DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

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From: Samara Lorenz, Director, Oversight Group, Center for Consumer Information & Insurance Oversight

Title: Insurance Standards Bulletin Series – INFORMATION

Subject: Treatment of Risk Corridors Recovery Payments in the Medical Loss Ratio and Rebate Calculations

I. Purpose

Section 2718 of the Public Health Service Act (PHS Act), as added by the Patient Protection and Affordable Care Act (PPACA), and the implementing regulations at 45 C.F.R. Part 158 require health insurance issuers (issuers) offering group or individual health insurance coverage to submit a report to the Secretary of the Department of Health and Human Services (HHS) concerning their medical loss ratio (MLR) and issue an annual rebate to enrollees if the issuer's MLR is less than the applicable MLR standard established in section 2718(b)(1)(A)(i) and (ii).

Section 1342 of the PPACA and the implementing regulations at 45 C.F.R. Part 153 established a temporary risk corridors (RC) program covering issuers of qualified health plans (QHPs) in the individual and small group markets for the 2014, 2015, and 2016 benefit years. Under the RC program, HHS collected charges from issuers whose allowable costs[1] fell below 97 percent of the target amount[2] and made payments to issuers whose allowable costs exceeded 103 percent of the target amount. HHS outlined in regulation and guidance that it would operate the program in a budget neutral manner.[3] In the event that charge collections were insufficient to make full payments, HHS explained that payments for the 2014 benefit year would be reduced pro rata to the extent of any shortfall, and the charge amounts collected in subsequent years would be used to address any payment shortfalls from prior years.[4]

[1] Allowable costs include claims and quality improvement activity (QIA) expenses.
[2] The target amount is 80% of after-tax premium.
[3] See, e.g., the HHS Notice of Benefit and Payment Parameters for 2015; Final Rule, 79 FR 13743 at 13787, 13829 (March 11, 2014) and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.
[4] See, e.g., https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf and https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_Obligation_Guidance_11-19-15.pdf

Congress included language in appropriations laws beginning in December 2014[5] that barred the use of other appropriated program funds from being used for RC payments to issuers. Because the RC payments owed to issuers significantly exceeded the RC charges collected and there was no appropriation to make RC payments in excess of RC charges collected, issuers received less than the full calculated RC payments for the 2014 benefit year and no payments for the 2015 or 2016 benefit years. Issuers filed multiple lawsuits seeking to collect the unpaid RC payments, and on April 27, 2020, the Supreme Court ruled that section 1342 created an enforceable government obligation to pay RC amounts as calculated under the RC formula.[6] Since that time, the United States has made (and is continuing to make) payments from the Judgment Fund to issuers for their previously unpaid RC amounts.

Under section 2718 of the PHS Act, an issuer's MLR and rebate calculations must account for, among other things, the net payments or receipts related to the RC program. The purpose of this guidance is to describe how issuers must treat the RC payment amounts recovered as a result of the Supreme Court decision in their MLR and rebate calculations. On September 30, 2020, CMS published a draft of this guidance and invited public comments. CMS has received comments and questions from 16 issuers, issuer associations, and state regulators, and has made several revisions in this final guidance document in response to the comments.

II. Background

Section 2718(b) of the PHS Act, and the implementing regulations at 45 C.F.R. Part 158, require an issuer to provide an annual rebate to enrollees,[7] on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on reimbursement for clinical services provided to enrollees under the health insurance coverage and for activities that improve health care quality to the total amount of premium revenue (excluding Federal and state taxes and licensing or regulatory fees) is less than 80 percent in the individual and small group markets and 85 percent in the large group market.[8] The MLR requirements generally apply to all health insurance issuers offering large group, small group, or individual health insurance coverage.

In order to determine whether its MLR met the applicable standard, an issuer is required to submit to the Centers for Medicare & Medicaid Services (CMS), by July 31st of the year following the end of an MLR reporting year, an Annual MLR Reporting Form concerning premium revenue and expenses related to the group and individual health insurance coverage that it issued in the prior benefit year.[9] Under 45 C.F.R. § 158.140(b)(4)(ii), RC payments received by an issuer are subtracted from the MLR numerator, reducing the MLR, and

[5] See, e.g., Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. 113-235, enacted Dec. 16, 2014).
[6] *Maine Community Health Options v. United States*, 140 S. Ct. 1308 (2020), 590 U.S. __ (2020).
[7] For the sole purpose of determining who is entitled to receive an MLR rebate, the term "enrollee" means the subscriber, policyholder, and/or government entity that paid the premium for health care coverage received by an individual during the respective MLR reporting year. See 45 C.F.R. § 158.240(b).
[8] States have the option to set higher MLR thresholds. See section 2718(b)(1)(A) of the PHS Act and 45 C.F.R. § 158.211.
[9] 45 C.F.R. § 158.110(b).

potentially increasing rebates; while RC charges paid by an issuer are added to the MLR numerator, increasing the MLR, and potentially reducing rebates.

When issuers submitted the 2014 MLR reporting form by July 31, 2015, the actual amount of RC payments that issuers would receive for the 2014 benefit year was not known. CMS instructed issuers to report the full value of the calculated RC amount in the 2014 MLR reporting form regardless of whether the issuer would receive the full payment.[10] As a result, the MLR and rebate calculations for the 2014 reporting year accurately captured the impact of the full calculated RC payment amounts for the 2014 benefit year. However, with no additional appropriation to make RC payments in excess of RC charges collected, it subsequently became uncertain whether issuers would receive the full calculated RC payments for the 2014, 2015, or 2016 benefit years. In recognition of this uncertainty, CMS instructed issuers, starting with the 2015 MLR reporting form, to report only the RC payments actually received from HHS; that is, to report the reduced RC payment amount actually received from HHS for 2014 and $0 for 2015 and 2016.[11] Because the MLR and rebate calculations are based on three years of data, reporting less than the full calculated RC payment amounts impacted the MLR and rebate calculations for the 2015 through 2018 reporting years.[12]

As a result of the Supreme Court ruling, issuers may recover the remaining calculated RC payment amounts for the 2014, 2015, and 2016 benefit years (recovered RC payment amounts). For issuers that reported less than the full calculated RC payment amount and receive recovered RC payment amounts as a result of the litigation, the MLR reports filed for the 2015 through 2018 reporting years will no longer accurately reflect the RC amounts received.

Consistent with 45 C.F.R. §153.710(g)(3), CMS is issuing this guidance to provide instructions to guide issuers in how to revise the affected MLR reports for the 2015 through 2018 reporting years to include the recovered RC payment amounts.[13] Further, if the issuer's updated MLR calculations for the individual and small group markets using the recovered RC payment amounts do not meet or exceed the applicable MLR standard, the issuer may now owe a rebate for the affected reporting years, or a rebate owed may be higher than the rebate previously calculated for the respective reporting year.[14] This guidance therefore also provides

[10] https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2014-MLR-Annual-Reporting-Form-Instructions-20150528c.pdf

[11] https://www.regtap.info/uploads/library/RC_CSRandMLR_091516_v1_5CR_091516.pdf. See also, Annual Reporting Form Instructions for 2015 through 2018, available at https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index#Medical_Loss_Ratio.

[12] The MLR reporting form for a given year collects information for each of the two prior reporting years. For example, the 2014 data is reported on the 2014, 2015, and 2016 reporting forms. In 2014, the issuers reported the full calculated RC payment amount. In the 2015 and 2016 reporting forms, issuers revised the 2014 amount to reflect the amount of the payment received.

[13] As specified in 45 C.F.R. § 153.710(g)(3), in cases where HHS reasonably determines the reporting instructions in § 153.710(g)(1) or (2) would lead to unfair or misleading reporting, issuers must correct their data submissions in a form and manner to be specified by HHS.

[14] The inclusion of the additional RC payment amounts will reduce the MLR numerator. However, it is possible that the recalculated MLR, which is rounded to the third decimal place, will be unchanged. In this case, the issuer's rebate liability will be unchanged.

instructions regarding payment of additional rebates owed as a result of recalculating an issuer's MLR to include the recovered RC payment amounts.

III. Guidance

Issuers must submit a revised MLR reporting form(s) for the 2015 through 2018 reporting years for each state, market, and year in which the issuer has a greater rebate liability based on inclusion of the recovered RC payment amounts. Issuers must pay the outstanding rebate amounts to the enrollees who were enrolled in the respective MLR reporting year.[15] Issuers that do not have a higher rebate obligation based on the inclusion of the recovered RC payment amounts for any of the applicable reporting years do not need to submit a revised MLR reporting form. CMS has authority to enforce compliance with the MLR reporting and rebate requirements, including compliance with the directions in this guidance to submit revised MLR reporting forms and to pay any rebates owed as a result of receiving recovered RC payment amounts.[16]

Issuers must revise their MLR and rebate calculations and pay the additional rebate amounts based on the full recovered RC payment amounts, even if issuers do not receive the full amounts, such as due to having sold the rights to receive all or a portion of the recovered RC payment amounts to a third party.

If an issuer has been acquired by a new company and the acquired issuer's rebate obligation based on the inclusion of recovered RC payment amounts is higher than the rebate amount paid in the respective reporting year, the acquiring company is responsible for submitting the revised prior year MLR reporting form(s) and paying the additional rebate amount to the acquired entity's enrollees in the respective MLR reporting year(s).[17] Similarly, if an issuer has transferred the block of business that was subject to the requirements of 45 C.F.R. Parts 153 and 158 via a 100% assumption reinsurance agreement, the assuming entity is responsible for submitting the revised MLR reporting form(s) and providing rebates owed on the assumed business.[18]

When revising the prior year MLR reporting form(s), issuers must use the MLR Annual Reporting Form Filing Instructions that were applicable for the respective prior reporting year, except that the Part 2, Line 1.11 (Federal Risk Corridors Program Payments or Charges) must reflect the updated payment amount for the relevant state, market, and reporting year based upon the recovered RC payment amount,[19] and all calculated amounts impacted by Part 2,

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Some issuers, at their discretion, reported the full calculated RC payment amount or an amount in excess of the payments actually received from HHS but less than the full RC payment amount calculated.

[15] 45 C.F.R. § 158.240(b).

[16] See section 2718(b)(3) of the PHS Act. Also see 45 C.F.R. §§ 153.710(g)(3), 158.401, 158.402, 158.501, and 158.502.

[17] 45 C.F.R § 158.110(c).

[18] Ibid.

[19] In determining the updated RC payment amount to be reported on Part 2, Line 1.11 of the MLR reporting form(s), issuers may use either the actual recovered RC payment amount or the corresponding amount that was calculated on

Line 1.11 must be updated accordingly, including in the prior year (PY2 and PY1) columns of the MLR reporting form(s) for subsequent years. Similar to the standard MLR filing process, for the 2016-2018 reporting years, issuers will need to upload the complete zip file in the Health Insurance Oversight System (HIOS) that includes MLR reporting form(s) for all states, including unmodified copies of the original templates for states where the rebate amounts would not be impacted by inclusion of the recovered RC payment amounts.[20] Issuers should email MLRQuestions@cms.hhs.gov prior to uploading the zip file in HIOS. For the 2015 reporting year, issuers will need to email the complete zip file described above to MLRQuestions@cms.hhs.gov instead of uploading it directly in HIOS.

For purposes of revising the prior year MLR reporting form(s), issuers should treat the taxes attributable to the recovered RC payment amounts in accordance with established accounting principles and tax guidelines, and using allocation methods consistent with 45 C.F.R. § 158.170, including ensuring that any such tax amounts are not double-counted in multiple reporting years.

For purposes of revising the prior year MLR reporting form(s), issuers should not include any adjustments to risk adjustment payments that were not paid in those prior years. Such adjustments must be reported on the MLR reporting form(s) for the same reporting year in which such adjustments are paid or approved by CMS, consistently with 45 C.F.R. § 153.710(g)(2).

Timing of Submission of the Revised Prior Year MLR Annual Reporting Form(s) and Disbursement of Additional Rebates

Issuers with a higher rebate obligation based on the inclusion of the recovered RC payment amounts for one or more of the applicable prior reporting years must submit the revised MLR reporting form(s) to CMS and disburse additional rebate payments to enrollees in the respective year within 150 days of receiving recovered RC payment amounts or publication of this guidance, whichever is later, except as directed otherwise by CMS in conjunction with an open MLR examination or audit. If an issuer fails to pay the additional rebates by the required deadline, rebate payments must then include late payment interest amounts at the Federal Reserve Board lending rate or ten percent annually, whichever is higher, on the total amount of the additional rebate, accruing from the date on which the additional rebate was due as outlined in this guidance.[21]

Affected issuers should contact CMS at MLRQuestions@cms.hhs.gov for instructions on how to submit the applicable prior year MLR reporting form(s) in HIOS.

Tab 3, Line 10 of the original Risk Corridors Plan-level Reporting Form (which should be reflected on Part 3, Line 3.12, Column RC of the MLR reporting form) for the relevant year.

[20] While issuers are not required to revise the MLR reporting form(s) for states where the rebate amounts would not be impacted by inclusion of the recovered RC payment amounts, they are allowed to make such revisions.

[21] 45 C.F.R. § 158.240(f).

Rebate Disbursement

The pro-rata rebate amount, the form of the rebate, and the rebate recipient must be determined in accordance with 45 C.F.R. §§ 158.240, 158.241, and 158.242 and be based on the year in which health insurance coverage was received and not based on the year in which the issuer receives the recovered RC payment amounts or when the additional rebate is paid. Consistent with 45 C.F.R. § 158.250, additional rebate disbursements must include a notice explaining to enrollees why they are receiving a rebate or an additional rebate. Issuers may use either the standard notices accompanied by an explanatory cover letter or appropriately modify the standard notices, such as in the examples attached to this bulletin.

For the purposes of determining whether a rebate amount is considered *de minimis* pursuant to the applicable threshold established in 45 C.F.R. § 158.243(a), the issuer must use the full rebate amount in the respective reporting year and not just the additional rebate amount owed as a result of recovered RC payments.

Consistent with 45 C.F.R. § 158.244, issuers must make a good faith effort to locate and deliver to an enrollee the additional rebate amount owed. To the extent that issuers' contact information for the recipients of the additional rebates may be outdated, to demonstrate a good faith effort, issuers should pursue alternative means if necessary in addition to steps they ordinarily take to locate rebate recipients. An issuer would be considered to have made a good faith effort if the issuer contacted former enrollees at the last known phone or email address; as well as performed a search on the internet or social media; or utilized other methods that the issuer would use to pursue debt collection for an older debt. If, after making a good faith effort, an issuer is unable to locate a former enrollee, the issuer must comply with any applicable State law regarding the disposition of unclaimed rebates.

IV. Where to Get More Information

If you have any questions regarding this Bulletin, please contact CMS by email at MLRQuestions@cms.hhs.gov.

Attachment 1
This is an example of a notice that may be used with any (additional) rebates paid in the individual market for the 2015, 2016, 2017, and/or 2018 MLR reporting years as a result of the issuer receiving recovered risk corridors payment amounts.

Notice of Health Insurance Premium Rebate

[Month Day, Year **1**]

[Subscriber or Policyholder Name **2a**
123 Main Street **2b**
Anytown, USA **2c**]

Re: Health Insurance Premium Rebate for Year [X **3**]; [Policy #XXXXX **4**]

Dear [Subscriber or Policyholder Name **5**]:

This letter is to inform you that you will receive a rebate of a portion of your health insurance premiums for the year(s) stated above. This rebate is required by the Affordable Care Act. As a result of the United States Supreme Court decision on April 27, 2020 in *Maine Community Health Options v. United States*, [Health Insurer **6**] recently received additional payment from the Federal Government that impacted our Medical Loss Ratio for that year(s), and we are providing you with a premium rebate that is due as a result.

The Affordable Care Act requires [Health Insurer **7**] to issue a rebate to you if [Health Insurer **8**] does not spend at least 80 percent of the premiums it receives on health care services, such as doctors and hospital bills, and activities to improve health care quality, such as efforts to improve patient safety. No more than 20 percent of premiums may be spent on administrative costs such as salaries, sales, and advertising. This requirement is referred to as the "Medical Loss Ratio" standard or the "80/20 rule." The 80/20 rule in the Affordable Care Act is intended to ensure that consumers get value for their health care dollars. You can learn more about the 80/20 rule and other provisions of the health reform law at: https://www.healthcare.gov/health-care-law-protections/rate-review/.

[The Affordable Care Act allows States to require health insurers to meet a higher ratio. [Your State **9**] sets a higher Medical Loss Ratio standard, so [Health Insurer **10**] must meet a [XX% **11**] Medical Loss Ratio, meaning that [XX% **12**] of premiums must be spent on medical services and activities to improve health care quality, and no more than [XX% **13**] of premiums can be spent on administrative costs.]

What the Medical Loss Ratio Rule Means to You

The Medical Loss Ratio rule is calculated on a State-by-State basis. In [your State **14**], [Health Insurer **15**] did not meet the Medical Loss Ratio standard for [X **16**] as a result of recalculating the Medical Loss Ratio to account for payments we recently received from the Federal Government. After recalculation, [Health Insurer **17**] spent only [XX% **18**] of a total of [$YYY **19**] in premium dollars on health care and activities to improve health care quality in [X **20**].

Since it missed the [80 percent target / target in your State **21**] by [XX% **22**] of premium received, [Health Insurer **23**] must rebate [XX% / $XX **24**] of your health insurance premiums for [X **25**]. [[Health Insurer **26**] previously rebated [XX% / $XX **27**] of your health insurance premiums for [X **28**] and is now providing the additional rebate resulting from the recalculation.]

[We are enclosing a check/We are sending you a check separately from this letter/We are giving you this rebate by reducing your next premium payment/We are issuing a credit to the credit or debit card you used to pay your premium **29**]. [OPTIONAL FOR ISSUERS: Your rebate/credit provided right now is $XX **30**].

Need more information?

If you have any questions about the Medical Loss Ratio and your health insurance coverage, please contact [Health Insurer **31**] toll-free at [1-XXX-XXX-XXXX **32**] or [website or email address **33**].

Sincerely,

[Jane Doe, Authorized Executive **34**] [Health Insurer **35**]

Attachment 2
This is an example of a notice that may be used with any (additional) rebates paid in the small group market to the group policyholder for the 2015, 2016, 2017, and/or 2018 MLR reporting years as a result of the issuer receiving recovered risk corridors payment amounts.

Notice of Health Insurance Premium Rebate

[Month Day, Year **1**]

[Subscriber or Policyholder Name **2a**
123 Main Street **2b**
Anytown, USA **2c**]

Re: Health Insurance Premium Rebate for Year [X **3**]; [Policy #XXXXX **4**]

Dear [Subscriber or Policyholder Name **5**]:

This letter is to inform you that [Health Insurer **6**] will be rebating a portion of your health insurance premiums for the year(s) stated above through your employer or group policyholder. This rebate is required by the Affordable Care Act. As a result of the United States Supreme Court decision on April 27, 2020 in *Maine Community Health Options v. United States*, [Health Insurer **7**] recently received additional payment from the Federal Government that impacted our Medical Loss Ratio for that year(s), and we are providing your employer or group policyholder with a premium rebate that is due as a result.

The Affordable Care Act requires [Health Insurer **8**] to rebate part of the premiums if it does not spend at least 80 percent of the premiums it receives on health care services, such as doctors and hospital bills, and activities to improve health care quality, such as efforts to improve patient safety. No more than 20 percent of premiums may be spent on administrative costs such as salaries, sales, and advertising. This requirement is referred to as the "Medical Loss Ratio" standard or the "80/20 rule." The 80/20 rule in the Affordable Care Act is intended to ensure that consumers get value for their health care dollars. You can learn more about the 80/20 rule and other provisions of the health reform law at: https://www.healthcare.gov/health-care-law-protections/rate-review/.

[The Affordable Care Act allows States to require health insurers to meet a higher ratio. [Your State **9**] sets a higher Medical Loss Ratio standard, so [Health Insurer **10**] must meet a [XX% **11**] Medical Loss Ratio, meaning that [XX% **12**] of premiums must be spent on medical services and activities to improve health care quality, and no more than [XX% **13**] of premiums can be spent on administrative costs.]

What the Medical Loss Ratio Rule Means to You

The Medical Loss Ratio rule is calculated on a State-by-State basis. In [your State **14**], [Health Insurer **15**] did not meet the Medical Loss Ratio standard for [X **16**] as a result of recalculating the Medical Loss Ratio to account for payments we recently received from the Federal

Government. After recalculation, [Health Insurer **17**] spent only [XX% **18**] of a total of [$YYY **19**] in premium dollars on health care and activities to improve health care quality in [X **20**]. Since it missed the [80 percent target / target in your State **21**] by [XX% **22**] of premium received, [Health Insurer **23**] must rebate [XX% / $XX **24**] of total health insurance premiums paid by the employer and employees in your group health plan for [X **25**]. [[Health Insurer **26**] previously rebated [XX% / $XX **27**] of the total health insurance premiums for [X **28**] and is now providing the additional rebate resulting from the recalculation.] Employers and other group policyholders must follow certain rules for distributing the rebate to employees and subscribers.

Ways in Which an Employer Can Distribute the Rebate

If your group health plan is a non-Federal governmental plan, the employer or group policyholder must distribute the rebate in one of two ways:

- Reducing premium for the upcoming year; or
- Providing a cash rebate to employees or subscribers that were covered by the health insurance on which the rebate is based.

If your group health plan is a church plan, the employer or group policyholder has agreed to distribute the portion of the rebate that is based on the total amount all of the employees contributed to the health insurance premium in one of the ways discussed in the prior paragraph.

If your group health plan is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA), the employer or the administrator of the group health plan may have fiduciary responsibilities regarding use of the Medical Loss Ratio rebates. Some or all of the rebate may be an asset of the plan, which must be used for the benefit of the employees covered by the policy. Employees or subscribers should contact the employer or group policyholder directly for information on how the rebate will be used. For general information about your responsibilities regarding the rebate, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or review the Department's technical guidance on this issue on its web site at https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/11-04.

Need more information?

If you have any questions about the Medical Loss Ratio and your health insurance coverage, please contact [Health Insurer **31**] toll-free at [1-XXX-XXX-XXXX **32**] or [website or email address **33**].

Sincerely,

[Jane Doe, Authorized Executive **34**] [Health Insurer **35**]

Attachment 3
This is an example of a notice that may be used with any (additional) rebates paid in the small group market directly to subscribers for the 2015, 2016, 2017, and/or 2018 MLR reporting years as a result of the issuer receiving recovered risk corridors payment amounts.

Notice of Health Insurance Premium Rebate

[Month Day, Year **1**]

[Subscriber Name **2a**
123 Main Street **2b**
Anytown, USA **2c**]

Re: Health Insurance Premium Rebate for Year [X **3**]; [Policy #XXXXX **4**]

Dear [Subscriber Name **5**]:

This letter is to inform you that you will receive a rebate of a portion of your health insurance premiums for the year(s) stated above. This rebate is required by the Affordable Care Act. As a result of the United States Supreme Court decision on April 27, 2020 in *Maine Community Health Options v. United States*, [Health Insurer **6**] recently received additional payment from the Federal Government that impacted our Medical Loss Ratio for that year(s), and we are providing you with a premium rebate that is due as a result.

The Affordable Care Act requires [Health Insurer **7**] to rebate part of the premiums if [Health Insurer **8**] does not spend at least 80 percent of the premiums it receives on health care services, such as doctors and hospital bills, and activities to improve health care quality, such as efforts to improve patient safety. No more than 20 percent of premiums may be spent on administrative costs such as salaries, sales, and advertising. This requirement is referred to as the "Medical Loss Ratio" standard or the "80/20 rule." The 80/20 rule in the Affordable Care Act is intended to ensure that consumers get value for their health care dollars. You can learn more about the 80/20 rule and other provisions of the health reform law at: https://www.healthcare.gov/health-care-law-protections/rate-review/.

[The Affordable Care Act allows States to require health insurers to meet a higher ratio. [Your State **9**] sets a higher Medical Loss Ratio standard, so [Health Insurer **10**] must meet a [XX% **11**] Medical Loss Ratio, meaning that [XX% **12**] of premiums must be spent on medical services and activities to improve health care quality, and no more than [XX% **13**] of premiums can be spent on administrative costs.]

What the Medical Loss Ratio Rule Means to You

The Medical Loss Ratio rule is calculated on a State-by-State basis. In [your State **14**], [Health Insurer **15**] did not meet the Medical Loss Ratio standard for [X **16**] as a result of recalculating the Medical Loss Ratio to account for payments we recently received from the Federal Government. After recalculation, [Health Insurer **17**] spent only [XX% **18**] of a total of [$YYY

19] in premium dollars on health care and activities to improve health care quality in [X **20**]. Since it missed the [80 percent target / target in your State **21**] by [XX% **22**] of premium received, [Health Insurer **23**] must rebate [XX% / $XX **24**] of the total health insurance premiums paid by the employer and employees in your group health plan for [X **25**]. [[Health Insurer **26**] previously rebated [XX% / $XX **27**] of total health insurance premiums for [X **28**] and is now providing the additional rebate resulting from the recalculation.]

[We are enclosing a check/We are sending you a check separately from this letter/We are giving you this rebate by reducing your next premium payment/We are issuing a credit to the credit or debit card you used to pay your premium **29**]. [OPTIONAL FOR ISSUERS: Your rebate/credit provided right now is $XX **30**].

Need more information?

If you have any questions about the Medical Loss Ratio and your health insurance coverage, please contact [Health Insurer **31**] toll-free at [1-XXX-XXX-XXXX **32**] or [website or email address **33**].

Sincerely,

[Jane Doe, Authorized Executive **34**] [Health Insurer **35**]

Attachment 4
Instructions for completing the examples of notices of MLR rebates for the 2015-2018 MLR reporting years resulting from the receipt of recovered risk corridors payment amounts – Individual and Small Group Market Policyholders and Small Group Market Subscribers

These instructions describe the information to be entered in each numbered field. Within each notice, many of the labeled fields require the same information. The information entered on each notice should be for the relevant state and market (individual, small group) for the policyholder or subscriber receiving the notice. A single notice may be used if the issuer is providing a combined rebate amount for multiple years; in this case, the issuer should expand the relevant sentences to separately provide the information with respect to each affected year.

- **1** Enter the date the notice is sent.
- **2** Enter the subscriber's name and mailing address.
    - **2a** - Enter the subscriber's first and last name.
    - **2b** - Enter the subscriber's street address.
    - **2c** - Enter the subscriber's city, State and zip code.
- **3, 16, 20, 25, 28** Enter the year(s) to which the Notice applies.
- **4** Enter the policy number of the subscriber's/policyholder's policy
- **5** Enter the policyholder's or subscriber's full name.
- **6, 7, 8, 10, 15, 17, 23, 26, 31, 35** Enter the name of the issuer responsible for providing the estimated rebate.
- **9-13** The entire paragraph that contains Fields 9-13 should only be used if the subscriber resides in a State that requires a loss ratio higher than 80 percent in the applicable market.
- **9, 14, 21** Enter either the name of the State in which the MLR experience applies or the words "your State."
- **11, 12** Enter the MLR standard required by the subscriber's State for the applicable market.
- **13** Enter the percentage difference between 100 percent and the MLR standard entered in Fields 11 and 12.
- **18** Enter the issuer's actual credibility-adjusted MLR, as reported on the MLR Form.
- **19** Enter the total amount of premium dollars the issuer received, adjusted for taxes and regulatory fees, for the MLR reporting year at issue.
- **21** Enter "80 percent target" if issuers in the applicable market in the policyholders'/subscriber's State must meet an 80 percent MLR. Enter the MLR standard required by the State if the policyholder's/subscriber's State requires an MLR standard that is higher than 80 percent.
- **22** Enter the percentage difference between the MLR the issuer is required to meet and its actual MLR.
- **24** Enter the percentage of the health insurance premiums that the issuer is rebating, or enter the dollar amount of the rebate being provided to each policyholder/subscriber.
- **27** Enter the percentage of the health insurance premiums or the dollar amount that the issuer previously rebated.
- **29** Select the wording in this bracket that represents the method of the rebate.

- **30** OPTIONAL FOR ISSUERS: Issuers may, at their option, choose to insert the amount of the rebate being provided to each policyholder/subscriber.
- **32, 33** Enter both the toll-free telephone number that policyholders/subscribers may call and also a website or email address that policyholders/subscribers may visit or email if they have questions regarding the MLR and their rebate.
- **34** Enter the name of one of the executives of the issuer authorized to attest to the information in the MLR Annual Reporting Form. The notice must be signed by one of these authorized executives. No exceptions are permitted.