

§ 158.102

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 in-

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clude 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 §144.103 of this subchapter.

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 §144.103 of this subchapter.

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; 81 FR 12352, Mar. 8, 2016]

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. Reporting requirements of this part that apply to expenses incurred directly by the issuer also apply to expenses for functions outsourced to or services provided by other entities retained by the issuer.

(b) *Timing and form of report.* The report for each of the 2011, 2012, and 2013 MLR reporting years 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. Beginning with the 2014 MLR reporting year, the report for each MLR reporting year must be submitted to the Secretary by July 31 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; 78 FR 15539, Mar. 11, 2013; 85 FR 29262, May 14, 2020]

§ 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