# 2018 Medical Loss Ratio (MLR) – What You Need to Know

## What is Medical Loss Ratio (MLR)?

Both Massachusetts (MA) and Federal law (Affordable Care Act) require that health insurance companies spend a minimum percentage of premium dollars on medical claims, including clinical services and activities designed to improve health care quality. The MLR standard applies to health insurance plans offering group or individual coverage. It does not apply to self-insured plans.

## What defines the Small and Large Group market?

For 2018, the MLR measure for Small Group is 1 to 50 total employees. Large Group is 51 or more total employees.

## What was the required Medical Loss Ratio for 2018?

- Individual and Small Group Market – 88% (in MA), 80% (in Rhode Island (RI) or Federal standard)
- Large Group Market – 85% (Federal)

## What were the 2018 Medical Loss Ratio results for Tufts Health Plan?

**Tufts Associated Health Maintenance Organization, Inc. (TAHMO):**

- Individual and Small Group Market – 85.6% (in MA)*, 99.7% (in RI)
- Large Group Market – 86.4% (in MA), 95.4% (in RI)

**Tufts Insurance Company (TICO):**

- Individual and Small Group Market – 87.0% (in MA)**, 89.5% (in RI)
- Large Group Market – 86.6% (in MA), 93.1% (in RI)

## How does MLR impact my company?

If your company had coverage in a market segment where Tufts Health Plan did not meet the MLR requirement, then Tufts Health Plan will issue a rebate check or premium credit. You'll be responsible for handling and/or distributing the money back to your eligible employees.

## When will the rebates go out?

Massachusetts state and/or Federal MLR rebates and notification letters will be sent to employer groups, postmarked by August 30, 2019.

## How do I distribute rebates to employees?

If your group health plan is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA), you may have fiduciary responsibilities regarding use of the Medical Loss Ratio rebates. Some or the entire rebate may be an asset of the plan, which must be used for the benefit of the employees covered by the policy. 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), reference the FAQ at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/medical-loss-ratio

It will be the employer's responsibility to distribute the rebate to their employees according to the Department of Labor Rebate Regulations.

*Based on Federal calculation. In MA, State and Federal calculations differ for the Individual and Small Group Market.

** TICO MA's book of business in small group is not fully credible in terms of membership, so there can be fluctuations in MLR from year to year. This is the first year that Tufts Health Plan has dropped below this MLR threshold, and as a result MA small group employers will receive a rebate from Tufts Insurance Company.

For more information, contact your sales office:

Watertown 800-208-8013 | Worcester 800-208-9545
Providence 800-455-2012

tuftshealthplan.com

COM-20100057-201908

## Receiving a rebate of such a small dollar amount is an administrative burden for me. Can you just not issue the rebate next time?

Tufts Health Plan must comply with the MLR regulations as part of health care reform. This means issuing rebates that meet the criteria, regardless of the amount.

## What are the tax implications?

Rebates may have a tax impact both to plans receiving rebates and to consumers. Please consult your tax advisor for information on how a rebate will impact you, or contact the IRS at 800.829.1040.

## Are employers who are not receiving a rebate getting notified?

No, only employers who will be receiving an MLR rebate for 2018 will be notified.

## Will subscribers be notified if their employers are receiving a rebate?

Yes. The notice we send to enrolled subscribers whose employers are receiving a Massachusetts state and/or Federal rebate will be postmarked no later than August 30, 2019.

## What is considered an activity that improves health care quality?

Activities that improve health care quality, increase the likelihood of desired health outcomes, and are grounded in evidence-based medicine are to be included in medical costs for the medical loss ratio calculation.

Quality Improvement programs are designed to achieve the following goals:

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

Examples of quality improvement activities include the following case and disease management and care coordination services:

- Arranging and managing transitions;
- Medication and care compliance;
- Programs to support shared decision-making with patients, their families, and the patient's representatives;
- Use of medical homes (as defined in the Affordable Care Act);
- Nurse-line (with some exceptions);
- Comprehensive discharge planning;
- Prospective medical and drug utilization review;
- Certain wellness and health promotion activities (e.g., coaching and incentives);
- Fraud and abuse programs (the lesser of expenses and recoveries);
- Certain limited health technology (HIT) expenses.

Quality improvement activities must be designed to improve the quality of care received by an enrollee and be able to be objectively measured for producing verifiable results and achievements.

## What activities are not considered quality improvement activities in the MLR calculation?

Activities designed primarily to control or contain costs are not to be reported as quality improvement. When calculating medical costs, the following items are not considered part of medical costs, and thus are administrative costs:

- Cost containment expenses that do not otherwise meet quality improvement criteria set forth above, which may include:
  - Retrospective and concurrent utilization review
  - Most fraud prevention activities (beyond those that recover incurred claims);
  - Provider network contracting and management costs;
  - Provider credentialing;
  - Costs associated with calculating and administering enrollee/employee incentives.
- Clinical data collection without data analysis;
- Claims adjudication expenses;
- Marketing expenses;
- Broker commissions