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2016 Medical Loss Ratio (MLR) Background and Talking Points

MLR BACKGROUND

Under the Affordable Care Act, health plans are required to spend a minimum percentage of premium revenue on medical expenses. This percentage is called the Medical Loss Ratio (MLR).

The ACA requires that health plans spend at least

- **80%** of premiums received for **Individual and Family Plan (IFP) and Small Business** plans on medical care or quality improvement programs;
- **85%** of premiums received for **Large Group** plans on medical care or quality improvement programs.

The MLR reporting and rebate requirements apply to all fully insured group and individual plans, including grandfathered plans. They do not apply to self-funded (ASO) business. MLR calculations and rebate determinations are based on market segment. All plans are grouped by market (individual, small business and large group), and rebates are paid to all plans in the market if the minimum loss ratio is not met.

Blue Shield does owe rebates to approximately 30,000 small business policyholders in plans regulated by the Department of Managed Health Care (DMHC), but does not owe any rebates to Individual and Family Plan (IFP) members or Large Group contract holders in DMHC plans. Additionally, no rebates are owed by Blue Shield of California Life & Health Insurance Company (Blue Shield Life), which is regulated by the California Department of Insurance (CDI), for any IFP or group health insurance plans.

As required by law, rebates will be paid by September 30, 2016 to Small Business contract holders (businesses, not individuals) in those plans with the rebates based on their premiums paid in 2015.

Q&A

How will Blue Shield notify small business contract holders that they are getting a rebate? Blue Shield will send a notification letter and rebate check if one is required to all contract holders who are eligible to receive a rebate by September 30, 2016.

Why are some employer group contract holders not getting a rebate? Blue Shield met or exceeded the MLR thresholds for health plans offered to IFP members and Large Group contract holders regulated by DMHC, and for all plans issued by Blue Shield Life, which are regulated by CDI.

What do members need to do to qualify for a rebate from Blue Shield or to claim a rebate that is owed? Blue Shield calculated the MLR for each of our market segments based on requirements provided by the Department of Health and Human Services. If a contract holder is owed a rebate, they do not need to take any action to claim it. They will be notified by Blue Shield per HHS requirements and a rebate check will be sent to them.

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Why are some small business contract holders getting a small rebate relative to the total premium amount they paid in 2015? In 2015, some groups' plans were regulated by the California Department of Insurance (CDI) for 11 months and by the Department of Managed Health Care (DMHC) for one month. Blue Shield only owes rebates in DMHC-regulated plans for 2015. For these groups, Blue Shield will pay a rebate for the one month their plan was regulated by the DMHC.

Why are members of the employer groups receiving letters about rebates owed? Will they receive rebates directly? This notification is required by law, but it is up to the group to determine how to distribute the rebate according federal MLR guidelines. Federal rules require rebates to be used in one of three ways:

(1) To reduce the subscribers' portion of the annual premium for the subsequent policy year for all subscribers covered under any group health policy offered by the plan;

(2) To reduce the subscribers' portion of the annual premium for the subsequent policy year for only those subscribers covered by the group health policy on which the rebate was based; or

(3) To provide a cash refund only to subscribers that were covered by the group health policy on which the rebate is based.