

# FACT SHEET

**FOR IMMEDIATE RELEASE**  
December 2, 2011

Contact: CMS Media Relations Group  
(202) 690-6145

## **Medical Loss Ratio: Getting Your Money's Worth on Health Insurance**

### **Final Rule Fact Sheet**

Under the Affordable Care Act, consumers will receive more value for their premium dollar because insurance companies are required to spend 80 percent (individual and small group markets) or 85 percent (large group markets) of premium dollars on medical care and health care quality improvement, rather than on administrative costs, starting in 2011. If they don't, the insurance companies must provide a rebate to their customers starting in 2012.

In December 2010, the Department of Health and Human Services (HHS) issued a regulation implementing this provision of the Affordable Care Act, known as the medical loss ratio (MLR). The MLR will make the insurance marketplace more transparent and make it easier for consumers to purchase plans that provide better value for their money.

In the 2010 rule, HHS requested comments on a number of the MLR provisions. HHS is now issuing a final rule amending these provisions of the regulation to provide certainty going forward.

### **What's Changing?**

The fundamental structure of the MLR policy is not changing. Beginning in 2011, the law requires insurance companies in the individual and small group markets to spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities. Insurance companies in the large group market must spend at least 85 percent of premium dollars on medical care and quality improvement activities. Insurance companies must report their MLR data to HHS on an annual basis so that residents of every State will have information on the value of health plans offered by different insurance companies in their State. Insurance companies that do not meet the MLR standard will be required to provide rebates to their consumers. Insurers will make the first round of rebates to consumers in 2012. Rebates must be paid by August 1st each year.

The changes in this final rule largely address technical issues involved in the way issuers calculate and report their MLR and the mechanism for distributing rebates to enrollees in group health plans.

**Rebates.** In the previous rule, rebates in the group market would have been subject to tax. The final rule streamlines the rebate process for those enrolled in group policies. In particular, the final rule directs issuers to provide rebates to the group policyholder (usually the employer) through lower premiums or in other ways that are not taxable. This process will vary by plan

type. Policyholders must ensure that the rebate is used for the benefit of subscribers. The final rule also requires that issuers provide notice of rebates to enrollees and the group policyholder. All enrollees must be given information about the MLR and its purpose, the MLR standard, the issuer's MLR, and the rebate provided.

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**Provide MLR information to more consumers.** Consistent with comments from consumer groups, the new regulation proposed a new notice requirement that will ensure all consumers receive information on either the amount of their rebate or their insurer's MLR, regardless of whether there is a rebate, as well as how the insurer's MLR has improved under the new law.

**Special Circumstances Adjustments.** Last year's rule required accelerated reporting by issuers of mini-med and expatriate plans. This allowed HHS to receive and review data on their unique structures and determine how best to address the special circumstances of these plans in the context of the general MLR calculation. The first two quarters of the data have informed the final rule. The final rule continues the application of a methodological adjustment to the way the medical loss ratio is calculated for these plans to ensure that consumers do not lose coverage. Issuers of mini-med and ex-patriate policies must continue to report this experience separately, on an annual basis. Specifically:

- **Expatriate Policies.** This final rule maintains for 2012 and future years the special circumstances adjustment of a multiplier of 2.0 to the MLR numerator for expatriate policies. This adjustment acknowledges the higher administrative costs and volatility of experience in these plans when compared to typical insurance plans, which primarily cover care in all parts of the world in a wide variety of health care systems.
- **Mini-med Policies.** This final rule reduces the special circumstances adjustment from a multiplier of 2.0 to 1.75 for 2012, 1.5 for 2013, and 1.25 for 2014 for mini-med policies. In 2014, the use of annual dollar limits on coverage will be banned and we expect that these mini-med policies will cease to exist, as plans offered in the Affordable Insurance Exchanges will offer affordable coverage options to all Americans without annual coverage limits. This adjustment should minimize market withdrawal while incentivizing issuers to reduce their administrative expenses and operate more efficiently.

In addition, the rule states that HHS will post the mini-med MLR data that we have collected from the issuers in the spring of 2012 to further enhance transparency to consumers.

**Other Changes in the MLR Calculation.** The final rule makes other changes to the calculation of the MLR in areas where HHS requested comment in the interim final rule. Specifically, the final rule allows ICD-10 conversion costs of up to 0.3 percent of an issuer's earned premium in the relevant State market to be considered quality improvement activities, for each of the 2012 and 2013 MLR reporting years. This final rule also levels the playing field within States by allowing an issuer to deduct from earned premiums the higher of either the amount paid in State premium tax or actual community benefit expenditures up to the highest premium tax rate in the State.

The MLR rule provides unprecedented accountability of health insurance companies. It will provide protection and value to approximately 74.8 million insured Americans. Estimates from last year indicate that, starting in 2012, up to 9 million Americans could receive rebates worth from \$0.6 to \$1.4 billion. However, the existence of the MLR requirement may have improved the pricing patterns of plans; some reports indicate that premium increases were tempered by the prospect of having to pay rebates. The rule, unchanged from the earlier publication, also allows insurers to include payments recovered through fraud reduction efforts in their calculation of incurred claims (up to the amount of fraudulent claims recovered), thereby encouraging plans to fight fraud. The final rule streamlines reporting and rebate requirements, and reduces the administrative burden on issuers and employers, while continuing to ensure that consumers receive maximum value for their health care dollar.

***Posted: December 2, 2011***