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Medical Loss Ratio ("MLR") FAQ

What is a Medical Loss Ratio?
A Medical Loss Ratio or "MLR" is the percentage of premium dollars an insurer spends to provide covered medical services and improve the quality of health care for its members.

How is a Medical Loss Ratio Calculated?
MLR is calculated by dividing the cost of medical services (incurred claims paid, plus expenses for health care quality improvement activities) for a period of time by the premium collected, minus federal or state taxes and licensing and regulatory fees, for the same period. For example, if an insurer uses 85 cents out of every premium dollar collected to pay its customers' medical claims and activities that improve the quality of care, the insurer has a medical loss ratio of 85 percent.

What are the MLR Requirements under the Patient Protection and Affordable Care Act (PPACA)?
The MLR provision under PPACA requires health insurance plans to report on various expenses, meet minimum MLR thresholds, and provide rebates in the event the minimum MLR is not achieved.

PPACA establishes minimum MLR requirements for large group products of 85 percent and small group and individual products of 80 percent. However, the minimum MLR requirement set by New York State (NYS) is 82 percent for small group and individual products. In the event that a state has set a higher MLR threshold, the federal requirement is replaced with the applicable higher state requirement. Thus, the minimum MLR requirement for small groups and individual products in NYS will be 82 percent. Plans, including grandfathered plans, are obligated to provide a refund to groups and/or members if these requirements are not met.

Is There a NYS MLR and Rebate Process?
Yes, however state and federal MLR calculations and rebate processes have different calculation methodologies and reporting requirements.

For example, it is conceivable that the small group classification will reach the 82 percent requirement under the federal calculation methodology, and therefore not require a rebate, but a given product pool not achieve 82 percent using the NYS methodology, thereby triggering a New York-only rebate.

How is Group Size Defined for MLR under PPACA?
NYS law currently defines small groups as those with 50 or fewer employees eligible for coverage. Large groups are defined as those with 51 or more eligible employees. However, under PPACA, small groups are defined as those with an average of 2-50 total employees in the preceding calendar year. Large groups are defined as those with an average of 51 or more total employees in the preceding calendar year. For the purposes of federal MLR

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calculations, sole proprietors are considered individuals and are not included in small group calculations.

If NYS does not change its definition of a small group from 50 to 100, for purposes of federal MLR, insurers may define a small group as 50 total employees until 2016. In 2016, this group size definition will change and the small group threshold will be increased to 100 total employees.

When are Federal MLR Reporting Requirements and Rebates Due?
Federal MLR requirements became effective on January 1, 2011. Plans that do not meet the MLR requirements must provide rebates beginning in 2012. Each year, MLR reporting is due to the Department of Health & Human Services (HHS) by June 1. If a rebate is required, plans must pay the rebate by August 1 of each year.

Who is Entitled to Receive a Rebate?
If a rebate is required, it will be paid to those entities that paid a premium. This may include employer groups and/or employees. The rebate will be paid based on the percentage of premium the policyholder and each subscriber paid. (i.e., according to employer contribution levels).

How is the Rebate Paid?
The Plan will provide the rebate in the form of a lump-sum check to eligible employer groups and/or subscribers, as appropriate.

If the Required MLR is not Met, are There any Payment Exceptions?
A “de minimis” threshold has been determined by HHS, under which a rebate does not need to be provided to the particular entities. A rebate is considered de minimis if the total rebate owed is less than $5 per subscriber covered by the policy. Plans may not retain de minimis rebates. Instead, de minimis rebates must be aggregated and distributed among all entities that are entitled to receive a rebate.

Are Employer Groups Impacted by MLR in 2011?
To ensure that our records are up-to-date and to enable us to distribute any potential rebates accurately and appropriately, we will collect relevant information from employer groups on an annual basis.

The information provided here is not intended to advise you on how to comply with any provisions of the referenced legislation or related legislation or regulations, nor is it otherwise intended to impart any legal advice.

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