

§ 158.110

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.

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.* (1) Except as provided in paragraph (b)(2) of this section, 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.

(2) An issuer that reports its experience separately under § 158.120(d)(3) or (4) of this subpart must submit a report for each quarter of the 2011 MLR reporting year, on the same form and in the same manner as described in paragraph (b)(1) of this section, as follows:

(i) By May 1 for the quarter ending March 31;

(ii) By August 1 for the quarter ending June 30; and

(iii) By November 1 for the quarter ending September 30.

(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.

45 CFR Subtitle A (10–1–11 Edition)

§ 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, 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, the experience of the issuer must be included in the State report for the State where the employer or the association has its principal place of business.

(3) For the 2011 MLR reporting year, 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) For the 2011 MLR reporting year, an issuer with group policies that provide coverage for employees working outside their country of citizenship, employees working outside of their country of citizenship and outside the employer's country of domicile, and non-U.S. citizens working in their home country, must aggregate the experience from these policies but report the experience from such policies separately from other policies.

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

§ 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 paid or received, excluding any rebate paid based upon an issuer's MLR.

(4) Account for unearned premium.

§ 158.140 Reimbursement for clinical services provided to enrollees.

(a) *General requirements.* The report required in § 158.110 of this subpart 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 claim portion of lawsuits, and any experience rating refunds paid or received. Reimbursement for clinical services as defined in this section are referred to as "incurred claims."

(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,