars in its operations and how the insurance company's MLR compares to the standard set by Congress.

Amount of Rebates

HHS in July 2014 announced that, based on 2013 performance, insurers would issue about $332 million in rebates to 6.8 million consumers.[59] That compares to $504 million in rebates to 8.5 million individuals for the 2012 plan year,[60] and $1.1 billion in rebates to 12.8 million individuals for 2011 plan performance. [61]

[56] Department of Health and Human Services "Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans; Interim Final Rule," *Federal Register*, December 7, 2011, §158.243, p. 76596-76600, http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/.

[57] Centers for Medicare & Medicaid Services, "Medical Loss Ratio (MLR) Annual Reporting Form Filing Instructions for all Parts," http://cciio.cms.gov/resources/files/mlr-annual-form-instructions051612.pdf.

[58] Centers for Medicare & Medicaid Services, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Under the Patient Protection and Affordable Care Act; Correcting Amendment," May 16, 2012, p. 82277-82279, https://www.federalregister.gov/articles/2012/05/16/2012-11773/health-insurance-issuers-implementing-medical-loss-ratio-mlr-under-the-patient-protection-and.

[59] Department of Health and Human Services, "Consumers Benefited From 80/20 Rule in 2013," http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report_07-22-2014.pdf

[60] Department of Health and Human Services,"80/20 Rule Delivers More Value to Consumers in 2012," http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf.

[61] Department of Health and Human Services, "The 80/20 Rule: Providing Value and Rebates to Millions of Consumers," http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/mlr-rebates06212012a.html.

Table 4. 2013 MLR Rebates

Based on Insurance Plan Activity During Calendar 2013

	Individual Market	Small Group Market	Large Group Market
Total Amount of Rebates	$ 128,280,633	$ 122,365,085	$ 81,506,757
Enrollees Receiving Rebates	2,102,671	2,704,466	2,009,286
Average Rebate Per Family	$85	$79	$73

Source: Department of Health and Human Services, http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2013_MLR_Refunds_by_State.pdf

Average rebates per family were highest in Alaska, Iowa, Minnesota, Montana, and Wyoming. (See **Appendix A** for a complete table of aggregate rebates by state.)

In general, health insurers subject to the ACA MLR provisions have reduced the share of premium dollars spent on overhead since the ACA provisions took effect. The overall share of premium revenues dedicated to overhead (including administration costs and profits) in the individual market declined to 11.5% in 2013 from 15.3% in 2011. In the small group market, overhead costs dipped to 16.4% of premiums in 2013 from 17.4% in 2011(though costs rose slightly from 2012 to 2013). In the large group market, the share of premiums dedicated to overhead declined to 10.7% of premiums in 2013 from 11.2% in 2011.[62]

Issues for Congress

Brokers' Commissions

Health insurance agents and brokers act as middlemen (known collectively as producers), assist consumers and small employers in choosing and enrolling in health insurance products. Producers may be self-employed, work for an independent agency or brokerage, work as "captive agents" that are direct employees of an insurance carrier, or work for banks and other companies within the financial services industry that have an insurance business segment. Captive agents may also receive a salary, but all producers generally are paid sales commissions by insurers, which are set as a percentage of the premiums paid by the enrollee or policyholder.[63]

Insurance companies are not allowed to deduct broker fees and commissions from their administrative expenses when calculating the ACA MLR. During the regulatory process, the National Association of Health Underwriters (NAHU), a professional association representing agents and brokers, argued that agent and broker commissions were essentially an add-on to already-set plan premiums, similar to state and federal taxes. Because commissions are a pass-through, rather than a part of an insurance company revenue stream, they should not be counted as an expense, according to the NAHU.[64] Consumer organizations argued that Congress intended

[62] Department of Health and Human Services, "Consumers Benefitted From 80/20 Rule in 2013," http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report_07-22-2014.pdf .

[63] For more information see archived CRS Report R41439, *Health Insurance Agents and Brokers in the Reformed Health Insurance Market*, by Bernadette Fernandez.

[64] Letter from Janet Trautwein, Executive Vice President and CEO of the National Association of Health Underwriters, to the Department of Health and Human Services, May 14, 2010, http://www.nahu.org/legislative/mlr/ (continued...)

for the commissions to be counted as an administrative cost in the MLR calculation, and not to be excluded from the MLR like taxes and other fees.[65]

The NAIC in its recommendations to HHS ultimately concluded that the ACA does not provide a clear path for waiving inclusion of commissions in the calculation of the MLR, but encouraged "HHS to recognize the essential role served by producers (i.e., agents and brokers) and accommodate producer compensation arrangements in any MLR regulations promulgated."[66] The HHS, in its final regulations, noted that the ACA allowed state regulators to seek MLR waivers if they were concerned that their state's individual insurance market could be destabilized by implementation of the ACA, which would include any potentially adverse effects from the calculation of brokers' and agents' commissions.[67]

A July 2014 Government Accountability Office report found that if broker commissions and fees were excluded from the MLR calculation, ACA MLR rebates to consumers would have been 75% lower on average for the 2011 and 2012 plan years.[68]

During the 112th Congress, the House Energy and Commerce Subcommittee on Health approved by voice vote H.R. 1206, which would exclude brokers' commissions, fees, or rebates from the MLR formula. Similar legislation was introduced during the 113th Congress.

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NAHU%20Comments%20on%20MLR.pdf.

[65] Letter from Timothy Jost, et al. to Insurance Commissioner Sandy Praeger, October 8, 2010, p. 4, http://www.naic.org/documents/committees_models_mlr_rebate_regulation_comments_1.pdf.

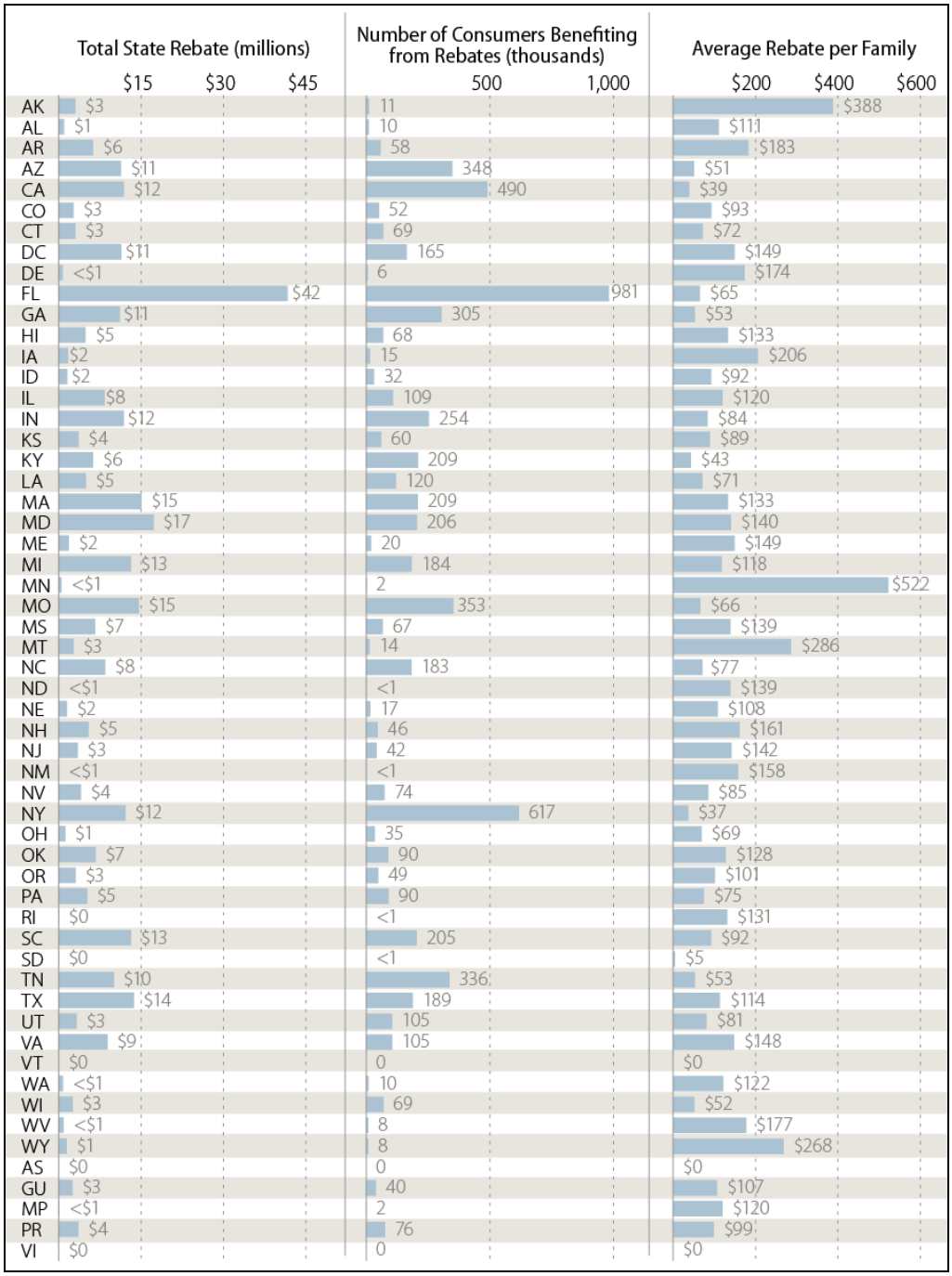
[66] NAIC, "Resolution Urging the U.S. Department of Health and Human Services to Take Action to Ensure Continued Consumer Access to Professional Health Insurance Producers," November 22, 2011, http://www.naic.org/documents/committees_ex_phip_resolution_11_22.pdf; Also see NAIC news release on adoption of the resolution, http://www.naic.org/Releases/2011_docs/statement_naic_president_voss_resolution.htm.

[67] Department of Health and Human Services, "Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule," *Federal Register***,** December 1, 2010, (§158.241); https://www.federalregister.gov/articles/2010/12/01/2010-29596/health-insurance-issuers-implementing-medical-loss-ratio-mlr-requirements-under-the-patient.

[68] Government Accountability Office, Private Health Insurance: Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers and Enrollees, July 2014, http://gao.gov/assets/670/664719.pdf.

Appendix A. Rebates by State

Figure A-1. 2013 MLR Rebates



Source: Department of Health and Human Services, 2013 data. Because their overall rebate levels are so small, South Dakota and Rhode Island show up as zero in total rebates even though they display positive values for consumer rebates and average rebates per family. Total rebates were $2,582 for South Dakota and $48,696 for Rhode Island. For a detailed breakdown of state rebates in the individual, small group, and large group markets see http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2013_MLR_Refunds_by_State.pdf.

Appendix B. State MLRs

State governments are the primary regulators of health insurance. Many states have their own MLR requirements, which they use for a variety of purposes including evaluating corporate performance and insurance company requests for an increase in premium rates.

The NAIC in 1980 developed MLR guidelines for state regulators to use in determining whether benefits paid under individual medical policies were reasonable in relation to premiums charged.[69] A number of states also set separate MLR standards for other insurance products. When the ACA was passed in 2010, 34 states had established some type of MLR guidelines; required the filing or reporting of MLR information; set limits on administrative expenses for comprehensive major medical insurance; or enacted a combination of such policies. Of the total, six states required insurers that did not meet MLR standards to provide premium refunds or credits. (See **Table B-1**.)

States developed a range of MLR targets. For example, state MLR requirements for insurers selling products in the individual market ranged from 55% to 80%. MLRs in the group market ranged from 60% to 85%.[70] The federal ACA provisions are now the national, minimum requirement that insurers must meet in terms of calculating potential consumer rebates. States were allowed to apply for limited waivers of the federal MLR standards for their individual insurance markets, however, if they had evidence that the ACA requirements could disrupt the state market for such policies.

Since the ACA was enacted, several states have passed additional MLR laws including some that require insurers participating in Medicaid to meet specific MLRs or to publish their premium and profit information.[71] State policies can range widely depending on differences between rural and urban areas and markets that have a number of insurance options, as opposed to those where business is more concentrated in a few companies.[72]

One key difference between many state MLR calculations and the federal MLR standards enacted under ACA is that the federal standards allow for adjustments based on quality improvements, taxes and fees, credibility adjustments, and other factors. According to a 2011 GAO analysis, the combined effect of the federal allowances has been to raise federal MLRs above MLRs that are based only on medical claims compared to premium revenue. Analyzing 2010 data, the GAO said that average MLRs calculated under the ACA formula were 7.5 percentage points higher than traditional MLRs in the individual market, 6.5 points higher in the small group market, and 4.8 points higher in the large group market.[73]

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[69] America's Health Insurance Plans, "State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations," April 15, 2010, http://www.naic.org/documents/committees_e_hrsi_comdoc_ahip_chart_mlr.pdf.

[70] Ibid. Pennsylvania imposed a 50% initial MLR for the individual market and a 60% renewal MLR.

[71] National Conference of State Legislatures, "Medical Loss Ratios for Health Insurance," Updated June 20, 2013, http://www.ncsl.org/issues-research/health/health-insurance-medical-loss-ratios.aspx.

[72] Health Affairs/Robert Wood Johnson Foundation, "Medical Loss Ratios. Health Insurers Will Soon Be Required To Spend A Specific Share Of The Premiums They Collect On Health Care For Policyholders," *Health Brief*, November 12, 2010.

[73] Government Accountability Office, Letter to Rep. Robert Andrews, "Subject: Private Health Insurance: Early Indicators Show That Most Insurers Would Have Met or Exceeded New Medical Loss Ratio Standards," October 31, (continued...)

Table B-1. State MLR Policies Prior to ACA

State Policies as of 2010

Policy	States
Filing and Reporting Requirements	AR, CA, CT, DE, FL, GA, IA, KS, KY, MA, MD, MI, MN, NH, NJ, NY, OR, PA, TN, UT, VA, WA, WV
Group Market Requirements	AZ, CA, CO, DE, FL, KY, MD, ME, MI, MN, ND, NH, NJ, NM, NY, OK, SD, UT, WV
Individual Market Requirements	AZ, CA, CO, DE, IA, KS, KY, MA, MD, ME, MI, MN, NC, ND, NH, NJ, NM, NY, PA, SC, SD, TN, UT, VA, VT, WA, WV
Premium Refunds, Dividends, or Credits	ME, NJ, NM, NY, NC, SC[a]
Other Approaches	CA, NJ, OH, TN[b]

Source: America's Health Insurance Plans and NAIC.

a. These states in 2010 required carriers to issue a dividend, credit, or refund to policyholders for failure to comply with state MLR requirements.

b. These four states, rather than setting a minimum MLR, required either health maintenance organizations or certain types of insurance companies to limit administrative expenses to a specified percentage of premiums.

(...continued)

2011, p. 3, http://www.gao.gov/new.items/d1290r.pdf.

Appendix C. Mini-med and Expatriate Plans

Final HHS rules allow separate adjustments in the MLR formula for two less commonly used types of health insurance: expatriate and mini-medical (mini-med) policies.[74]

Expatriate Plans

Expatriate plans are defined by the HHS in its December 7, 2011, interim final rule as "group policies that provide coverage to employees, substantially all of whom are: Working outside their country of citizenship; working outside of their country of citizenship and outside the employer's country of domicile; or non-U.S. citizens working in their home country."

Expatriate plans often have lower premiums and higher administrative costs than comparable insurance plans, due to the inherent difficulty of coordinating international coverage, according to the NAIC.[75] The plans may offer unique benefits such as coverage of medical evacuation or language translation services. Insurers may have to spend time helping beneficiaries in foreign countries find English-speaking doctors. "These additional services would be classified as "administrative" under the medical loss ratio, but are critical to the delivery of care," the NAIC noted in a letter to HHS regarding the plans. The NAIC recommended that expatriate plans be exempt from the MLR, or, if that were not possible, that HHS allow additional MLR adjustments for such plans.

ACA rules allow insurers offering expatriate plans to multiply incurred claims and activities that improve health care quality (the numerator of the formula) by a factor of 2.00 when calculating the MLR. Without the 2.00 adjustment, the majority of expatriate insurers in the large group market had MLRs "significantly" below the 85% standard, according to HHS. Using the 2.00 multiplier, HHS said more insurers should be able to meet the standard for the plans, "thus ensuring that Americans working abroad will still have access to U.S.-based coverage." The 2.00 multiplier applied beginning in 2011 and will remain in place indefinitely.

Mini-medical

Mini-medical or limited-benefit health plans subject to different MLR standards are defined by CMS as policies with annual benefit limits of $250,000 or less. While there is substantial variability in the marketplace, mini-med plans generally have higher copayments and deductibles and provide a lower dollar-value level of benefits than comprehensive health plans. In some cases, the plans impose limits on specific types of services such as hospitalization and physician care.

[74] Department of Health and Human Services, "Medical Loss Ratio Rebate Requirements for Non-Federal Governmental Plans; Interim Final Rule," *Federal Register*, December 7, 2011, p. 76574-76594, http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31289.pdf#page=21.

[75] NAIC Letter to HHS Secretary Kathleen Sebelius, October 13, 2010, p. 3, http://www.naic.org/documents/committees_ex_grlc_mlr_sebelius_letter_101013.pdf.

In its December 2011 final rules, HHS noted concerns from mini-medical insurers about their ability to meet the ACA MLR. Companies issuing the policies noted that mini-medical plans were apt to have higher administrative costs, relative to benefits paid, than comprehensive health insurance; higher enrollee turnover; shorter enrollment periods; and lower incurred claims (due to higher deductibles and limited coverage). Consumer, healthcare, and labor organizations opposed efforts to relax MLR requirements for mini-medical plans. Consumer groups have said that such policies expose beneficiaries to unacceptably high costs and that insurers should be required to become more efficient.[76]

In its interim final rule, HHS included a special allowance for mini-med plans (which it defines as plans with total annual benefit limits of $250,000 or less). For calendar 2011, HHS allowed insurers offering such policies to multiply incurred claims and activities (the MLR numerator) that improve health care quality by 2.00.

After reviewing comments, the HHS in its interim final rule on December 7, 2011, extended and modified the special treatment of mini-medical plans. HHS set a multiplier of 1.75 in 2012, 1.50 in 2013, and 1.25 in 2014. (Starting in 2014, the ACA bars the sale of health plans that impose annual limits on essential health benefits, other than grandfathered plans in the individual market. The ACA provisions are expected to eliminate most mini-med plans.) The HHS based its final rule on data from insurers selling limited benefit plans. According to the data, 7 of the 12 issuers in the individual market and 6 of the 15 firms in the large group market would not meet the standard MLR targets. With the 2.00 multiplier in place, only 3 of the 12 companies in the individual market would not meet the MLR requirements, while all issuers in the small and large group market would meet the standard.

[76] Consumers Union, "Mini-med Health Plans: Don't Call It Insurance," January, 2011, http://yourhealthsecurity.org/wordpress/wp-content/uploads/2011/01/consumers_union-mini_med_health_plans-2011_01.pdf

Appendix D. Medicare Credibility Adjustments

CMS set separate credibility adjustments for MA and Part D plans.

Table D-1. Credibility Factors for Calculating the MLR for MA-PD Contracts

Member Months	Credibility Adjustment
<2,400	Not Credible
2,400	8.4%
6,000	5.3%
12,000	3.7%
24,000	2.6%
60,000	1.7%
120,000	1.2%
180,000	1.0%
>180,000	Fully credible

Source: Centers for Medicare & Medicaid Services, "Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs; Final Rule," *Federal Register*, May 23, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf.

Note: MA–PD combined with MA-only.

Table D-2. Credibility Factors for Part D Stand-Alone Contracts

Member Months	Credibility Adjustment
<4,800	Not Credible
4,800	8.4%
12,000	5.3%
24,000	3.7%
48,000	2.6%
120,000	1.7%
240,000	1.2%
360,000	1.0%
>360,000	Fully credible

Source: Centers for Medicare & Medicaid Services, "Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs; Final Rule," *Federal Register*, May 23, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf.

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