Health Care Reform:
Minimum Loss Ratios - MLR

Health Plan Reporting Requirement

The 2010 Patient Protection and Affordable Care Act requires health insurers to provide rebates to their customers for each year that the insurers do not meet a set financial target called a medical loss ratio (MLR).

At its most basic, a MLR measures the share of a health care premium dollar spent on medical benefits, as opposed to company expenses such as overhead or profits

Large group insurers (groups with more than 50 employees) must spend at least 85 percent of premium dollars on claims and activities to improve health care quality. Individual and small group insurers (less than 50 employees) must spend at least 80 percent of premium dollars on claims and activities to improve health care quality.

For example, if total premiums collected are $100,000, and $85,000 is spent on medical care, the MLR would be 85%. The ACA sets the minimum required MLR at 80% for the individual and small group markets and at 85% for the large group market.

In general, the higher the MLR, the more value a policyholder receives for his or her premium payment. Congress imposed the MLR in an effort to provide “greater transparency and accountability around the expenditures made by health insurers and to help bring down the cost of health care.” Insurers that fail to meet these minimum standards must provide rebates to policyholders.

The calculations will be based on the aggregate experience of the issuer for each state in which the issuer is licensed. Medical cost activities that are grounded in evidence-based medicine and improve health care quality will be included in the calculations. Activities designed primarily to control or contain costs will be considered administrative.

The equation for the insurer is as follows:

$$\frac{\text{Medical care claims} + \textit{quality improvement expenses}}{\text{Premiums} - (\text{federal and state taxes} + \text{licensing and regulatory fees})}$$

Quality improvement activities include

- improve health care outcomes
- improve patient safety
- reduce rehospitalizations are counted
- the cost of healthcare hotline
- encourage wellness and prevention
- reduce medical errors
- related IT expenses

Adjustments will be made for:

- Prevention of market destabilization
- Insurers with low volume in a state
- New plans with over 50 percent of premium in state in the new plan
- Mini-med and expatriate plans

Rebate Requirement

Beginning Aug. 2012, health plans must provide rebates *to policyholders* (not plan administrators or employers) if their medical loss ratio – the percentage of premiums spent on reimbursement for clinical services and activities that improve health care quality – does not meet the minimum standards for a given plan year.

MLR Basics

- The Medical Loss Ratio provision applies only to fully insured individual and group health insurance business.
- MLR does not apply to self-funded (ASO) business.
- In general, MLR is determined for medical products only.
- MLR does not apply to HIPAA excepted benefits such as stand-alone dental, vision or disability.
- The MLR calculation is done on an aggregation set of groups and individuals based on the legal insurance entity writing the business, the state of contact issuance and group size as determined by the MLR definition of groups based on the Average Total Number of Employees (ATNE).
- MLR is not determined by the traditional "block of business" or at the policyholder level.
- The group size definition relies on determining the ATNE, which includes all full-time, part-time and seasonal employees for a given calendar year.
- MLR group size does not rely on eligible or enrolled employees.
- The U.S. Department of Health and Human Services calls for small group size to be defined as 1-100 ATNE employees by no later than 2016, with states having the option to use up to 50 ATNE employees or follow the HHS definition now.