Medical Loss Ratio (MLR)

Frequently Asked Questions

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) will distribute all eligible types of Medical Loss Ratio (MLR) rebates in the current (payout) plan year as required by the premium ratio for the previous (rebate) plan year. As in previous years, the rebate checks will be mailed during the month of September of this (payout) year for the previous (rebate) calendar year. All rebate checks will be mailed no later than September 30 of the payout year, and are determined by product, market segment and jurisdiction as explained in the general questions below.

General questions

Q: What is Medical Loss Ratio (MLR)?
A: The Affordable Care Act (ACA) – the federal healthcare reform law – requires health insurers to spend a minimum percentage of the premiums they collect every calendar year on healthcare services and certain quality improvement activities for their members. This percentage is called the Medical Loss Ratio (MLR).

Q: Does the MLR requirement apply to all plans?
A: No. The minimum MLR requirement applies only to insured (risk) health plans. The MLR rules do not apply to self-insured (non-risk or Administrative Services Only) accounts. Medicare Supplemental Plans are also excluded from MLR rebates.

Q: What is required under the minimum MLR provision?
A: MLR is calculated for an insurer's entire book of business within each of three market segments in every state the insurer does business. MLR is not calculated under the federal rules for each individual employer group, individual insurance product or subscriber. MLR is calculated for each of the following market segments:

- Large group market (groups with 51+ employees) – Generally, insurers must spend at least 85 cents of every premium dollar they receive on health services and health quality initiatives for their members.
- Small group market (groups with 50 or fewer employees) – Generally, insurers must spend at least 80 cents of every premium dollar on health services and health quality initiatives for their members.
- Individual market – Generally, insurers must spend at least 80 cents of every premium dollar on health services and health quality initiatives for their members.

Beginning in calendar year 2011, if the minimum MLR threshold is not met within a market segment for the full calendar (rebate) year, insurers must issue rebates for the difference in the following (payout) year.

Q: What timeframe is used to calculate the previous calendar (rebate) year rebates paid in September of the current (payout) year?
A: The MLR rebate for each payout year is calculated based on medical costs incurred in the previous *calendar* year, referred to as the rebate year.

Q: How are rebates calculated?
A: The U.S. Department of Health and Human Services (HHS) has issued detailed instructions to health insurers for calculating MLR rebates. In its simplest form, MLR rebates are calculated by taking the amount spent on medical claims and qualified health quality initiatives and dividing it by the premiums collected, minus certain federal and state taxes and fees. CareFirst files its calculations with all applicable regulatory agencies – HHS, the National Association of Insurance Commissioners (NAIC), and state regulatory agencies in our service area as required under the law.

Q: What is a health quality initiative?
A: Insurers may include in the MLR calculation their costs for certain quality initiatives designed to improve the health of their members. If included, these costs would increase an insurer's MLR. Examples may include case management services by a nurse or caregiver and wellness activities (such as smoking cessation classes). Insurers can also include spending to the following:

- Improve the health of members;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors;
- Modify member behavior through wellness and health promotion activities; or
- Develop healthcare data used to improve quality, transparency and outcome—such as incentive payments to providers in support of health improvement activities.

Q: When will rebates be paid?
A: All rebates must be issued to eligible subscribers or employer groups by September 30 of the payout year, following the eligible rebate calendar year.

Q: Will all insurers pay rebates?
A: No. Some insurers owe rebates in one or more market segments, while others may not. CareFirst will pay rebates for any market segment(s) and product line(s) for which the MLR did not meet the minimum threshold.

Q: Why did some insurers not meet the minimum MLR threshold?
A: Insurers typically file proposed premiums with state regulators as much as 15 months before new prices take effect. These proposed premiums are based on historical estimates of medical spending trends and are projected forward to cover the expected cost of future claims costs. In short, it's an inexact science, which makes it extremely difficult to set prices at exactly the level needed to avoid paying rebates.

Q: Why would insurers seek to increase premiums if they paid rebates?
A: Premium increases are driven primarily by the underlying costs of providing medical care, which includes increases in both the prices of medical services—hospital stays, doctor visits, prescription drugs, etc.—and how much those services are utilized. In setting future premiums, insurers attempt to price their products to cover the actual costs and the estimated costs of future medical claims, reflecting the unique circumstances of their particular marketplace and enrollment profiles. Avoiding the need to pay rebates is just one element in the complex task of setting future premiums.

Q: How will eligible employer groups and subscribers receive their rebates?
A: As required under the law, CareFirst will mail any rebates to groups and individual subscribers, along with a letter that includes additional information about MLR.

⇨ To ensure proper delivery, please be sure all contact information and addresses are up to date.

Q: How large is the typical rebate?
A: There is no "typical" rebate size since amounts can vary by product, state, and market segment.

Q: How will groups and subscribers know if they will receive a rebate?
A: All eligible employer groups and subscribers will be notified or receive a rebate by September 30 of the payout year for the previous calendar (rebate) year. Eligible individual plan subscribers will receive rebate checks directly. Rebates for subscribers who are part of small or large group accounts will receive notification that a rebate will be paid to their employer (with certain exceptions).

Q: Can groups and members get more than one notice/rebate if they had more than one product or if the group changed plans during the rebate year?
A: The law requires that all groups and members qualifying for a rebate receive a letter for each product/legal entity/jurisdiction, notifying them they will receive a rebate. A group may have different products with different legal entities and therefore could receive a rebate for one product and not for another. Groups and members could also receive multiple notices/rebate checks for different reasons, including if a group changed jurisdictions in the rebate year (e.g., a group's physical address changed from DC to VA), a midyear renewal switched the products for a group's plan, or other similar situations.

Q: Do I need to do anything to receive my rebate?
A: If you are eligible to receive a rebate, no action is required. Eligible subscribers with individual plans will receive rebate checks directly. In most cases, for group accounts, rebate checks will be sent to the employer. Under the law, the rebates are to be used for the benefit of the health plan's subscribers (i.e., covered employees).

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Q: Can rebate-eligible individuals and employer groups that dropped their CareFirst plan still receive rebates for the time in the rebate year they were covered by CareFirst?
A: Yes. Both employer groups and individual plan subscribers who terminated their CareFirst coverage can receive rebates for that portion of the rebate year that was used for calculating MLR. You do not have to be a current member to receive a rebate in the payout year.

Q: What are the tax implications for receiving a rebate?
A: Eligible MLR rebate recipients should consult with a tax adviser or attorney as to whether there are any tax implications in receiving a rebate. *CareFirst is not in the position to offer tax guidance.*

Q: Do COBRA subscribers receive a rebate?
A: The COBRA premium is paid to CareFirst by the group, not directly by the subscribers. Therefore, rebates are paid directly to the group. Rebate notices are mailed to COBRA subscribers in the groups. The group should provide the benefits of the rebate to COBRA subscribers in the same manner in which they provide benefits to their employees.

Q: Why are two signatures needed to endorse the rebate check?
A: Two signatures are not required to endorse the check. The recipient of the check is the only name needed to endorse the check. The message on the top of the check "The face of this check has a burgundy and blue background on white paper and requires two (2) signatures" refers to the two signatures of the CareFirst executives printed on the bottom right of the check front.

Q: Why wasn't my rebate larger?
A: The amount of the rebate can differ depending on the specific product, geographic location, and CareFirst affiliate (CFMI, GHMSI, and CareFirst BlueChoice) applicable to your account. Rebates are also proportional to the premiums you paid on a particular health plan in the rebate year.

Q: What happens if I changed CareFirst health plans during the rebate year?
A: Your rebate can vary depending on how much of the year you were covered by a rebate-eligible plan. If you changed CareFirst plans during the rebate year and both products triggered rebates, you should receive separate checks that are prorated for the number of months that you were covered under each plan.

Q: My neighbor/friend/co-worker received a rebate. Why didn't I receive a rebate?
A: Whether a rebate is paid, and the amount of the rebate, will differ depending on the health plan, the state in which the plan was issued and the CareFirst affiliate that administered the plan. If you know other CareFirst members who received rebates, they may have been covered under a different CareFirst health plan or affiliate.

Q: Can I appeal the rebate amount I received?
A: No. Since your rebate is calculated using specific criteria required under the law and federal regulation, ACA does not offer an appeals process. The amounts used in calculating rebates (premiums, fees, etc.) are filed with and subject to review by federal and state regulators.

Q: What happens if my check is lost in the mail?
A: If you believe that you are eligible for a rebate and did not receive a rebate check in the mail, you should call the Member Services telephone number on the back of your member ID card to confirm that your correct address is on file. You should follow the normal process for reporting to your employer or broker any address changes or corrections.

Q: Since I received a rebate this year, am I likely to receive a rebate again next year?
A: MLR rebates are calculated based on actual medical costs incurred, money spent on quality initiatives, premiums charged, taxes and other fees paid—all of which change from year to year. Receiving a rebate last year will not increase your chances for future rebates.

Q: Does receiving a rebate mean that CareFirst will reduce my future premiums?
A: CareFirst seeks to price products at a level that's sufficient to cover the costs to administer and pay our members' healthcare claims, with a tiny margin that goes into reserves for the future protection and benefit of members. Going forward, CareFirst will continue to seek to ensure that premiums track closely to actual and anticipated medical spending trends.

Q: Does the fact that rebates were paid mean that insurers overcharged their members?
A: No. Premiums are typically set far in advance of when they take effect. In setting prices, insurers project the expected cost of medical claims based on the then-current cost trends, which do not perfectly predict future results.

Q: Do subscribers over 65 get a rebate?
A: Individuals over age 65 who are enrolled in a Medicare Supplemental plan/product were not included in the MLR calculations because there are different federal reporting requirements. Subscribers with those products are not eligible for MLR rebates.
Please note: *Subscribers over age 65 who are covered under an employer group should benefit from any rebates paid to those employer groups, as noted below.*

Rebates for groups

Q: Are employer groups required to provide employment data annually?
A: Yes. At renewal each year, insurers will collect an employer's employee counts for the prior calendar year. These group size counts are needed to determine the proper market segment classification of the employer needed for determining whether rebates are due under the MLR requirement.

Q: What should employers do with the rebates they receive?
A: Employers or administrators of a group health plan, including plans offered by non-governmental employers subject to the Employee Retirement Income Security Act of 1974 (ERISA), may have fiduciary responsibilities regarding use of the MLR rebates. Some or all of an MLR rebate may be an asset of the plan, which must be used for the benefit of employees covered by the policy.

As a general summary, for group health plans that are employer plans governed by ERISA or that are state or local governmental plans, an employer must distribute the rebate in one of two ways:

- Reduce premium for the upcoming year; or
- Provide a cash rebate to employees or subscribers.

CareFirst, however, cannot provide legal advice regarding an employer's obligations. Groups should consult with their legal or benefit advisors considering their specific circumstances. Employers also may consult the Department of Labor's guidance for group health plans subject to ERISA in Technical Release 2011-04, available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act, the guidance for state or local governmental plans at 45 C.F.R. § 158.242, or for general information, the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272).

Plans that are part of the Federal Employees Health Benefits Program are not subject to ERISA. These plans are subject to the Federal Employees Health Benefits Act and are administered by the United States Office of Personnel Management (OPM). OPM has indicated that it will use the rebate to adjust premiums for the upcoming year.

Q: How will the group know which employees are included in the rebate?
A: Under the law, the rebate(s) should be used for the benefit of the health plan's subscribers (i.e., covered employees). The rebate check(s) will be sent directly to the employer. With the check is

included a list or array of subscribers deemed eligible, and they will receive notification correspondence of the rebate during the rebate year. This array includes a disclaimer explaining the requirement for the group to distribute the rebate to proper subscribers according to their records and to not rely on the list provided.

Q: Will subscribers of employer groups that are no longer in business still qualify for rebates?
A: Yes. If CareFirst is unable to provide a rebate payment to a former group, rebate checks will be sent to any subscriber who was active or enrolled in the group for the period covered by the rebate.

Q: Why does my letter list a state other than the one in which I live?
A: For group accounts, rebates are calculated and paid to an employer based on the state in which the contract was issued. Thus, the state identified in the notice that you receive may differ from the state in which you live.

Church/religious groups and written assurance

Q: What is meant by "written assurance?"
A: Certain employer groups not governed by the Employee Retirement Income Security Act of 1974 (ERISA)—churches and other tax-exempt religious organizations (church/religious groups or plans)—must provide a signed statement, or written assurance, that any rebate they receive will be used for the benefit of their subscribers.

Q: What is the federal regulation for MLR rebates regarding church/religious groups?
A: A group health plan that is (1) not a governmental plan and (2) not governed by ERISA, such as a church or religious plan, should only receive a rebate if the plan provided CareFirst with *written assurance* that the plan would utilize any MLR rebates in the same manner as an ERISA plan or non-federal governmental plan. If so, the plan should comply with that written assurance. If a church/religious plan does not provide such written assurance, CareFirst must distribute any applicable rebate to the group's members in accordance with federal regulations.

Rebates paid during this payout year for the previous calendar (rebate) year are based on the information that was provided in the payout year or prior. If your church/religious group provided the form we requested in the past, then it will be used for the current rebate payout, if one is due. The church/religious group will also receive a report showing the list of subscribers that received the rebate directly from CareFirst.

Q: What happens if a church/religious group provides written assurance?
A: If a church/religious group provides written assurance that any rebate it receives will be used for the benefit of its subscribers, the rebate will be paid directly to the group, rather than to the members in the group. Such groups must use the rebate to reduce future premiums for subscribers or pay their subscribers directly.

Q: What happens if a church/religious group does not provide written assurance?
A: For those groups that did not provide written assurance this year or prior, CareFirst will send rebates directly to subscribers who were active during the MLR reporting period.

Student Health Plan (SHP)

Q: What is Student Health Plan (SHP)?
A: A SHP is a type of individual health insurance coverage that is provided to students enrolled in an institution of higher education and their dependents that meets the following conditions:

- There is a written agreement between the issuer (legal entity) and the institution of higher education.
- The agreement does not make health insurance coverage available other than in connection with enrollment as a student (or as a dependent of a student) in the institution of higher education.
- Eligibility for the health insurance coverage is not conditioned on any health status-related factor relating to a student (or a dependent of a student).
- The coverage meets any additional requirement that may be imposed under Federal or State law.

Note: For the full text of the definition, refer to the Student Health Plan regulation under Federal law 45 CFR 147.145 and applicable State laws.

Q: Why is the SHP called out separately in the FAQs?
A: The SHP first became eligible for rebates in the 2018 (rebate) plan year. Due to the specific nature of the SHP and the newness of MLR rebate guidelines for the plan, it was determined to be important for the idiosyncrasies of the rebate for this plan type to be called out separately. See further details above.

Q: Why did my roommate receive a check, but I have not?
A: There could be several reasons you have not received a check:

- You did not participate in the SHP in the previous health plan (rebate) year.
- You moved or changed your school mailing address since the previous health plan (rebate) year.
- Your mail is sent to your home address or an address different than your school mailing address.
  ⇨ To ensure proper delivery, please be sure all contact information and addresses are up to date
- You were not enrolled in the same SHP at the same school for the same time period. If none of the above are true, please contact the phone number on your member ID card.

Updated 08/01/2024