DEPARTMENT OF INSURANCE
Legal Division
45 Fremont Street, 24th Floor
San Francisco CA 94105

Guidance 1163: 6

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Pursuant to Senate Bill 1163 (Chapter 661, Statutes 2010), the California Department of Insurance issues the following guidance regarding compliance. [1] Further guidance may be forthcoming in the future.

Section A: Unreasonable Rate Increases

For all health insurance rate filings filed on or after October 1, 2012, for the purpose of the actuarial certification required under Insurance Code section 10181.6(b)(2) and review under Insurance Code section 10181.11, the following additional factors will be considered by the Department in determining whether a rate increase is "unreasonable" in addition to, but not limited to, the 15 factors described in Guidance 1163:2. For clarity, these factors will be numbered continuing the sequence established in Guidance 1163:2:

Factor 16:

Guidance 1162:2, issued April 5, 2011, provided Factor 15 as a factor that will be considered in determining whether a rate increase is unreasonable. Guidance 1163:2 Factor 15 provided that, in addition to the fourteen factors listed, additional factors considered in evaluating whether a rate increase is unreasonable include, but are not limited to, those set forth in the most current version of 45 Code of Federal Regulations section 154.301. The factors set forth in the federal regulation include administrative costs. This new Factor 16 clarifies that the factors described in Guidance 1163:2 Factor 15 include, but are not limited to, administrative costs, as follows: Whether the ratio of total

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[1] Senate Bill 1163 provides, at Insurance Code section 10181.2, that Article 4.5 (Insurance Code section 10181 *et seq.*) does not

> apply to a specialized health insurance policy; a Medicare supplement policy subject to Article 6 (commencing with Section 10192.05); a health insurance policy offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code); a health insurance policy offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5)); a health insurance conversion policy offered pursuant to Section 12682.1; or a health insurance policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900).

Accordingly, the above guidance does not apply to the types of insurance listed in Insurance Code section 10181.2.

general and administrative expenses to direct premium, gross of reinsurance, is reasonable in relation to the ratios of other issuers in the most recent year for which data is available.

Factor 17:

Whether the filed rates appropriately reflect the effects of reinsurance, risk adjustment, and risk corridor programs that are expected to be in place during the time the filed rates are anticipated to be in effect.

Section B: Updated Reference to Federal Regulation

Factor 1 of Guidance 1163:2, issued April 5, 2011, included a reference to an interim final federal rule. This reference is now updated as follows:

Factor 1:

The relationship of the projected aggregate medical loss ratio to the federal medical loss ratio standard in the market segment to which the rate applies, after accounting for any adjustments allowable under federal law. This includes, but is not limited to, the language in the attachment to this guidance, sections 158.101- 158.232 [source: 45 C.F.R. sections 158.101- 158.232, 75 Fed. Reg. 74864 (December 1, 2010), and subsequent amendments: Correction of Interim Final Rule, 75 Fed. Reg. 82277 (December 30, 2010), Final Rule, 76 Fed. Reg. 76574 (December 7, 2011), Final Rule, 77 Fed Reg. 16453 (March 21, 2012), Final Rule, 77 Fed. Reg. 28790 (May 16, 2012), and Interim Final Rule Correcting Amendment, 77 Fed. Reg. 28788 (May 16, 2012)].

For questions, please contact Bruce Hinze at bruce.hinze@insurance.ca.gov.

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45 Code of Federal Regulations sections 158.101-158.232

Source: 75 FR 74921, Dec. 1, 2010, unless otherwise noted.

§ 158.101 Basis and scope.

(a) *Basis.* This Part implements section 2718 of the Public Health Service Act (PHS Act).

(b) *Scope.* Subpart A of this part establishes the requirements for health insurance issuers ("issuers") offering group or individual health insurance coverage to report information concerning premium revenues and the use of such premium revenues for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. Subpart B describes how this information will be used to determine, with respect to each medical loss ratio (MLR) reporting year, whether the ratio of the amount of adjusted premium revenue expended by the issuer on permitted costs to the total amount of adjusted premium revenue (MLR) meets or exceeds the percentages established by section 2718(b)(1) of the PHS Act. Subpart B also addresses requirements for calculating any rebate amounts that may be due in the event an issuer does not meet the applicable MLR standard. Subpart C implements the provision of section 2718(b)(1)(A)(ii) of the PHS Act allowing the Secretary to adjust the MLR standard for the individual market in a State if requiring issuers to meet that standard may destabilize the individual market. Subparts D through F provide for enforcement of this part, including requirements for issuers to maintain records and civil monetary penalties that may be assessed against issuers who violate the requirements of this part.

[75 FR 74921, Dec. 1, 2010, as amended at 75 FR 82278, Dec. 30, 2010]

§ 158.102 Applicability.

General requirements. The requirements of this Part apply to issuers offering group or individual health insurance coverage, including a grandfathered health plan as defined in §147.140 of this subpart.

§ 158.103 Definitions.

For the purposes of this Part, the following definitions apply unless specified otherwise.

Blended rate means a single rate charged for health insurance coverage provided to a single employer through two or more of an issuer's affiliated companies for employees in one or more States.

Contract reserves means reserves that are established by an issuer which, due to the gross premium pricing structure at issue, account for the value of the future benefits that at any time exceeds the value of any appropriate future valuation of net premiums at that time. Contract reserves must not include premium deficiency reserves. Contract reserves must not include reserves for expected MLR rebates.

Direct paid claims means claim payments before ceded reinsurance and excluding assumed reinsurance except as otherwise provided in this Part.

Enrollee means an individual who is enrolled, within the meaning of §144.103 of this title, in group health insurance coverage, or an individual who is covered by individual insurance coverage, at any time during an MLR reporting year.

Experience rating refund means the return of a portion of premiums pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium.

Group conversion charges means the portion of earned premium allocated to providing the privilege for a certificate holder terminated from a group health plan to purchase individual health insurance without providing evidence of insurability.

Health Plan means health insurance coverage offered through either individual coverage or a group health plan.

Individual market has the meaning given the term in section 2791(e)(1) of the PHS Act and section 1304(a)(2) of the Affordable Care Act.

Large Employer has the meaning given the term in section 2791(e)(2) of the PHS Act and section 1304(b)(1) of the Affordable Care Act, except that as provided by section 1304(b)(3) of the Affordable Care Act, until 2016 a State may substitute “51” employees for “101” employees in the definition.

Large group market has the meaning given the term in section 2791(e)(3) of the PHS Act and section 1304(a)(3) of the Affordable Care Act.

MLR reporting year means a calendar year during which group or individual health insurance coverage is provided by an issuer.

Policyholder means any entity that has entered into a contract with an issuer to receive health insurance coverage as defined in section 2791(b) of the PHS Act.

Situs of the contract means the jurisdiction in which the contract is issued or delivered as stated in the contract.

Small Employer has the meaning given the term in section 2791(e)(4) of the PHS Act and section 1304(b)(2) of the Affordable Care Act, except that as provided by section 1304(b)(3) of the Affordable Care Act, until 2016 a State may substitute “50” employees for “100” employees in the definition.

Small group market has the meaning in section 2791(e)(5) of the PHS Act and section 1304(a)(3) of the Affordable Care Act.

Student administrative health fee has the meaning given the term in §147.145 of this subchapter.

Student health insurance coverage has the meaning given the term in §147.145 of this subchapter.

Student market means the market for student health insurance coverage.

Subscriber refers to both the group market and the individual market. In the group market, subscriber means the individual, generally the employee, whose eligibility is the basis for the enrollment in the group health plan and who is responsible for the payment of premiums. In the individual market, subscriber means the individual who purchases an individual policy and who is responsible for the payment of premiums.

Unearned premium means that portion of the premium paid in the MLR reporting year that is intended to provide coverage during a period which extends beyond the MLR reporting year.

Unpaid Claim Reserves means reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within 3 months of the end of the MLR reporting year.

[75 FR 74921, Dec. 1, 2010, as amended at 77 FR 16469, Mar. 21, 2012; 77 FR 28790, May 16, 2012]

Subpart A—Disclosure and Reporting

§ 158.110 Reporting requirements related to premiums and expenditures.

(a) *General requirements.* For each MLR reporting year, an issuer must submit to the Secretary a report which complies with the requirements of this Part, concerning premium revenue and expenses related to the group and individual health insurance coverage that it issued.

(b) *Timing and form of report.* The report for each MLR reporting year must be submitted to the Secretary by June 1 of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary.

(c) *Transfer of Business.* Issuers that purchase a line or block of business from another issuer during an MLR reporting year are responsible for submitting the information and reports required by this Part for the assumed business, including for that part of the MLR reporting year that was prior to the purchase.

[75 FR 74921, Dec. 1, 2010, as amended at 76 FR 76592, Dec. 7, 2011]

§ 158.120 Aggregate reporting.

(a) *General requirements.* For purposes of submitting the report required in §158.110 of this subpart, the issuer must submit a report for each State in which it is licensed to issue health insurance coverage that includes the experience of all policies issued in the State during the MLR reporting year covered by the report. The report must aggregate data for each entity licensed within a State, aggregated separately for the large group market, the small group market and the individual market. Experience with respect to each policy must be included on the report submitted with respect to the State where the contract was issued, except as specified in §158.120(d) of this subpart.

(b) *Group Health Insurance Coverage in Multiple States.* Group coverage issued by a single issuer that covers employees in multiple States must be attributed to the applicable State based on the situs of the contract. Group coverage issued by multiple affiliated issuers that covers employees in multiple States must be attributed by each issuer to each State based on the situs of the contract.

(c) *Group Health Insurance Coverage With Dual Contracts.* Where a group health plan involves health insurance coverage obtained from two affiliated issuers, one providing in-network coverage only and the second providing out-of-network coverage only, solely for the purpose of providing a group health plan that offers both in-network and out-of-network benefits, experience may be treated as if it were all related to the contract provided by the in-network issuer. However, if the issuer chooses this method of aggregation, it must apply it for a minimum of 3 MLR reporting years.

(d) *Exceptions.* (1) For individual market business sold through an association or trust, the experience of the issuer must be included in the State report for the issue State of the certificate of coverage.

(2) For employer business issued through a group trust or multiple employer welfare association (MEWA), the experience of the issuer must be included in the State report for the State where the employer (if sold through a trust) or the MEWA (if the MEWA is the policyholder) has its principal place of business.

(3) An issuer with policies that have a total annual limit of $250,000 or less must report the experience from such policies separately from other policies.

(4) An issuer with group policies that provide coverage to employees, substantially all of whom are: Working outside their country of citizenship; working outside of their country of citizenship and outside the employer's country of domicile; or non-U.S. citizens working in their home country, must aggregate and report the experience from these policies on a national basis, separately for the large group market and small group market, and separately from other policies.

(5) An issuer in the student market must aggregate and report the experience from these policies on a national basis, separately from other policies.

[75 FR 74921, Dec. 1, 2010, as amended at 75 FR 82278, Dec. 30, 2010; 76 FR 76592, Dec. 7, 2011; 77 FR 16469, Mar. 21, 2012; 77 FR 28790, May 16, 2012]

§ 158.121 Newer experience.

If, for any aggregation as defined in §158.120, 50 percent or more of the total earned premium for an MLR reporting year is attributable to policies newly issued and with less than 12 months of experience in that MLR reporting year, then the experience of these policies may be excluded from the report required under §158.110 of this subpart for that same MLR reporting year. If an issuer chooses to defer reporting of newer business as provided in this section, then the excluded experience must be added to the experience reported in the following MLR reporting year.

§ 158.130 Premium revenue.

(a) *General requirements.* An issuer must report to the Secretary earned premium for each MLR reporting year. Earned premium means all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan.

(1) Earned premium is to be reported on a direct basis except as provided in paragraph (b) of this section.

(2) All earned premium for policies issued by one issuer and later assumed by another issuer must be reported by the assuming issuer for the entire MLR reporting year during which the policies were assumed and no earned premium for that MLR reporting year must be reported by the ceding issuer.

(3) Reinsured earned premium for a block of business that was subject to indemnity reinsurance and administrative agreements effective prior to March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

(b) *Adjustments.* Earned premium must include adjustments to:

(1) Account for assessments paid to or subsidies received from Federal and State high risk pools.

(2) Account for portions of premiums associated with group conversion charges.

(3) Account for any experience rating refunds incurred, excluding any rebate paid based upon an issuer's MLR.

(4) Account for unearned premium.

[75 FR 74921, Dec. 1, 2010, as amended at 77 FR 28790, May 16, 2012]

§ 158.140 Reimbursement for clinical services provided to enrollees.

(a) *General requirements.* The report required in §158.110 must include direct claims paid to or received by providers, including under capitation contracts with physicians, whose services are covered by the policy for clinical services or supplies covered by the policy. In addition, the report must include claim reserves associated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the medical claim portion of lawsuits, and any incurred experience rating refunds. Reimbursement for clinical services, as defined in this section, is referred to as “incurred claims.” All components of and adjustments to incurred claims, with the exception of contract reserves, must be calculated based on claims incurred only during the MLR reporting year and paid through March 31st of the following year. Contract reserves must be calculated as of December 31st of the applicable year.

(1) If there are any group conversion charges for a health plan, the conversion charges must be subtracted from the incurred claims for the aggregation that includes the conversion policies and this same amount must be added to the incurred claims for the aggregation that provides coverage that is intended to be replaced by the conversion policies. If an issuer transfers portions of earned premium associated with group conversion privileges between group and individual lines of business in its Annual Statement accounting, these amounts must be added to or subtracted from incurred claims.

(2) Incurred claims must include the current year's unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.

(3) Incurred claims must include claims incurred but not reported based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.

(4) Incurred claims must include changes in other claims-related reserves.

(5) Incurred claims must include incurred experience rating refunds and exclude rebates paid as required by §158.240 based upon prior MLR reporting year experience.

(b) *Adjustments to incurred claims.* (1) Adjustments that must be deducted from incurred claims:

(i) Prescription drug rebates received by the issuer.

(ii) Overpayment recoveries received from providers.

(2) Adjustments that must be included in incurred claims:

(i) Market stabilization payments or receipts by issuers that are directly tied to claims incurred and other claims based or census based assessments.

(ii) State subsidies based on a stop-loss payment methodology.

(iii) The amount of incentive and bonus payments made to providers.

(iv) The amount of claims payments recovered through fraud reduction efforts not to exceed the amount of fraud reduction expenses.

(3) Adjustments that must not be included in incurred claims:

(i) Amounts paid to third party vendors for secondary network savings.

(ii) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management. For example, if an issuer contracts with a behavioral health, chiropractic network, or high technology radiology vendor, or a pharmacy benefit manager, and the vendor reimburses the provider at one amount but bills the issuer a higher amount to cover its network development, utilization management costs, and profits, then the amount that exceeds the reimbursement to the provider must not be included in incurred claims.

(iii) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee. For example, medical record copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks must not be included in incurred claims.

(iv) Amounts paid to a provider for services that do not represent reimbursement for covered services provided to an enrollee and are directly covered by a student administrative health fee.

(4) Adjustments that must be either included in or deducted from incurred claims:

(i) Payment to and from unsubsidized State programs designed to address distribution of health risks across issuers via charges to low risk issuers that are distributed to high risk issuers must be included in or deducted from incurred claims, as applicable.

(ii) [Reserved]

(5) Other adjustments to incurred claims:

(i) Affiliated issuers that offer group coverage at a blended rate may choose whether to make an adjustment to each affiliate's incurred claims and activities to improve health care quality, to reflect the experience of the issuer with respect to the employer as a whole, according to an objective formula that will be defined prior to January 1, 2011, so as to result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as the ratio of incurred claims to earned premium calculated for the employer group in the aggregate. An issuer that chooses to use such an adjustment must use it for a minimum of three MLR reporting years.

(ii) [Reserved]

[75 FR 74921, Dec. 1, 2010, as amended at 75 FR 82278, Dec. 30, 2010; 77 FR 16469, Mar. 21, 2012; 77 FR 28790, May 16, 2012]

§ 158.150 Activities that improve health care quality.

(a) *General requirements.* The report required in §158.110 of this subpart must include expenditures for activities that improve health care quality, as described in this section.

(b) *Activity requirements.* Activities conducted by an issuer to improve quality must meet the following requirements:

(1) The activity must be designed to:

(i) Improve health quality.

(ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(iii) Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.

(iv) Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(2) The activity must be primarily designed to:

(i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.

(A) Examples include the direct interaction of the issuer (including those services delegated by contract for which the issuer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:

(*1*) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in section 3502 of the Affordable Care Act.

(*2*) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.

(*3*) Quality reporting and documentation of care in non-electronic format.

(*4*) Health information technology to support these activities.

(*5*) Accreditation fees directly related to quality of care activities.

(*6*) For each of the 2012 and 2013 MLR reporting years, implementing ICD–10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and

Accountability Act (HIPAA), 42 U.S.C. 1320d–2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in §158.130 of this subpart.

(B) [Reserved]

(ii) Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

(A) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;

(B) Patient-centered education and counseling.

(C) Personalized post-discharge reinforcement and counseling by an appropriate health care professional.

(D) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.

(E) Health information technology to support these activities.

(iii) Improve patient safety, reduce medical errors, and lower infection and mortality rates.

(A) Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

(*1*) The appropriate identification and use of best clinical practices to avoid harm.

(*2*) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.

(*3*) Activities to lower the risk of facility-acquired infections.

(*4*) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions.

(*5*) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.

(*6*) Health information technology to support these activities.

(B) [Reserved]

(iv) Implement, promote, and increase wellness and health activities:

(A) Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include—

(*1*) Wellness assessments;

(*2*) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

(*3*) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

(*4*) Public health education campaigns that are performed in conjunction with State or local health departments;

(*5*) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS Act;

(*6*) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(*7*) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and

(*8*) Health information technology to support these activities.

(B) [Reserved]

(v) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with §158.151 of this subpart.

(c) *Exclusions.* Expenditures and activities that must not be included in quality improving activities are:

(1) Those that are designed primarily to control or contain costs;

(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;

(3) Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;

(4) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;

(5) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD–10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d–2, as amended.

(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

(7) All retrospective and concurrent utilization review;

(8) Fraud prevention activities;

(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

(10) Provider credentialing;

(11) Marketing expenses;

(12) Costs associated with calculating and administering individual enrollee or employee incentives;

(13) That portion of prospective utilization that does not meet the definition of activities that improve health quality; and

(14) Any function or activity not expressly included in paragraph (a) or (b) of this section, unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity's costs support the definitions and purposes in this Part or otherwise support monitoring, measuring or reporting health care quality improvement.

[75 FR 74921, Dec. 1, 2010, as amended at 76 FR 76592, Dec. 7, 2011; 77 FR 28790, May 16, 2012]

§ 158.151 Expenditures related to Health Information Technology and meaningful use requirements.

(a) *General requirements.* An issuer may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities allowed in §158.150 of this subpart and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

(1) Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their “meaningful use” as defined by HHS to the extent such payments are not included in reimbursement for clinical services as defined in §158.140 of this subpart;

(2) Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments;

(3) Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

(4) Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law.

(5) Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.

(6) Advancing the ability of enrollees, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management.

(7) Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.

(8) Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

(b) [Reserved]

§ 158.160 Other non-claims costs.

(a) *General requirements.* The report required in §158.110 of this subpart must include non-claims costs described in paragraph (b) of this section and must provide an explanation of how premium revenue is used, other than to provide reimbursement for clinical services covered by the benefit plan, expenditures for activities that improve health care quality, and Federal and State taxes and licensing or regulatory fees as specified in this part.

(b) *Non-claims costs other than taxes and regulatory fees.* (1) The report required in §158.110 of this subpart must include any expenses for administrative services that do not constitute adjustments to premium revenue as provided in §158.130 of this subpart, reimbursement for clinical services to enrollees as defined in §158.140 of this subpart, or expenditures on quality improvement activities as defined in §§158.150 and 158.151 of this subpart.

(2) Expenses for administrative services include the following:

(i) Cost-containment expenses not included as an expenditure related to an activity at §158.150 of this subpart.

(ii) Loss adjustment expenses not classified as a cost containment expense.

(iii) Direct sales salaries, workforce salaries and benefits.

(iv) Agents and brokers fees and commissions.

(v) General and administrative expenses.

(vi) Community benefit expenditures.

§ 158.161 Reporting of Federal and State licensing and regulatory fees.

(a) *Licensing and regulatory fees included.* The report required in §158.110 must include statutory assessments to defray operating expenses of any State or Federal department, and examination fees in lieu of premium taxes as specified by State law.

(b) *Licensing and regulatory fees excluded.* The report required in §158.110 must include fines and penalties of regulatory authorities, and fees for examinations by any State or Federal departments other than as specified in §158.161(a) as other non-claims costs, but not as an adjustment to premium revenue."

[75 FR 82279, Dec. 30, 2010]

§ 158.162 Reporting of Federal and State taxes.

(a) *Federal taxes.* The report required in §158.110 of this subpart must separately report:

(1) Federal taxes excluded from premium under subpart B which include all Federal taxes and assessments allocated to health insurance coverage reported under section 2718 of the PHS Act.

(2) Federal taxes not excluded from premium under subpart B which include Federal income taxes on investment income and capital gains as other non-claims costs.

(b) *State taxes and assessments.* The report required in §158.110 of this subpart must separately report:

(1) State taxes and assessments excluded from premium under subpart B which include:

(i) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State.

(ii) Guaranty fund assessments.

(iii) Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(iv) Advertising required by law, regulation or ruling, except advertising associated with investments.

(v) State income, excise, and business taxes other than premium taxes.

(vi) State premium taxes plus State taxes based on policy reserves, if in lieu of premium taxes.

(vii) In lieu of reporting amounts described in paragraph (b)(1)(vi) of this section, an issuer may choose to report payment for community benefit expenditures as described in paragraph (c) of this section, limited to the highest premium tax rate in the State for which the report is being submitted.

(2) State taxes and assessments not excluded from premium under subpart B which include:

(i) State sales taxes if the issuer does not exercise options of including such taxes with the cost of goods and services purchased.

(ii) Any portion of commissions or allowances on reinsurance assumed that represent specific reimbursement of premium taxes.

(iii) Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

(c) *Community benefit expenditures.* Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes any of the following activities that:

(1) Are available broadly to the public and serve low-income consumers;

(2) Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);

(3) Address Federal, State or local public health priorities such as advancing health care knowledge through education or research that benefits the public;

(4) Leverage or enhance public health department activities such as childhood immunization efforts; and

(5) Otherwise would become the responsibility of government or another tax-exempt organization.

[75 FR 74921, Dec. 1, 2010. Redesignated and amended at 75 FR 82279, Dec. 30, 2010; 76 FR 76593, Dec. 7, 2011]

§ 158.170 Allocation of expenses.

(a) *General requirements.* Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit lines of business or products other than those being reported, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata share.

(b) *Description of the methods used to allocate expenses.* The report required in §158.110 of this subpart must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other non-claims costs, to each health insurance market in each State. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

(1) Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the issuer should provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses.

(2) Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense.

(3) Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

(c) *Disclosure of allocation methods.* The issuer must identify in the report required in §158.110 of this subpart the specific basis used to allocate expenses reported under this Part to States and, within States, to lines of business including the individual market, small group market, large group market, supplemental health insurance coverage, health insurance coverage offered to beneficiaries of public programs (such as Medicare and Medicaid), and group health plans as defined in §145.103 of this chapter and administered by the issuer.

(d) *Maintenance of records.* The issuer must maintain and make available to the Secretary upon request the data used to allocate expenses reported under this Part together with all supporting information required to determine that the methods identified and reported as required under paragraph (b) of this section were accurately implemented in preparing the report required in §158.110 of this subpart.

Subpart B—Calculating and Providing the Rebate

§ 158.210 Minimum medical loss ratio.

Subject to the provisions of §158.211 of this subpart:

(a) *Large group market.* For all policies issued in the large group market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 85 percent, as determined in accordance with this part.

(b) *Small group market.* For all policies issued in the small group market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80 percent, as determined in accordance with this part.

(c) *Individual market.* For all policies issued in the individual market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80 percent, as determined in accordance with this Part.

(d) *Adjustment by the Secretary.* If the Secretary has adjusted the percentage that issuers in the individual market in a specific State must meet, then the adjusted percentage determined by the Secretary in accordance with §158.301 of this part *et seq.* must be substituted for 80 percent in paragraph (c) of this section.

§ 158.211 Requirement in States with a higher medical loss ratio.

(a) *State option to set higher minimum loss ratio.* For coverage offered in a State whose law provides that issuers in the State must meet a higher MLR than that set forth in §158.210, the State's higher percentage must be substituted for the percentage stated in §158.210 of this subpart.

(b) *Considerations in setting a higher minimum loss ratio.* In adopting a higher minimum loss ratio than that set forth in §158.210, a State must seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

§ 158.220 Aggregation of data in calculating an issuer's medical loss ratio.

(a) *Aggregation by State and by market.* In general, an issuer's MLR must be calculated separately for the large group market, small group market and individual market within each State. However, if, pursuant to section 1312(c)(3) of the Affordable Care Act, a State requires the small group market and individual market to be merged, then the data reported separately under subpart A for the small group and individual market in that State may be merged for purposes of calculating an issuer's MLR and any rebates owing.

(b) *Years of data to include in calculating MLR.* Subject to paragraphs (c) and (d) of this section, an issuer's MLR for an MLR reporting year is calculated according to the formula in §158.221 of this subpart and aggregating the data reported under this Part for the following 3-year period:

(1) The data for the MLR reporting year whose MLR is being calculated; and

(2) The data for the two prior MLR reporting years.

(c) *Requirements for MLR reporting years 2011 and 2012.* (1) For the 2011 MLR reporting year, an issuer's MLR is calculated using the data reported under this Part for the 2011 MLR reporting year only.

(2) For the 2012 MLR reporting year—

(i) If an issuer's experience for the 2012 MLR reporting year is fully credible, as defined in §158.230 of this subpart, an issuer's MLR is calculated using the data reported under this Part for the 2012 MLR reporting year.

(ii) If an issuer's experience for the 2012 MLR reporting year is partially credible or non-credible, as defined in §158.230 of this subpart, an issuer's MLR is calculated using the data reported under this part for the 2011 MLR reporting year and the 2012 MLR reporting year.

(d) *Requirements for MLR reporting years 2013 and 2014 for the student market only.*

(1) For the 2013 MLR reporting year, an issuer's MLR is calculated using the data reported under this part for the 2013 MLR reporting year only.

(2) For the 2014 MLR reporting year—

(i) If an issuer's experience for the 2014 MLR reporting year is fully credible, as defined in §158.230 of this subpart, an issuer's MLR is calculated using the data reported under this part for the 2014 MLR reporting year.

(ii) If an issuer's experience for the 2014 MLR reporting year is partially credible or non-credible, as defined in §158.230 of this subpart, an issuer's MLR is calculated using the data reported under this part for the 2013 MLR reporting year and the 2014 MLR reporting year.

[75 FR 74921, Dec. 1, 2010, as amended at 77 FR 16469, Mar. 21, 2012]

§ 158.221 Formula for calculating an issuer's medical loss ratio.

(a) *Medical loss ratio.* (1) An issuer's MLR is the ratio of the numerator, as defined in paragraph (b) of this section, to the denominator, as defined in paragraph (c) of this section, subject to the applicable credibility adjustment, if any, as provided in §158.232 of this subpart.

(2) An issuer's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

(b) *Numerator.* The numerator of an issuer's MLR for an MLR reporting year must be the issuer's incurred claims, as defined in §158.140 of this part, plus the issuer's expenditures for activities that improve health care quality, as defined in §158.150 and §158.151 of this part, that are reported for the years specified in §158.220 of this subpart.

(1) The numerator of the MLR for the 2012 MLR reporting year may include any rebate paid under §158.240 of this subpart for the 2011 MLR reporting year if the 2012 MLR reporting year experience is not fully credible as defined in §158.230 of this subpart.

(2) The numerator of the MLR for the 2013 MLR reporting year may include any rebate paid under §158.240 for the 2011 MLR reporting year or the 2012 MLR reporting year.

(3) The numerator of the MLR for policies that are reported separately under §158.120(d)(3) of this part must be the amount specified in paragraph (b) of this section, except that for the 2012 MLR reporting year, the total of the incurred claims and expenditures for activities that improve health care quality are then multiplied by a factor of 1.75, for the 2013 MLR reporting year, the total of the incurred claims and expenditures for activities that improve health care quality are then multiplied by a factor of 1.50, and for the 2014 MLR reporting year, the total of the incurred claims and expenditures for activities that improve health care quality are then multiplied by a factor of 1.25.

(4) The numerator of the MLR for policies that are reported separately under §158.120(d)(4) of this part must be the amount specified in paragraph (b) of this section, except that the total of the incurred claims and expenditures for activities that improve health care quality are then multiplied by a factor of 2.00.

(5) The numerator of the MLR for policies that are reported separately under §158.120(d)(5) of this part must be the amount specified in paragraph (b) of this section, except that for the 2013 MLR reporting year the total of the incurred claims and expenditures for activities that improve health care quality is then multiplied by a factor of 1.15.

[75 FR 74921, Dec. 1, 2010, as amended at 77 FR 16469, Mar. 21, 2012]

(c) *Denominator.* The denominator of an issuer's MLR must equal the issuer's premium revenue, as defined in §158.130, minus the issuer's Federal and State taxes and licensing and regulatory fees, described in §§158.161(a) and 158.162(a)(1) and (b)(1) of this part.

[75 FR 74921, Dec. 1, 2010, as amended at 76 FR 76593, Dec. 7, 2011]

§ 158.230 Credibility adjustment.

(a) *General rule.* An issuer may add to the MLR calculated under §158.221(a) of this subpart the credibility adjustment specified by §158.232 of this section, if such MLR is based on partially credible experience as defined in paragraph (c)(2) of this section. An issuer may not apply the

credibility adjustment if the issuer's experience is fully credible, as defined in paragraph (c)(1) of this section, or non-credible, as defined in paragraph (c)(3) of this section.

(b) *Life-years.* The credibility of an issuer's experience is based upon the number of life-years covered by the issuer. Life-years means the total number of months of coverage for enrollees whose premiums and claims experience is included in the report to the Secretary required by §158.110 of this part, divided by 12.

(c) *Credible experience.* (1) An MLR calculated under §158.221(a) through (c) of this subpart is fully credible if it is based on the experience of 75,000 or more life-years.

(2) An MLR calculated under §158.221(a) through (c) of this subpart is partially credible if it is based on the experience of at least 1,000 life-years and fewer than 75,000 life-years.

(3) An MLR calculated under §158.221(a) through (c) of this subpart is non-credible if it is based on the experience of less than 1,000 life-years.

(d) If an issuer's MLR is non-credible, it is presumed to meet or exceed the minimum percentage required by §158.210 or §158.211 of this subpart.

§ 158.231 Life-years used to determine credible experience.

(a) The life-years used to determine the credibility of an issuer's experience are the life-years for the MLR reporting year plus the life-years for the two prior MLR reporting years.

(b) For the 2011 MLR reporting year, the life-years used to determine credibility are the life-years for the 2011 MLR reporting year only.

(c) For the 2012 MLR reporting year-

(1) If an issuer's experience for the 2012 MLR reporting year is fully credible, the life-years used to determine credibility are the life-years for the 2012 MLR reporting year only;

(2) If an issuer's experience for the 2012 MLR reporting year only is partially credible or non-credible, the life-years used to determine credibility are the life-years for the 2011 MLR reporting year plus the life-years for the 2012 MLR reporting year.

(d) For the 2013 MLR reporting year for the student market only, the life-years used to determine credibility are the life-years for the 2013 MLR reporting year only.

(e) For the 2014 MLR reporting year for the student market only—

(1) If an issuer's experience for the 2014 MLR reporting year is fully credible, the life-years used to determine credibility are the life-years for the 2014 MLR reporting year only;

(2) If an issuer's experience for the 2014 MLR reporting year only is partially credible or non-credible, the life-years used to determine credibility are the life-years for the 2013 MLR reporting year plus the life-years for the 2014 MLR reporting year.

[75 FR 74921, Dec. 1, 2010, as amended at 75 FR 82279, Dec. 30, 2010; 77 FR 16469, Mar. 21, 2012]

§ 158.232 Calculating the credibility adjustment.

(a) *Formula.* An issuer's credibility adjustment, if any, is the product of the base credibility factor, as determined under paragraph (b) of this section, multiplied by the deductible factor, as determined under paragraph (c) of this section.

(b) *Base credibility factor.* (1) The base credibility factor for fully credible experience or for non-credible experience is zero.

(2) The base credibility factor for partially credible experience is determined based on the number of life-years included in the aggregation, as determined under §158.231 of this subpart, and the factors shown in Table 1. When the number of life-years used to determine credibility exactly matches a life-year category listed in Table 1, the value associated with that number of life-years is the base credibility factor. The base credibility factor for a number of life-years between the values shown in Table 1 is determined by linear interpolation.

Table 1 to §158.232: Base Credibility Factors

Life-years	Base credibility factor
< 1,000	No Credibility.
1,000	8.3%.
2,500	5.2%.
5,000	3.7%.
10,000	2.6%.
25,000	1.6%.
50,000	1.2%.
≥ 75,000	0.0% (Full Credibility).

(c) *Deductible factor.* (1) The deductible factor is based on the average per person deductible of policies whose experience is included in the aggregation, as determined under §158.231 of this subpart. When the weighted average deductible, as determined in accordance with this section, exactly matches a deductible category listed in Table 2, the value associated with that deductible is the deductible factor. The deductible factor for an average weighted deductible between the values shown in Table 2 is determined by linear interpolation.

(i) The per person deductible for a policy that covers a subscriber and the subscriber's dependents shall be the lesser of: The sum of the deductible applicable to each of the individual family members; or the overall family deductible for the subscriber and subscriber's family, divided by two (regardless of the total number of individuals covered through the subscriber).

(ii) The average deductible for an aggregation is calculated weighted by the life-years of experience for each deductible level of policies included in the aggregation.

(2) An issuer may choose to use a deductible factor of 1.0 in lieu of calculating a deductible factor based on the average of policies included in the aggregation.

Table 2 to §158.232: Deductible Factor

Health plan deductible	Deductible factor
<$2,500	1.000
$2,500	1.164
$5,000	1.402
≥ $10,000	1.736

(d) *No credibility adjustment.* For the 2013 MLR reporting year, the credibility adjustment for an MLR based on partially credible experience is zero if both of the following conditions are met:

(1) The current MLR reporting year and each of the two previous MLR reporting years included experience of at least 1,000 life-years; and

(2) Without applying any credibility adjustment, the issuer's MLR for the current MLR reporting year and each of the two previous MLR reporting years were below the applicable MLR standard for each year as established under §158.210 in this subpart.

(e) *No credibility adjustment.* Beginning with the 2015 MLR reporting year for the student market only, the credibility adjustment for an MLR based on partially credible experience is zero if both of the following conditions are met:

(1) The current MLR reporting year and each of the two previous MLR reporting years included experience of at least 1,000 life-years; and

(2) Without applying any credibility adjustment, the issuer's MLR for the current MLR reporting year and each of the two previous MLR reporting years were below the applicable MLR standard for each year as established under §158.210 in this subpart.

[75 FR 74921, Dec. 1, 2010, as amended at 75 FR 82279, Dec. 30, 2010; 77 FR 16469, Mar. 21, 2012; 77 FR 28790, May 16, 2012]