Illinois Insurance Facts

Illinois Department of Insurance

Rebates and the Medical Loss Ratio Standard in the Individual Market

January 2015

Note: This information was developed to provide consumers with general information and guidance about insurance coverage and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

Medical Loss Ratio (MLR) refers to the percentage of insurance premiums an insurer spends on health care and expenses to improve health care quality. The Affordable Care Act (ACA) requires in the individual market that a minimum of 80% of each premium dollar is spent on health care services and health care quality improvement and not on company overhead and administrative costs. The Federal MLR Regulations are codified as 45 CFR Part 158.

If an insurer has an MLR of less than 80% for policies that are issued in the individual market, then for that MLR reporting year in that state the insurer must provide a rebate to participants on the plan.

Here are the basic facts about how the law affects plans in the individual market.

Background

- The National Association of Insurance Commissioners (NAIC) developed guidelines and definitions for how insurers should measure MLR, which were adopted by HHS in Interim Final Regulations in 2010 and amended in 2011.

Annually, for each state a Health insurer operates in an MLR is calculated for each of three markets in that state: the individual market, the small group market, and the large group market. In each of these three markets, the calculation is done using the premiums, claims, and quality improvement expenses for that entire market in that state.

When Did the Medical Loss Ratio Rule Take Effect?

- The Medical Loss Ratio Rule took effect in 2011, and the first rebates were paid in August 2012.
- The MLRs were based on premiums, claims, and quality expenses for the period January – December 2011.
- Rebate calculations for January-December 2012 were paid in August 2013.
- Rebates for Calendar Year 2013, and after, will be calculated using MLRs based on cumulative data for the current year and the prior two years. For example, the MLR used for 2013 rebates used combined data for 2011, 2012, and 2013.

Which Plans are Subject to MLR Requirements?

Health insurers providing benefits consisting of medical care in the individual, small group and large group markets, including grandfathered plans, are subject to the refund and reporting requirements.

Which Plans Are Not Subject to MLR Requirements?

The following are not subject to MLR requirements:

- Self-funded plans (coverage plans in which the employer pays for health claims, rather than relying on an insurance company to cover claims)
- Excepted benefit plans

> Certain benefits are always treated as excepted benefits, as defined by the Department of Labor, because they are **not considered health coverage**, such as: Accident Only; Disability Income Insurance; and Workers' Compensation.
>
> Other benefits are treated as excepted benefits if they are **offered separately or are not an integral part of the plan**, including: Limited-Scope Dental or Vision and Long-Term Care Benefits.
>
> Moreover, other benefits are treated as excepted benefits if they **are offered separately and not coordinated** with benefits under another group health plan, including: Coverage for a Specific Disease and Hospital Indemnity or Other Fixed Indemnity Plans
>
> Finally, other benefits are treated as excepted benefits if they are **offered as a separate insurance policy and supplemental** to Medicare, Armed Forces health care coverage, or (in very limited circumstances) group health plan coverage.

- Medicare Advantage and Medicare Prescription Drug plans
- Limited duration plans
- Stand-alone vision, dental, and Medicare supplemental plans

Reporting Requirements

- Insurers are required to submit a report to HHS by June 1st of each year showing how they used their premium revenue for the previous calendar year. If an insurer has failed to use 80% of each premium dollar on health care services and health care improvements (in the individual market) it must refund the policyholders in the individual market by August 1st.
- To assist the insurer with reporting its experience, HHS developed and published an MLR Annual Reporting Form, with instructions on how to complete and submit the report.

  http://www.cciio.cms.gov/resources/files/mlr-annual-form-instructions051612.pdf

Reports

2012
http://www.cms.gov/CCIIO/Resources/Files/Downloads/mlr-report-02-15-2013.pdf

2013
http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-MLR-Report_07-22-2014.pdf

Recipients of Rebates in the Individual Market

- An insurer must meet its MLR obligation to provide any rebate due to a policyholder in the individual market by providing it to the participant by August 1st of the year following the applicable MLR reporting period (the previous calendar year).

- For individual policies that cover more than one person, one lump-sum rebate may be provided to the policyholder on behalf of the participant and all his/her family members covered by the policy.

How Must Rebates be issued to Participants in the Individual Market?

- For current participants: by check, or by issuing a credit to the credit card or debit card that had previously been used to pay premiums, or by a premium credit to a single future bill (or successive bills if the rebate exceeds one month's premium)

- For former participants: by check, or by issuing a credit to the credit card or debit card that had previously been used to pay premiums.

Unclaimed Rebates

An insurer must make a good faith effort to locate and deliver to a participant any rebate entitled to him/her. If after making a good faith effort, an insurer is unable to locate a former participant, the insurer must comply with any applicable state laws.

De Minimis Rebates (Minimum Threshold)

- An insurer is not required to provide a rebate to a participant based upon the premium the participant paid in the individual market, if the total rebate owed to the participant is less than $5. In such cases, the insurer must aggregate the unpaid rebates in each market (in this case, the individual market) in a State and use them to increase the rebates provided to enrollees who receive rebates based upon the same MLR reporting calendar year as the aggregated unpaid rebates.

- The insurer must then distribute these rebates by providing additional premium credit or payment divided evenly among enrollees who are being provided a rebate. For example, an insurer in the individual market has aggregated unpaid rebates totaling $3000, and the insurer has 12,000 participants who are entitled to be provided a rebate above the minimum threshold for the applicable MLR reporting year. The $3,000 must be redistributed to the 12,000 and added to their existing rebate amounts. The $3,000 is divided evenly among the 12,000 participants, so each participant's rebate is increased by $0.25.

How is the Medical Loss Ratio Calculated?

$$MLR = \frac{\text{(health care claims) + (quality improvement expenses)}}{\text{(Premiums) – (taxes, licensing and regulatory fees)}}$$

Premiums: All premiums earned from policyholders.

Claims: Payments made by insurers for medical care and prescription drugs.

Quality Improvement: To be included in this calculation, health improvement activities must lead to measurable improvements in patient outcomes or patient safety, prevent hospital readmissions, promote wellness, or enhance health information technology in a way that improves quality, transparency, or outcomes.

Taxes, Licensing and Regulatory Fees: Includes federal taxes and assessments, state and local taxes, and regulatory licenses and fees.

Federal Tax Consequences of MLR Rebates in the Individual Market

Based on the Internal Revenue Service's (IRS) Frequently Asked Questions, issued on April 19, 2012, the IRS treats the rebate as a return on premiums, as follows:

- As long as the premium payments were not deducted on the individual's federal tax return, the MLR rebate should not be taxable.

- If the individual did deduct the premium payments, the MLR rebate will be taxable to the extent the individual received a tax benefit from that deduction.

Notice of Rebates

1. Medical Loss Ratio Rebate Notice Requirements in the Individual Market When a Rebate Is Not Being Issued For the 2011 MLR reporting year

- An issuer whose MLR meets or exceeds the applicable MLR standard required by Federal Regulations § 158.210 or § 158.211, must provide each policyholder in the individual market, a notice using standard language to inform them that the insurer has met the minimum MLR standards established by the ACA.
- This notice will not include the insurer's MLR for the current or prior reporting year. Instead, the notice will help educate consumers about the MLR measures and direct them to the HealthCare.gov website for information about insurers' actual MLRs.
- In addition, insurers will only need to produce this notice for the 2011 MLR reporting year, when consumer knowledge of MLR is low and the greatest benefit can be achieved by providing enrollees with educational information.
- An insurer who meets or exceeds the applicable MLR standard may provide the one-time notice of MLR separately from any other plan documents provided that they do so prior to or along with the first

plan documents that are provided to participants on or after July 2012. (Examples of plan documents include policies, summary plan descriptions and benefit summaries)

http://cciio.cms.gov/resources/files/Files2/2012-0511-medical-loss-ratio-information.pdf

2. **Medical Loss Ratio Rebate Notice Requirements When a Rebate Is Being Issued in the Individual Market for 2012 MLR reporting year.**

- Each insurer must provide a notice to all policyholders in the individual market who receive a rebate. The notice must be sent to the policyholder, and does not need to be sent to other family members on the same policy.

- The notices are standard and contain information about the insurer's MLR and the rebate. Insurers may not deviate from the content of the standard notices unless populating variable fields or adding the insurer's or the plan's logo.

  http://www.cciio.cms.gov/resources/files/mlr-notice-1-to-subscribers-in-individual-market.pdf

- Notices must be provided by the insurer by August 1 of the year following the MLR reporting year for which the rebate is being issued.

- The rebate itself may either be included with the Notice, or may be sent separately, The Notice may be sent prior to or after payment of the rebate as long as each is provided by August 1 of the year following the MLR reporting year for which the rebate is issued.

How Must the Notice Be Provided?

In the Individual Market, Notices must be mailed to policyholders at the mailing address on file by United States first-class mail, postage prepaid. Notices may instead be provided electronically if the insurer regularly communicates electronically with its policyholders. All reasonable effort should be made to ensure that each policyholder receives the required notice.

http://www.gpo.gov/fdsys/pkg/FR-2012-05-16/pdf/2012-11753.pdf

For Additional Guidance:

The MLR guidance is available at: http://cciio.cms.gov/programs/marketreforms/mlr/index.html. DOL's Technical Release 2011-4 is available at: www.dol.gov/ebsa/newsroom/tr11-04.html. IRS's FAQ's is available at: www.irs.gov/newsroom/article/0,,id=256167,00.html.

Search for MLR Reports by State and Company Name:
http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html

For More Information

Call the Department of Insurance
Office of Consumer Health Insurance toll free at (877) 527-9431
or visit us on our website at http://insurance.illinois.gov