Medical Loss Ratio
Tip Sheet

Background:

The Affordable Care Act (ACA) requires all health insurance plans to submit data on the proportion of premium revenues spent on clinical services and quality improvement programs, also known as the Medical Loss Ratio (MLR). The ACA sets a minimum value for that MLR (referred to as the minimum standards).

Effective January 1, 2011, if managed care organizations (MCOs) do not meet the minimum standards, they are required to issue rebates to enrollees. Medicare Advantage (MA) and Medicare Part D plans have additional penalties for non-compliance (which began January 1, 2014).

What are MLR Services?

MLR services include all paid claims for all medical services plus all quality improvement activity (QIA).

How is the MLR formula calculated?

The MLR formula is as follows:

$$\frac{\textit{Paid Medical Services Claims + QIA}}{\textit{Premium Revenue – Allowable Deductions}} = \textit{MLR}$$

Numerator: Paid medical services claims plus QIA (expenses for activities that improve health care quality – see below)

Denominator: Premium revenue minus allowable deductions (federal and state taxes, and licensing and regulatory fees, with adjustments for risk, risk corridors and reinsurance).

Quality Improvement Activities (QIA)

QIA activities can include services (e.g., Medication Therapy Management) that:

- Improve health outcomes, including an increased likelihood of desired outcomes compared to a baseline and reduced health disparities among specified populations
- Prevent hospital readmissions
- Improve patient safety, reduce medical errors, lower infection and mortality rates
- Increase wellness and promotion of health activities
- Enhance use of health care data to improve quality transparency and outcomes

All QIA expenses must meet the following criteria:

- They must stand up to audit
- Categories of QIA expenses must be consistent each year
- Services provided must be designed to improve health quality
- Services provided must be designed to increase the likelihood of desired health outcomes in ways that can be objectively measured and can produce verifiable results
- Services provided must be directed toward individual members or segments of members, as well as populations other than members (as long as no additional costs are incurred for the non-members).
- Services provided must be based on evidence-based medicine, best clinical practices, or criteria issued by professional medical associations
- Services provided must **require clinical expertise**

An example of services that meet the MLR requirement:
A community-based organization (CBO) contracts with an MCO to provide diabetes self-management training (DSMT) services, using the Stanford Model Diabetes Self-Management Program. The program has met the national accreditation standards of the American Association of Diabetes Educators. The CBO has a registered dietitian that provides clinical supervision for the DSMT program. The CBO successfully completes the credentialing process and lists its registered dietitian and the lead clinician for this service. The licensed dietitian and the organization successfully complete the credentialing process. Upon completion of the credentialing process, the program provides the DSMT services for the MCO, and those services fall under the MLR.

What is NOT part of MLR?

Items that are **not** considered part of MLR include:

- Fraud & abuse detection and prevention
- Cost containment management activities
- Broker commissions that are bundled with premium

What are the MLR Minimum Standards?

For Commercial Plans (began on January 1, 2011)

- 80% for individual and small group plans
  (The ACA defines a small group plan as one that has 1 – 100 average total number of employees [ATNE].)
- 85% for large group plans

For Medicare Advantage Plans (began on January 1, 2014)

- 85% for all MA plans

For Medicare Part D Plans (began on January 1, 2014)

- 85% for all Part D plans

Note: MLR does not apply to PACE programs

What happens if a plan does not comply with the MLR minimum standards?

If a plan does not meet the MLR required threshold, these are the penalties they face:

Commercial Plans:

The plan is required to submit a pro-rated rebate to all enrolled consumers in the amount equal to the difference between the plan's actual MLR and the required MLR.

MA or Part D Plans:

Annually, beginning with the 1st year of non-compliance with MLR:

- MA/Part D plan must remit the rebate to the Centers for Medicare & Medicaid Services (CMS)

If a plan is non-compliant for three (3) consecutive years (in addition to annual rebate):

- Prohibition of new enrollment

If a plan is non-compliant for five (5) consecutive years (in addition to rebate and prohibition)

- Termination of the CMS contract

A hypothetical example of MLR penalties:

HealthABC has a Managed Care Plan in Washington, DC. They have 100,000 members and they receive premiums of $350 per member per month (PMPM).

MLR is calculated in the following manner:

$$\frac{\text{Claims + Quality Improvement Activities}}{\text{Total Premium}}$$

Denominator (Total Premium)
= 100,000 members x 12 months x $350 PMPM = $420,000,000

Numerator (Claims + QIA)
Let's assume the following:

- the total amount they spent on claims for the year was $294,000,000
- they also spent $42,000,000 on QIA.

Therefore, the numerator is $294,000,000 + $42,000,000 = $336,000,000

$$\text{MLR} = \frac{\$336{,}000{,}000 \text{ (Claims + QIA)}}{\$420{,}000{,}000 \text{ (Total Premiums)}}$$

Doing the math, that ratio equals 0.8 or 80%.

HealthABC's required MLR is 85%. They did not meet this standard. As a result, they must pay 5% of premiums back to CMS. 5% of their total premium of $420,000,000 equals $21,000,000.

Quality requirements:

MCOs must ensure that they have a process to monitor the quality of the providers that make up their network of providers of services that meet the MLR requirement.

Credentialing is part of the process of plan quality assurance. Credentialing is a health insurance industry-standard systematic approach to the collection and verification of a provider's professional qualifications. The verification of these qualifications helps to confirm that the provider meets certain professional competence.

The health insurance industry has standardized the process of credentialing all providers. The National Committee for Quality Assurance (NCQA) provides accreditation of health plans and provides the standard for provider credentialing for physicians, non-physician providers, hospitals, home health providers, and other health care delivery organizations. Individual providers, hospitals, home health agencies, and other non-physician providers of health care services must successfully complete the credentialing process outlined by NCQA. MCOs that have contracts with

public entities (i.e., State Medicaid, Medicare Advantage, etc.) are required to adhere to the NCQA standards to credential all providers of services to MCO beneficiaries.

New NCQA standards require that all eligible providers under the scope of the health plan must be credentialed according to the NCQA standard even if the provider type is not one that the NCQA would include in a file audit. Home health companies that only provide health aides are also required to adhere to the NCQA credentialing standards.

Providers that deliver health care services and/or QIA under the MLR guidelines are generally expected to meet the minimum NCQA credentialing standards. These organizations will have to submit consumer and disease-specific claims for services, using industry-standard methods of claims submission.

Opportunity for CBOs:

CBOs that provide QIA services have an opportunity to provide services to health plans that are now required to meet the MLR standard. This means the CBO can provide something of value to health plans, and the health plans should be willing to pay for this value.
However, in order to be of value to the health plans, the CBO's services must meet the QIA standard that requires a level of clinical expertise. In addition, CBOs must be prepared to meet the NCQA credentialing standards. The NCQA credentialing standards require licensed personnel to provide oversight and quality assurance for services provided. CBOs that have been successful in meeting these requirements have employed some or all of the following licensed staff members:

- Nurse Practitioners
- Registered Nurses
- Licensed Clinical Social Workers
- Registered Dietitians

For more information:
http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html