Centers for Medicare & Medicaid Services (CMS)
Medical Loss Ratio (MLR) Annual Reporting Form
Filing Instructions for the 2023 MLR Reporting Year

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Instructions for the 2023 MLR Reporting Year

These are the filing instructions for the report to the Secretary required by section 2718 of the Public Health Service Act (PHSA), which includes elements that make up the medical loss ratio (MLR) and the calculation and provision of rebates to enrollees. The data included in the MLR Annual Reporting Form (MLR Form) are the exact data that will be used to calculate an issuer's MLR and rebates, if any, under section 2718 of the PHSA and the implementing regulation, codified at 45 CFR Part 158.

The MLR implementing regulations can be found at:
http://www.cms.gov/cciio/resources/regulations-and-guidance#Medical-Loss-Ratio.

These MLR Form Filing Instructions only apply to the 2023 MLR reporting year and its reporting requirements. These Filing Instructions will be revised to reflect changes that apply to the filing years subsequent to 2023. Filing requires a one-time registration by the issuer through the secured CMS Enterprise Portal for the Health Insurance Oversight System (HIOS) to submit its report to the Secretary. If an issuer registered for a previous MLR reporting year, it does not need to reregister, but will need to confirm or update its issuer associations. The CMS Enterprise Portal can be accessed at https://portal.cms.gov/portal.

For information regarding HIOS, including user roles, company/issuer associations, downloading and submitting MLR Form templates, and attestation, please refer to the HIOS User Manual, which will be posted on the CCIIO MLR Training webpage, https://www.cms.gov/cciio/Resources/Training-Resources/index.html#Medical_Loss_Ratio.

References are made in these instructions to the National Association of Insurance Commissioners (NAIC) Statements of Statutory Accounting Principles (SSAP) and Supplemental Health Care Exhibit (SHCE) (as filed by many issuers with the NAIC) in effect for the MLR reporting year. These references are solely for the convenience of the filer in identifying the information needed for this MLR Form.

These Filing Instructions are to be used in completing the MLR Form by all health insurance issuers (issuers) offering health insurance coverage subject to section 2718 of the PHSA and the MLR implementing regulations. All terms used in these Filing Instructions that are not defined here have the meaning used in 45 CFR Part 158 and the PHSA.

The term "**health insurance coverage**" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. The definition includes any insurance product, such as drug, chiropractic, or mental health coverage, whether sold as a stand-alone product or in conjunction with any other health insurance coverage, unless specifically identified as "excepted benefits" by the PHSA.

An MLR Form must be prepared and submitted for each State in which the issuer has written direct health insurance coverage or has direct amounts paid, incurred, or unpaid for the provision of health care services. In addition, the issuer must submit a Grand Total (GT) template containing the grand total of its business in all States. **(Note: The experience of expatriate and student health plans is aggregated on a national basis and should be reported only on the GT template.)** Parts 1 and 2, both the 12/31 and 3/31 columns, must be completed for each State in which the issuer provides any health insurance coverage subject to MLR requirements, even if a particular State will show $0 earned premium in Part 1.

Except for the GT template, Parts 3 through 5 must be completed for any State in which there are non-zero amounts in Part 1. Part 3 through 5 of the GT template should only be completed for Student Health Plans. Part 6 should be completed in the GT template only. However, while an issuer is not required to submit State templates for those States where the issuer has no business subject to MLR, the GT template should include the issuer's entire nationwide business for Columns 40-43. Note that this may cause Columns 40-43 on the GT template to show higher amounts than the sum of the corresponding amounts on the State templates.

If you have any questions about the Form Instructions or uploading the MLR Forms into HIOS, please refer to the below contact information for assistance:

MLR Contact Information

Email:

MLR policy matters and MLR Form and Instructions: MLRQuestions@cms.hhs.gov.
HIOS technical matters: CMS_FEPS@cms.hhs.gov.

Telephone:

HIOS technical matters: 855-267-1515 (Marketplace Service Desk)

Changes to the 2023 MLR Annual Reporting Form

The MLR Form has been updated to incorporate provisions in 45 CFR Part 158 that are effective for the 2023 MLR reporting year. Below are the most significant changes.

Merged markets: Added Maine.

General Instructions

Company Information Tab

The information in the Company Information tab of the MLR Form is pre-populated. If any of the information needs to be changed, please refer to the Company/Issuer Associations tab in HIOS (see section 5 of the HIOS User Manual).

Recommended Order for Completing the MLR Form

Part 2	→	Part 1	→	Part 3	→	Parts 4-6
Premium and Claims		Summary of Data		MLR and Rebate Calculation		Rebate Disbursement Additional Responses Expense Allocation

The information populated into Part 2 of the MLR Form is used to populate certain cells in Part 1, and information in Parts 1 and 2 is used for certain calculations in Parts 3 and 4. Therefore, it is suggested that Part 2 be completed first, followed by Part 1, Part 3, and then Parts 4-6. (Note: Part 6 is only completed in the GT template.)

General Submission Process

Submission of the MLR templates should be completed in the following order:

1) Upload the zip file that includes all required MLR templates.
2) Wait for the automated email from HIOS confirming that the MLR upload was successful.
3) Complete attestation only after you successfully upload MLR templates.

General Requirements for Reporting Certain Types of Business

Reinsurance

Experience under a 100% assumption reinsurance agreement (with a novation) must be reported by the assuming issuer as direct business, for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer.

Reporting of 100% indemnity reinsurance and administrative agreements is limited to those agreements both entered into and effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business. Experience under those indemnity reinsurance and administrative agreements must be reported by the assuming issuer as direct business, and must not be reported by the ceding issuer.

If a reinsurance arrangement does not meet the exact criteria specified in the two preceding paragraphs, the experience under that reinsurance arrangement must be reported on a direct basis by the ceding issuer and not by the assuming issuer. The reinsurance premium and claims amounts must also be reported by the ceding and assuming issuers on Part 1, Lines 1.4 and 2.5, in the 12/31 column for the relevant market.

Closed Blocks of Business

All health insurance issuers offering health insurance coverage subject to Section 2718 of the PHSA must submit an MLR report. CMS will use its enforcement discretion and will not initiate an enforcement action against an issuer of group or individual health insurance coverage who fails to submit a full MLR report if the issuer's only health insurance coverage consists of grandfathered or transitional (grandmothered) plans in closed blocks of business. To qualify, the issuer must provide and the issuer's CFO and CEO must attest to the following information regarding the applicable MLR reporting year:

1. The issuer has ceased offering health insurance coverage, as defined by §2791(b)(1) of the PHSA, in the small group, large group, and individual health insurance markets in every State in which it is licensed to offer health insurance coverage;
2. The issuer has only grandfathered health plans (as defined in 45 CFR §147.140(a)) or transitional health plans (as described in the Nov. 14, 2013 CMS letter to State Insurance Commissioners and related technical guidance[1]) in closed blocks of business that are in run-off;
3. The issuer did not submit a Supplemental Health Care Exhibit (SHCE) or other similar State filing for business during the applicable MLR reporting year, has been exempted from filing a SHCE or similar State filing by the State in which it is domiciled, and submits to CMS evidence of this exemption on State letterhead. If the issuer is not subject to a SHCE or similar State filing requirement, this criterion is not applicable;
4. The issuer has less than 1,000 life-years nationwide (combined for all health insurance coverage) for the MLR reporting year; and
5. The issuer has non-credible experience in each State market in which it provides coverage. The issuer must report the number of life-years in each State market for each MLR reporting year that is aggregated to determine whether the issuer has non-credible experience.

Like all issuers that are subject to the MLR reporting requirements, a company that meets all of the criteria described above must register with the MLR module of HIOS, and complete, update, or confirm the "company issuer association" form in HIOS. A company that meets all of the above criteria may select "yes" in the "small closed blocks of business" box on the HIOS company issuer association confirmation. When a company that selects "yes" in the "small closed blocks of business" box downloads the MLR reporting form from HIOS, it may complete only Part 3, Line 3.1 of the MLR reporting form for every State and market in which it has health insurance coverage. The company should use HIOS' "upload supplemental material" function to submit an attestation statement that affirms the criteria described above. The company should also upload any State Supplemental Health Care Exhibit (or other similar State required filing) exemption it has received from its State of domicile. The company should then complete the HIOS process.

Issuers satisfying the above criteria may instead choose to complete the full MLR form for their grandfathered or transitional plans in closed blocks of business. The option described in this closed block of business policy is intended to reduce MLR reporting burden.

If CMS determines that an issuer does not satisfy the criteria described above, CMS will notify the issuer that it must complete the full MLR reporting form as specified in 45 CFR Part 158.

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[1] *See* Extended Non-Enforcement of Affordable Care Act-Compliance With Respect to Certain Policies, issued March 23, 2022, available at https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2023-and-later-benefit-years.pdf.

Deferred Business

If, for any aggregation as defined in 45 CFR §158.121, 50% or more of the total earned premium for an MLR reporting year is attributable to policies newly issued in that MLR reporting year, then the experience of these policies may be deferred, at the option of the issuer. For the purposes of this provision, policies are *not* considered to be "newly issued" if issued to previously enrolled policyholders as a result of enrollment changes (e.g., adding dependents or new employees), or as a result of price or plan changes such as modifications to cost-sharing or provider networks, or policies were transferred from one issuer to another as a result of a merger or split of the company or transferred between affiliated issuers. If an issuer defers the reporting of newer business as provided in this paragraph, then the experience of such policies must be excluded from the MLR calculation for the MLR reporting year in which the experience occurred and must be added to the experience reported in the following MLR reporting year (i.e., treated as if the experience occurred in the following MLR reporting year for the next three years).

Allocation of Expenses

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 the two (or more) types of expenses. Expenditures that benefit more than one affiliate must be allocated, on a pro rata basis, between the affiliates that benefit from these expenditures. Expenditures that benefit all lines of business or products, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata basis.

Aggregation of Experience

An issuer's experience, aggregated by individual, small group, and large group markets, with respect to each policy must be included on the report submitted with respect to the State where the policy was issued, except as specified below.

Group Coverage in Multiple States:

Group coverage issued by a single issuer to an employer that covers employees in multiple States must be reported for the State where the contract is sitused. Situs of the contract is the jurisdiction in which the contract is issued or delivered, as stated in the contract.

Dual-Contract Group Health Coverage:

If an issuer has a group health plan which provides only in-network coverage and an affiliate issuer provides only out-of-network coverage solely for the purpose of providing a group health plan that offers both in-network and out-of-network benefits, the issuer *may choose* to treat the out-of-network experience of the affiliate that provides the out-of-network coverage as if it were related to the contract providing the in-network coverage. If an issuer chooses this method of aggregation, it must do so for a minimum of three consecutive reporting years and the affiliate that provides the out-of-network coverage must not report this experience. After an issuer applies this method for the initial three consecutive reporting years, the issuer may either continue to apply this method for any number of additional consecutive reporting years, or may choose to discontinue applying this method.

Individual Business through an Association:

For individual business sold through an association, the issuer shall include the experience in the State report for the issue State of the certificate of coverage.

Employer Business through Group Trust, Association, or MEWA:
For non-association health plan (AHP) employer-sponsored health insurance coverage issued through a group trust, the issuer shall include the experience in the State report for the State where the employer has its principal place of business. For employer-sponsored health insurance coverage issued through a multiple employer welfare association (MEWA) that is not an AHP, the issuer shall include the experience in the State report for the State where the MEWA has its principal place of business (if the MEWA is the policyholder). For employer-sponsored health insurance coverage issued through an AHP, where the AHP does not meet the requirements to be capable of establishing a group health that is an employee welfare benefit plan, consistent with 29 C.F.R. § 2510.3-5 or with other applicable guidance, experience with respect to each employer shall be reported as large group or small group based on the size of each employer and be reported in each State based upon the aggregation rules for employer based insurance. For employer-sponsored health insurance coverage issued through an AHP where the AHP meets the requirements to be capable of establishing a group health plan that is an employee welfare benefit plan, consistent with 29 C.F.R. § 2510.3-5 or with other applicable guidance, experience should be reported in the State report for the State where the policy is sitused and in the segment of the group market that corresponds with the size of the AHP.

Definition of Small Group and Large Group:
The large group and small group markets are defined as those where health insurance coverage is obtained by a large or small employer, respectively. Large employer and small employer are defined by the number of employees employed; a small employer has 1 to 50 employees, but if a State elects to use "100" employees as the upper limit for a small employer, then "100" must be substituted for "50" employees.

- For the purposes of the MLR program, a sole proprietor or a sole proprietor's spouse is not considered a group of one. An employer's number of employees is determined by averaging the total number of all employees employed on business days during the preceding calendar year. This includes each full-time, part-time, and seasonal employee. Alternatively, an issuer may choose to determine an employer's number of employees using the applicable State counting method, unless the State method does not take into account non-full-time employees, in which case the issuer must use the full-time equivalent method described in section 4980H(c)(2) of the Internal Revenue Code if electing this reporting option.

Non-Affiliate Business:
An issuer must report on this MLR Form only the business issued by the reporting entity. Business that is written by an unaffiliated entity as part of a package provided to the enrollee (e.g., inpatient coverage written by the reporting entity, outpatient coverage written by an unaffiliated separate entity) ***must not*** be included in this MLR Form.

Merged Markets:
Issuers of health insurance coverage in the individual and small group markets that merge their markets in accordance with state law (such as in Massachusetts, Maine, and the District of Columbia) should report all experience separately for the individual and small group markets, and combine it only in MLR numerator, denominator, and credibility fields (Part 3, Lines 1.9, 2.3, 3.1, 3.3, and 5.6).

Column Definitions for MLR Annual Reporting Form – Parts 1 and 2

Health insurance coverage, Columns 1 through 15, includes policies that provide medical coverage, including office visits, hospital, surgical, and major medical (illness and injury). Include risk contracts and the Federal Employees Health Benefit Plan (FEHBP). Exclude from Columns 1–15 mini-med plans, since they are reported separately in Columns 16–24 of each State MLR Form, and exclude expatriate plans and student health plans reported in Columns 25–39 on the GT template.

Do not include in Columns 1–39 business specifically included in Columns 40–43 (e.g., uninsured or self-funded business, Medicare (Title XVIII, including Medicare Advantage), Medicaid (Title XIX), vision only, dental only, State Children's Health Insurance Program (SCHIP) (Title XXI), other Federal or State government-sponsored coverage (other than the Federal Employees Health Benefits Program or non-Federal governmental plans, such as State or local government sponsored coverage for its employees), and short-term, limited duration insurance as further defined in the PHSA). The experience for pharmacy, chiropractic, or mental health coverage, whether sold as a stand-alone product or in conjunction with any other health insurance coverage, should be reported with the health insurance coverage for the applicable market if the coverage does not meet the definition of "excepted benefits" under the PHSA.

The experience of stop loss or excess of loss coverage for self-funded groups should be reported in Parts 1 and 2, Column 41 – Other Health Business Plans (business excluded by statute). Column 41 includes information reported in Column 11 of the SHCE.

For any data element that is not separately reported in the financial statement filings to the issuer's regulatory authority, an issuer does not need to separately report that element in the 12/31 column of the MLR Form. However, an issuer must separately report that data element in the 3/31 column as required by 45 CFR Part 158 and as instructed in the MLR Form instructions. For example, an issuer may not need to report the amount of contingent benefit and lawsuit reserves in Part 2, Line 2.13 in the 12/31 column, but must report such amounts in the 3/31 column. An issuer must still report, in the detail provided by the MLR Form, the amounts for premiums and unearned premium reserves, taxes and fees, claims and claims-related reserves, quality improving activities, and non-claims costs, in both the 12/31 and the 3/31 columns, to the extent the issuer reports such amounts to the issuer's regulatory authority.

Columns 1, 6, 11, 16, 19, 22, 25, 30, 35, 40, 41, 42, 43 – **Business as of 12/31 of the MLR reporting year**

Financial information reported for the 12/31 columns should generally equal the exact amounts that were reported directly to the State regulatory authority of the issuer, including amounts that may have been amended in the SHCE the issuer submitted to the NAIC prior to filing the MLR Form.

Include: Experience of policies in each of the relevant markets for the MLR reporting year, as reported as of December 31, to the regulatory authority in the issuer's State of domicile or as filed on the NAIC SHCE filing for the MLR reporting year regardless of incurred date.

Columns 2, 7, 12, 17, 20, 23, 36 – **Business as of 3/31 of subsequent MLR reporting year**

Financial information reported in the 3/31 columns should equal the amount of each element related specifically to experience in the MLR reporting year and paid through March 31 of the subsequent reporting year (incurred in 12, paid or received in 15), plus any provision for items properly allocable to the MLR reporting year but not yet paid as of 3/31 of the following year, except as otherwise noted in line instructions. For example, these columns could include differences from the 12/31 columns in the upper limit for a small group and the lower limit for a large group, if State group size regulations differ from Federal group size regulations. (See the Definitions of Small Group and Large Group, in the General Instructions above.) These columns could also include differences from the 12/31 columns in the accounting for the Federal risk adjustment amounts. If the issuer elects to treat the out-of-network experience of an affiliate that provides the out-of-network coverage as if it were related to the contract providing the in-network coverage, the issuer must include such out-of-network experience in the 3/31 columns, as well as separately report it in the Dual Contract columns (see the column definition below).

Include: Experience of policies in each market, incurred, paid or received relevant only to coverage provided during the MLR reporting year, reported as of March 31 of the subsequent MLR reporting year.

Columns 3, 8, 13, 18, 21, 24, 37 – **Dual Contract**

If an issuer chooses to treat the out-of-network experience of an affiliate that provides the out-of-network coverage as if it were related to the contract providing the in-network coverage, the issuer must report the out-of-network experience in the 3/31 columns, as well as the Dual Contract column.

Include: Experience reported in columns 2, 7, 12, 17, 20, 23, and 36 that is attributable to dual contracts. Note that these amounts are a *subset* of what is reported as of 3/31.

Columns 4, 9, 14, 38 – **Deferred Newer Business from prior MLR reporting year**

Include: Experience from policies for the relevant market newly issued in the 2022 MLR reporting year (PY1), previously deferred, as provided in the General Instructions. Data elements constituting adjusted incurred claims for business deferred from the preceding MLR reporting year should be restated as of 3/31 of the year following the MLR reporting year.

Columns 5, 10, 15, 39 – **Deferred Newer Business for the MLR reporting year**

Include: Policies for the relevant market newly issued in the 2023 MLR reporting year, as defined more specifically in the General Instructions, deferred for reporting purposes at the issuer's option.

Columns 1–5 **Individual Market**

Include: Health insurance where the policy is issued to an individual covering the individual and his or her dependents in the individual market.

Columns 6–10 **Small Group Market**

Include: All policies issued in the small group market (including fully insured State and local government policies).

Columns 11–15 **Large Group Market**

Include: All policies issued in the large group market (including the Federal Employees Health Benefit Program and fully insured State and local government policies).

Columns 16–24 **Mini-Med Plans**

Include: All policies that have a total annual limit of $250,000 or less for individual, small group, and large group markets, in their respective columns.

Columns 25–34 **Expatriate Plans** (GT Template only. 12/31 column only)

Include: All group policies written in the United States that provide coverage for employees 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. These policies are to be reported on a nationwide, aggregated basis, separately for the small group and the large group markets, as of 12/31 on the GT template only.

Columns 35–39 **Student Health Plans** (GT template only)

Include: All health insurance policies issued to students and their dependents pursuant to a written agreement between the issuer and the institution of higher education, as defined by 45 CFR §147.145.

Exclude: Policies reported in other columns. Also exclude 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.

Column 40 **Government Program Plans (Not Subject to Section 2718 of the PHSA)**

Include: Government sponsored programs that are not subject to section 2718 of the PHSA, such as Medicaid (Title XIX), State Children's Health Insurance Program (SCHIP) (Title XXI), the Basic Health Program (established under section 1331 of the PHSA), and other Federal or State government-sponsored coverage (other than the Federal Employees Health Benefits Program or non-Federal governmental plans, such as State or local government sponsored coverage for its employees).

Report the experience of the issuer's government program plans for the MLR reporting year as of December 31, as reported to the regulatory authority in the issuer's State of domicile or as filed on the NAIC SHCE filing for the MLR reporting year.

Exclude: Medicare Advantage Part C and Medicare Part D stand-alone plans subject to the Medicare MLR requirements pursuant to section 1857(e) of the Social Security Act, reported in Column 42

Column 41 **Other Health Business (Not Subject to Section 2718 of the PHSA)**

Information reported here is similar to that reported in the SHCE Part 1, Columns 9 and 10. Report health plan arrangements that are not group *or* individual health insurance coverage provided by a health insurance issuer. Report all other health care business that is not reported in Columns 1–39, including stand-alone dental and vision coverage, long-term care, disability income, etc.

Include: Short-term, limited-duration insurance (as defined under 45 CFR §144.103); supplemental coverage if offered as a separate policy, certificate, or contract of insurance (45 CFR §146.145), including Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided under a group health plan; hospital or other fixed indemnity insurance, and specified disease or illness coverage if offered under a separate policy, certificate, or contract of insurance (45 CFR §146.145), and other "excepted benefits" as specified by regulations promulgated by HHS (45 CFR §146.145). The experience for pharmacy, chiropractic, or mental health coverage, whether sold as a stand-alone product or in conjunction with any other health insurance coverage, should be reported with the health insurance coverage for the applicable market if the coverage does not meet the definition of "excepted benefits" under the PHSA.

Report the experience of the issuer's Other Business for the MLR reporting year as of December 31, as reported to the regulatory authority in the issuer's State of domicile or as filed on the NAIC SHCE filing for the MLR reporting year.

Column 42 **Medicare MLR Business**

Include: Medicare Advantage Part C and Medicare Part D plans subject to the Medicare MLR requirements pursuant to section 1857(e) of the Social Security Act.

Column 43 **Uninsured (Self-Funded) Plans**

Include: Plans for which a reporting entity, as an administrator, performs administrative services such as claims processing for an employer that is at risk, and accordingly, the administrator has not issued an insurance policy.

Report the experience of the issuer's Uninsured (Self-Funded) Plans for the MLR reporting year as of December 31, as reported to the regulatory authority in the issuer's State of domicile or as filed on the NAIC SHCE filing for the MLR reporting year.

Instructions for MLR Annual Reporting Form – Part 1
(Summary of Data)

These MLR Form Filing Instructions apply to the 2023 MLR reporting year and its reporting requirements. These Filing Instructions may be revised to reflect changes that apply to the filing years subsequent to 2023.

<u>In addition to the instructions below, the General Instructions and Column Definitions at the beginning of these Filing Instructions apply to Part 1</u>. The General Instructions and Column Definitions include instructions regarding reporting of reinsurance, deferred business, individual business through an association, employer business through a group trust or MEWA, group coverage in multiple States, and dual contract group health coverage.

Please note that the MLR Form and Filing Instructions implement the requirements of 45 CFR Part 158 and are not identical to the definitions or instructions of the NAIC's SHCE.

<u>Section 1 – Premium</u>

Line 1.1 – Total direct premium earned

> Part 2, Lines 1.1 + 1.2 – 1.3 – 1.7 + 1.8 + 1.9 + 1.10

Line 1.2 – Federal high risk pools

> Enter subsidies received or (assessments paid) under Federal high risk pools.

Line 1.3 – State high risk pools

> Enter subsidies received or (assessments paid) under State high risk pools.
>
> Exclude: Amounts included in Line 2.4.

Line 1.4 – Net assumed less ceded reinsurance premiums earned

> The amount to net against the assumed reinsurance premiums earned is: the ceded reinsurance premiums written; plus the change in unearned premium reserve that is transferred to the company assuming the risk; plus the change in reserve credit taken other than for unearned premiums.

Line 1.5 – Other adjustments due to MLR calculations – premiums

> Include: Any amounts excluded from premium for MLR calculation purposes that are normally included in premiums for financial statement purposes.
>
> Amounts for rate credits paid and the change in reserve for rate credits that were excluded from Line 1.1 Total Direct Premiums Earned.

Line 1.6 – Risk revenue

Include: Amounts charged by the reporting entity as a provider or intermediary for specified medical services (e.g., full professional, dental, radiology, etc.) provided to the policyholders or members of another issuer or reporting entity.

Unlike premiums that are collected from an employer group or individual member, risk revenue is the prepaid (usually on a capitated basis) payment, made by another insurer or reporting entity to the reporting issuer in exchange for services to be provided or offered by such organization.

<u>Section 2 – Claims</u>

Line 2.1 – Total incurred claims

Part 2, Line 2.17.

Line 2.2 – Prescription drugs (informational only; already included in total incurred claims above)

Include: Expenses for prescription drugs and other pharmacy benefits covered by the reporting entity.

Exclude: Prescription drug charges that are included in a hospital billing which should be classified as Hospital/Medical Benefits.

Line 2.3 – Pharmaceutical rebates (informational only; already excluded from total incurred claims above)

Line 2.4 – State stop loss, market stabilization, and claim/census based assessments (informational only; already excluded from total incurred claims above)

Adjustments that must be included in incurred claims:

- Market stabilization payments or receipts by issuers that are directly tied to claims incurred and other claims-based or census-based assessments
- State subsidies based on a stop-loss payment methodology

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

- 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

Line 2.5 – Net assumed less ceded claims incurred (exclude amounts already reported in Line 2.1)

Assumed reinsurance claims paid; plus the change in the assumed reinsurance claims liability and aggregate assumed reinsurance claims reserve; less the ceded reinsurance claims paid; plus the change in the ceded reinsurance claims liability and aggregate ceded reinsurance claims reserve; less the change in claims related reinsurance recoverable.

Line 2.6 – Other adjustments due to MLR calculation – claims incurred

Any amounts excluded from claims for MLR calculation purposes that are normally included in claims for financial statement purposes. For example, premium deficiency reserves are excluded from contract reserves for MLR purposes in Part 2; thus, premium deficiency reserves would be included on this Line. Include the adjustment for multi-option coverage amounts (report as a negative amount if offsetting Part 2, Line 2.15).

Line 2.7 – Rebates paid

MLR rebates paid during the MLR reporting year.

Line 2.8 – Estimated rebates unpaid at the end of the previous MLR reporting year

Amount should equal Line 2.9 from the previous MLR reporting form.

Line 2.9 – Estimated rebates unpaid at the end of the MLR reporting year

MLR rebates estimated but unpaid as of the end of the MLR reporting year.

Line 2.10 – Fee-for-service and co-pay revenue (net of expenses)

Include: Revenue recognized by the issuer for collection of co-payments from members and revenue derived from health services rendered by reporting entity providers that are not included in member policies (generally only applicable to staff-model HMOs).

Deduct: Medical expenses associated with fee-for-service business.

Line 2.11 – Allowable claims recovered through fraud reduction efforts Part 2, Line 2.18.

Section 3 – Federal and State Taxes and Licensing or Regulatory Fees

PLEASE NOTE: Any amounts for ACA fees collected in advance of the MLR reporting year in which the fee is payable may not be reported in Section 3. In most cases, the pre-tax underwriting gain/(loss) – which should reflect all relevant revenue and expenses, including cost-sharing reduction amounts, premium stabilization program amounts, and administrative expense amounts – is the most appropriate basis for allocating income taxes; consequently, a loss is expected to yield a negative income tax allocation.

Line 3.1 – Federal taxes and assessments incurred by the reporting issuer during the MLR reporting year

3.1a – Federal income taxes deductible from premiums in MLR calculations

Include: Federal income taxes attributed to the MLR reporting year allocated to the respective lines of business reported.

Exclude: Federal income taxes on investment income and capital gains.

3.1b – Patient Centered Outcomes Research Institute (PCORI) Fee

This fee is imposed on an issuer of a specified health insurance policy and a plan sponsor of an applicable self-insured health plan.

Include: PCORI fees attributed to applicable policies during the MLR reporting year.

3.1c – Reserved

3.1d – Other Federal taxes and assessments deductible from premium

Include: Federal taxes and assessments (other than taxes and assessments that must be reported on Lines 3.1a-b and 3.3a-b) allocated to the respective lines of business.

Exclude:

- Risk adjustment and Marketplace user fees. Report these fees on Line 3.3b.
- Fines, penalties, and fees for examinations by any Federal departments.
- Federal employment taxes (such as the Federal Insurance Contributions Act (FICA), the Railroad Retirement Tax Act (RRTA), and the Federal Unemployment Act (FUTA) taxes). Report these taxes on Line 5.5c.

Line 3.2 – State insurance, premium, and other taxes incurred by the reporting issuer during the MLR reporting year (deductible from premium in MLR calculation)

3.2a – State income, excise, business, and other taxes, allocated to the respective lines of business reported, that may be excluded from earned premium under 45 CFR §158.162(b) (1)

Include:

- 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, or market stabilization redistributions, or cost transfers for the purpose of rate subsidies, not directly tied to claims, and that are authorized by State law
- Contributions to State Reinsurance Programs, whether in form of fees, assessments, or ceded premium.
- Guaranty fund assessments. Note: if such assessments will be offset in future years through reductions in state taxes or through premium surcharges, as permitted by the state, the issuer may defer reporting such guaranty fund assessments until the year(s) of offset.
- 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
- Advertising required by law, regulation or ruling, except advertising associated with investments
- State income, excise, and business taxes other than premium taxes

Exclude:

- Risk adjustment and Marketplace user fees. Report these fees on Line 3.3b.
- Fines, penalties, and fees for examinations by any State departments.

- State employment taxes and assessments (such as State unemployment / reemployment insurance, employment training, and other similar taxes and assessments). Report these taxes on Line 5.5c.

3.2b – State premium taxes

Include: State premium taxes or State taxes based on policy reserves if in lieu of premium taxes related to the respective lines of business.

3.2c – Community benefit expenditures deductible from premium in MLR calculations

<u>Federal tax exempt issuers:</u> May report a value for 3.2b *and* 3.2c. DO NOT enter community benefit expenditures in excess of the allowable capped amount. Community benefit expenditures are limited to the highest of either:

1. Three percent of earned premium; or
2. The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market.

<u>Non-Federal tax exempt issuers</u>: May report a value for 3.2b *or* 3.2c, but not both. Issuers *may not* report zero ($0) community benefit expenditures in lieu of negative State premium taxes. DO NOT enter community benefit expenditures in excess of the allowable capped amount. Community benefit expenditures are limited to:

- The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market.

If an issuer uses the highest premium tax rate in the State, the issuer must report the applicable highest State health premium tax rate in Part 6, Line 1.

Note: Issuers must indicate their Federal tax exempt status in the Company Information tab. **Community benefit expenditures are 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 activities that:

- Are available broadly to the public and serve low-income consumers;
- Reduce geographic, financial or cultural barriers to accessing health services, and if ceased to exist would result in access problems (e.g., longer wait times or increased travel distances);
- Address Federal, State or local public health priorities, such as advancing health care knowledge through education or research that benefits the public;
- Leverage or enhance public health department activities, such as childhood immunization efforts; or
- Otherwise would become the responsibility of government or another tax-exempt organization.

Line 3.3 – Regulatory authority licenses and fees

3.3a – Federal Transitional Reinsurance Program Contributions

Include: Federal reinsurance contributions required under Section 1341 of the Affordable Care Act owed for the MLR reporting year. Report the entire contribution amount, including contribution amounts allocable to the reinsurance payment pool and program administrative expense, and to the General Fund of the U.S. Treasury.

3.3b – Other Federal and State regulatory authority licenses and fees incurred by the reporting issuer during the MLR reporting year

Include:

- Statutory assessments to defray operating expenses of any State or Federal regulatory authority, including user fees paid to State-based, State Partnership, or Federally-facilitated Marketplace, risk adjustment user fees, and examination fees in lieu of premium taxes as specified by State law.
- Amounts paid out to a third party administrator or incurred by or for the issuer in contraceptive claims costs under the accommodations for self-insured group health plans of eligible organizations, plus the associated allowance for administrative cost and margin allowed under 45 CFR 156.50(d)(3)(ii), plus the net Federally Facilitated Exchange user fee paid to HHS.

Exclude: Fines, penalties, and fees for examinations by any State or Federal regulatory authority other than as specifically included in Line 3.3.

Section 4 – Health Care Quality Improvement Expenses Incurred

Expenses for Quality Improvement (QI) activities are expenditures directly related to activities conducted by issuers that are designed to:

- Improve health quality;
- Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;
- 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; and
- 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.

QI activities must be primarily designed to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations;
- Prevent hospital readmissions through a comprehensive program for hospital discharge;
- Improve patient safety, reduce medical errors, and lower infection and mortality rates;
- Implement, promote, and increase wellness and health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with 45 CFR §158.151.

Expenditures and activities that must not be included in quality improving activities are:

- Those that are designed primarily to control or contain costs

- 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
- 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
- Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services
- 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
- That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality
- All retrospective and concurrent utilization review
- Fraud prevention activities
- 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
- Provider credentialing
- Marketing expenses
- Costs associated with calculating and administering individual enrollee or employee incentives
- That portion of prospective utilization that does not meet the definition of activities that improve health quality
- Indirect expenses, such as office space (including rent or depreciation, facility maintenance, janitorial, utilities, property taxes, insurance, art); computer and telephone usage and equipment; human resources; compensation of counsel and executives; travel, meals, and entertainment; company parties and retreats; IT software, systems, mainframes, and other infrastructure, unless primarily or exclusively supporting QIA; marketing; lobbying; pricing and financial reporting; vendor profits; other overhead
- Any function or activity not expressly included in Lines 4.1 through 4.5, 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

Expenses which otherwise meet the definition for QI activities but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI activities expenses.

Notes:

a. *Healthcare Professional Hotlines*: Expenses for healthcare professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Prevent Hospital Readmissions, Improve Patient Safety, Reduce Medical Errors, and Lower Infection and Mortality Rates, and Implement, Promote, and Increase Wellness and Health Activities.

b. *Prospective Utilization Review*: Expenses for prospective Utilization Review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Prevent Hospital Readmissions, Improve Patient Safety, Reduce Medical Errors, and Lower Infection and Mortality Rates, and Implement, Promote, and Increase Wellness and Health Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

Line 4.1 – Improve Health Outcomes

Include expenses directly related to the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers, and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions, or other means of communication) to improve health outcomes.

This category can include direct costs for associated activities such as:

- Effective case management, care coordination, and chronic disease management, including through the use of the medical homes model as defined in section 3606 of the Affordable Care Act
- Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in Lines 4.1 through 4.5
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine
- Quality reporting and documentation of care in non-electronic format

Line 4.2 – Activities to Prevent Hospital Readmission

Include expenses directly related to implementing activities to prevent hospital readmissions.

This category can include direct costs for associated activities such as:

- Comprehensive discharge planning (e.g., 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
- Personalized post discharge counseling by an appropriate health care professional
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission

Line 4.3 – Improve patient safety and reduce medical errors

Include expenses directly related to activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates.

This category can include direct costs for associated activities such as:

- The appropriate identification and use of best clinical practices to avoid harm
- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns
- Activities to lower risk of facility acquired infections
- Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions

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

Line 4.4 – Wellness and health promotion activities

Include expenses directly related to activities primarily designed to implement, promote, and increase wellness and health activities.

This category can include direct costs for associated activities such as:
- Wellness assessment
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition
- Public health education campaigns that are performed in conjunction with state or local health departments
- Actual rewards/incentives/bonuses/reductions in co-pays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI activities for the group market to the extent permitted by section 2705 of the PHSA
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity)

Line 4.5 – Health information technology (HIT) expenses related to improving health care quality

Report information technology expenses associated with the activities in Lines 4.1 through 4.4 for which expenses are reported. (45 CFR §158.151 allows "Health Information Technology" expenses that are required to accomplish the activities allowed in 45 CFR §158.150.)

Include HIT expenses required to accomplish the activities reported in Lines 4.1 through 4.4 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 activities that are 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 45 CFR §158.140;
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 (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law);
5. 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 – this 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;
6. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
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; or
8. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

Exclude costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. §1320d-2, as amended, including all expenditures related to ICD-10).

Line 4.6 – Total allowable quality improvement expenses

Part 1, Lines 4.1 + 4.2 + 4.3 + 4.4 + 4.5

<u>Section 5 – Non-Claims Costs</u>

Line 5.1 – Cost containment expenses not included in quality improvement expenses

Include: Expenses that serve to actually reduce the number of health services provided or the cost of such services.

This category can include costs only if they result in reduced costs or services such as:

- Post- and concurrent- claim case management activities associated with past or ongoing care
- Pre-service utilization review
- Detection and prevention of payment for fraudulent requests for reimbursement (including amounts reported in Part 2, Line 2.17a)
- Expenses for internal and external appeals
- Network access fees to preferred provider organizations and other network-based health plans (including prescription drug networks) and allocated internal salaries and related costs associated with network development and/or provider contracting

Exclude: Cost-containment expenses that improve the quality of health care reported in Part 1, Section 4.

Line 5.2 – All other claims adjustment expenses

Include any expenses for administrative services that do not constitute adjustments to premium revenue, reimbursement for clinical services to enrollees or expenditures on quality improvement activities or cost containment expenses.

This category can include such costs as:

- Estimating the amount of losses and disbursing loss payments
- Maintaining records, general clerical and secretarial costs
- Office maintenance, occupancy costs, utilities, and computer maintenance
- Supervisory and executive duties
- Supplies and postage
- Interest or other payments made in accordance with prompt payment laws or regulations to claimants. (Interest or penalties paid to regulatory authorities are reported as regulatory fines and fees.)

Line 5.3 – Direct sales salaries and benefits

Include compensation (including but not limited to salary and benefits) to employees engaged in soliciting and generating sales to policyholders for the issuer.

Line 5.4 – Agents and brokers fees and commissions

All expenses incurred by the issuer payable to a licensed agent, broker, or producer who is not an employee of the issuer in relation to the sale and solicitation of policies for the company.

Line 5.5 – Other taxes

5.5a – Taxes and assessments not excluded from premium. (Do not include amounts reported in Section 3 or Lines 5.5c or 9.)

Include:

- Taxes and assessments not deducted from Premium in Section 3
- State sales taxes if the issuer does not exercise the option of including such taxes with the cost of goods sold and services purchased
- Any portion of commissions or allowances on reinsurance assumed that represent specific reimbursement of premium taxes
- Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes

5.5b – Fines and penalties of regulatory authorities, and fees for examinations by any State or Federal departments other than those included in Line 3.3b, above. Interest, penalty, or other payments made in accordance with prompt payment laws or regulations to regulatory authorities.

5.5c – Federal and State employment taxes and assessments

Include: Federal and State employment taxes and assessments (such as the Federal Insurance Contributions Act (FICA), the Railroad Retirement Tax Act (RRTA), and the Federal Unemployment Act (FUTA) taxes; State unemployment / reemployment insurance and State employment training taxes; and other similar taxes and assessments)

Line 5.6 – Other general and administrative expenses

Include: General and Administrative Expenses not previously reported in Sections 3, 4, or 5 above.

These expenses include such examples as:

- Salaries
- Outsource services
- EDP equipment, other equipment
- Accreditation and certification fees
- Reimbursement by uninsured plans and fiscal intermediaries
- ICD-10 costs
- Community benefit expenditures – report only the amount in excess of what is already reported in Part 1, Line 3.2c
- Other additional expenses not included in another category such as rent, legal fees and expenses, medical examination expenses, inspection reports, professional consulting fees, travel, advertising, postage, utilities, etc.
- Services provided by affiliates under management agreements
- Rating agencies and other similar organizations
- Prescription drug rebates and other price concessions received by an entity providing pharmacy benefit management services (including drug price negotiation services) to the issuer to the extent the amounts are associated with administering the issuer's prescription drug benefits).

Exclude: Any elements already reported on Lines 5.1, 5.2, 5.3, 5.4, and 5.5

Line 5.7 – Total community benefit expenditures (informational only; include amounts reported in Lines 3.2c and 5.6)

<u>Section/Line 6 – Income from fees on uninsured plans</u>

<u>Section 7 – Other indicators or information</u>

Line 7.1 – Number of policies/certificates

In the individual market, this is the number of individual policies, not counting dependents, in force as of the last day of the reporting year.

In the group markets, this is the number of certificates issued to individuals covered under a group policy in force as of the last day of the reporting year (e.g. number of employees, NOT counting dependents). It is NOT the number of group policyholders (e.g. employers).

Reasonable approximations are allowed when exact information is not available to the issuer for group business.

Line 7.2 – Number of covered lives

This is the total number of lives insured, including dependents, under individual policies and under group certificates as of the last day of the reporting year. Reasonable approximations are allowed when exact information is not available to the issuer.

Line 7.3 – Number of groups

Applicable to the group markets *only*. This is the total number of employer groups insured as of the last day of the reporting year. This is NOT the number of certificates, employees, covered lives, or life-years.

Line 7.4 – Member months

The total number of lives, including dependents, insured on a pre-specified day of each month of the reporting period. Reasonable approximations are allowed when exact information is not available to the issuer.

Line 7.5 – Number of life-years

Part 1, Line 7.4 / 12

<u>Section 8 – Net investment income and other gain/ (loss)</u>

Enter the Grand Total as of 12/31 for ALL markets in Columns 1–43 of each State filing.

<u>Section 9 – Other Federal income taxes</u>

Enter the Grand Total as of 12/31 for ALL markets in Columns 1–43 of each State filing.

Include: Federal income taxes on investment income and capital gains.
Exclude: Taxes entered on Part 1, Lines 3.1a-d.

Instructions for MLR Annual Reporting Form – Part 2 (Premium and Claims)

These MLR Form Filing Instructions apply to the 2023 MLR reporting year and its reporting requirements. These Filing Instructions may be revised to reflect changes that apply to the filing years subsequent to 2023.

<u>In addition to the instructions below, the General Instructions and Column Definitions at the beginning of these Filing Instructions apply to Part 2</u>. The General Instructions and Column Definitions include instructions regarding reporting of reinsurance, deferred business, individual business through an association, employer business through a group trust or MEWA, group coverage in multiple States, and dual contract group health coverage.

Please note that the MLR Form and Filing Instructions implement the requirements of 45 CFR Part 158 and are not identical to the definitions or instructions of the NAIC's SHCE.

<u>Section 1 – Health Premiums Earned</u>

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 and reported on a direct basis. Include advance payments of the premium tax credit. Any amounts for ACA fees collected in advance of the MLR reporting year in which the fee is payable must not be reported as unearned premium.

Line 1.1 – Direct premium written

12/31 Column – report amount as of 12/31 of the MLR reporting year, as reported to the regulatory authority in the issuer's State of domicile or as filed on the NAIC SHCE filing for the MLR reporting year.

3/31 Column (premium for coverage in MLR reporting year only) – report premium collected from 1/01 of the MLR reporting year through 3/31 of the year following the MLR reporting year for coverage in the MLR reporting year only, plus uncollected (due and unpaid) premium for coverage in the MLR reporting year only as of 3/31 of the year following the MLR reporting year. Premium should reflect retroactive eligibility adjustments related to coverage in the MLR reporting year.

PLEASE NOTE: This methodology differs from NAIC SHCE methodology. However, issuers may choose to report amounts on the same basis as in the 12/31 columns, except that risk adjustment amounts must not be reflected in the 3/31 columns.

Premium should include all amounts collected toward ACA fees, regardless of whether the fees were included in premium or billed as a separate line item.

Include:

- Premium assumed under a 100% assumption reinsurance agreement (with a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer
- Premium assumed under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into and also effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business

Exclude:

- Premium ceded under a 100% assumption reinsurance agreement (with a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer
- Premium ceded under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into and also effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business
- Assessments paid to or subsidies received from State high risk pools
- Amounts for rate credits paid or received (these amounts must be reported separately on Part 2, Lines 1.4-1.6 and 2.8-2.10)
- In the 3/31 columns, exclude risk adjustment transfer amounts and accruals

Line 1.2 – Unearned premium (year preceding the MLR reporting year)

12/31 Column – report reserves established to account for the portion of the premium paid prior to the MLR reporting year that was intended to provide coverage during the MLR reporting year. Report reserves as of 12/31 of the year preceding the MLR reporting year, as reported to the regulatory authority in the issuer's State of domicile or as filed on the NAIC SHCE filing for the year preceding the MLR reporting year.

3/31 Column (premium for coverage in the MLR reporting year only) – report premium for coverage in the MLR reporting year only, collected in the immediately preceding MLR reporting year. Report amounts as of 12/31 of the year preceding the MLR reporting year.

PLEASE NOTE: This methodology differs from NAIC SHCE methodology. However, if the issuer chose to report direct written premium in Line 1.1 on the same basis as in the 12/31 column, the issuer should report unearned premium reserves consistently with how it reports direct written premium. Do not include any risk adjustment transfer amounts or accruals.

Line 1.3 – Unearned premium (MLR reporting year)

12/31 Column – report reserves established to account for the portion of the premium paid in the MLR reporting year that was intended to provide coverage during the following MLR reporting year. Report reserves as of 12/31 of the MLR reporting year, as reported to the regulatory authority in the issuer's State of domicile or as filed on the NAIC SHCE filing for the MLR reporting year.

3/31 Column – report zero (note that if collected and due and unpaid premium is reported correctly in Line 1.1 above, Line 1.1 should not include amounts that would constitute unearned premium for coverage in years subsequent to the MLR reporting year).

PLEASE NOTE: This methodology differs from the NAIC SHCE methodology. However, if the issuer chose to report direct written premium in Line 1.1 on the same basis as in the 12/31 column, the issuer should report unearned premium reserves consistently with how it reports direct written premium. Do not include any risk adjustment transfer amounts or accruals.

Line 1.4 – Experience rating refunds (rate credits) paid or received

1.4a – 12/31 Column – report all refunds paid or received through 12/31 of the MLR reporting year.

1.4b – 3/31 Column – report refunds associated only with claims incurred during the MLR reporting year, paid or received through 3/31 of the following year.

Include: Experience rating refunds and State premium refunds paid or received during the MLR reporting year. Experience rating refund is the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention, and margin are less than earned premium.

Exclude: Federal and State MLR rebates, and risk corridors payments or charges.

Line 1.5 – Reserves for experience rating refunds (MLR reporting year)

12/31 Column – all refunds unpaid as of 12/31 of the MLR reporting year.

3/31 Column –refunds associated only with claims incurred during the MLR reporting year, not paid or received through 3/31 of the following year.

Include: Reserves for experience rating refunds, plus reserves for State premium refunds.

Exclude: Reserves for Federal and State MLR rebates, premium stabilization reserves, and risk corridors reserves or accruals.

Deduct: Amounts receivable under retrospectively rated funding arrangements.

Line 1.6 – Reserves for experience rating refunds (year preceding the MLR reporting year)

12/31 Column – as of 12/31 of the year preceding the MLR reporting year.

See instructions for Line 1.5.

Line 1.7 – Premium write-offs

Include:

- Agents’ or premium balances determined to be uncollectible and written off as losses

- Recoveries made during the MLR reporting year on balances previously written off
- Include actual write-offs

Exclude:
- Reserves for bad debt or statutory non-admitted amounts

Line 1.8 – Group conversion charges

If the amount entered on Line 1.1 has been reduced or increased by the amount of any conversion charges associated with group conversion privileges between Group and Individual lines of business in your annual statement accounting, enter the reverse of these charges on this line in the appropriate columns.

- If an issuer transfers portions of earned premium associated with group conversion privileges between group and individual lines of business in its Annual Statement, these amounts must be added to or subtracted from incurred claims. (See Part 2, Section 2 – Claims.)
- If an issuer has only group lines of business and no other individual market experience, the issuer may choose to report the experience of the group conversion policies in the columns for the applicable group market, rather than the individual market columns, and leave this line blank.

Line 1.9 – Federal Transitional Reinsurance Program Payments

Include adjustments to amounts for prior benefit years, if not previously reported on an MLR Form for a prior MLR reporting year.

Line 1.10 – Federal Risk Adjustment Program Net Receipts or Charges

3/31 Column –

Include:
- Expected net payments from HHS (enter as a positive amount) or charges payable to HHS (enter as a negative amount), as shown on the notification received from HHS by June 30 of the year following the MLR reporting year (unless instructed otherwise by HHS)
- Risk adjustment default charges or default charge allocation amounts, if any
- Amounts related to the high-cost risk pools, if any (the HCRP charge amounts can be obtained from the HRPICR report in the EDGE Management Console in HIOS)
- Adjustments to amounts for prior benefit years, if not previously reflected on an MLR Form for a prior MLR reporting year, except as noted below (unless instructed otherwise by HHS)
- HHS-Risk Adjustment Data Validation (HHS-RADV) adjustments and default data validation charges and allocations for the benefit year(s) specified in the table below.

Do not include any estimates of the 2023 benefit year HHS-RADV adjustments or 2023 benefit year default *data validation* charges and allocations.

The following table explains which benefit years of risk adjustment and HHS-RADV adjustments should be reported in which MLR reporting years for the 2020-2025 reporting years:

MLR Reporting Year	RA Benefit Year to Include	RADV Benefit Year(s) to Include
2020 (Filed in 2021)	2020	None
2021 (Filed in 2022)	2021	2017
2022 (Filed in 2023)	2022	2018, 2019, 2020,[2] 2021
2023 (Filed in 2024)	2023	2022
2024 (Filed in 2025)	2024	2023
2025 (Filed in 2026)	2025	2024

Line 1.11 – Reserved

Line 1.12 – Premium ceded under 100% reinsurance (informational only; excluded from Lines 1.1 – 1.11)

Include:

- Premium ceded under a 100% assumption reinsurance agreement (with a novation)
- Premium ceded under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into and also effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business

Line 1.13 – Premium assumed under 100% reinsurance agreement (informational only; included in Lines 1.1 – 1.11)

Include:

- Premium assumed under a 100% assumption reinsurance agreement (with a novation)
- Premium assumed under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into and also effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business

Line 1.14 – Advance Payments of the Premium Tax Credit Received from HHS (informational only; included in Lines 1.1-1.11)

Include: Amount of advance premium tax credit received from HHS for the applicable benefit year (MLR reporting year).

<u>Section 2 – Claims</u>

Amounts reported in Section 2 must include direct claims paid to or received by physicians and other non-physician clinical providers, including under capitation contracts with those providers, whose services are covered by the policy for clinical services or supplies covered by the policy. Non-physician clinical providers must be licensed, accredited, or certified to perform clinical health services, consistent with State law, and engaged in the delivery of medical services to enrollees.

Reimbursement for clinical services to enrollees is also referred to as incurred claims.

When a pharmacy benefit manager (PBM) pays a retail pharmacy one amount for prescription drugs

[2] *See* the Delaying Release of 2020 Benefit Year HHS Risk Adjustment Data Validation Results memo released on June 21, 2022 at https://www.cms.gov/files/document/2020-hhs-radv-delaying-results.pdf.

covered by the plan and charges the issuer a higher amount (sometimes called the spread), the issuer may only include in its incurred claims the amounts paid by the PBM to the retail pharmacy, and may not include the entire amount the issuer paid to the PBM.

PLEASE NOTE: The relationship between the claim liability reported in the 3/31 Column and the paid claims reported in Line 2.1b should, on average, be consistent with the actual claims run-out following the three immediately preceding reporting years. While issuers may appropriately estimate the components of the incurred claims, such as liabilities, conservatively for State financial reporting purposes, claims liabilities, reserves, and other components for MLR purposes should be the most accurate estimate of actual payments, and therefore should not be consistently overestimated, including due to the use of conservative margins for adverse deviation.

Line 2.1 – Claims paid

2.1a – 12/31 Column – claims paid during the MLR reporting year regardless of incurred date.

2.1b – 3/31 Column – claims incurred only during the MLR reporting year, paid from 1/01 of the MLR reporting year through 3/31 of the following year. Do not reduce paid claims by the amount of reinsurance receipts. State reinsurance receipts are reported on Line 2.16 and subtracted from incurred claims in Line 2.17, below. Federal reinsurance receipts are subtracted from incurred claims in Part 3.

PLEASE NOTE: This methodology differs from the NAIC SHCE methodology used in the 12/31 Column.

Include:

- Report payments net of risk share amount collected or paid
- Any overpayment that has not yet been recovered should be included in paid claims and included in health care receivables
- Market stabilization payments by issuers that are directly tied to claims incurred and other claims based or census based assessments
- Claims assumed under a 100% assumption reinsurance agreement (with a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer
- Claims assumed under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into an effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business
- Payment to 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 incurred claims
- Payment by a group health insurance issuer for contraceptive services for participants and beneficiaries of its insured health plans under the accommodations for eligible organizations
- In the 3/31 columns, include all payments by a QHP issuer to enrollees in all plan variations, and do not reduce these payments by the amount of cost-sharing reductions (CSR) received by the issuer for the applicable benefit year (MLR reporting year). CSRs are subtracted from incurred claims in Part 3.

Exclude:

- Claims ceded under a 100% assumption reinsurance agreement (with a novation) must be reported by the assuming issuer for the entire MLR reporting year during which the policies are assumed and must not be reported by the ceding issuer
- Claims ceded under a 100% indemnity reinsurance and administrative agreement, limited to only those agreements both entered into an effective prior to March 23, 2010, where the assuming entity is responsible for 100% of the ceding entity's financial risk and takes on all of the administration of the block of business
- Amounts paid to third party vendors, including PBMs, for secondary network savings
- Amounts paid to third party vendors, including PBMs, for network development, administrative fees and profit, claims processing, and concurrent or post-service utilization management or any other issuer function
- 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
- Incentive and bonus payments made to providers (to be reported in Line 2.11)
- Late claims payment interest or penalty; report these amounts in Part 1, Lines 5.2 and 5.5b, as appropriate

Deduct:

- State subsidies based on a stop-loss payment methodology, other than receipts from State reinsurance programs reported on Line 2.16
- Any overpayment that has already been received from providers should not be reported as a paid claim
- Prescription drug rebates and other price concessions that decrease the costs of a prescription drug covered by the issuer, including rebates, refunds, incentive payments, bonuses, discounts, charge backs, free goods contingent on a purchase agreement, free or reduced-price services, coupons, grants, upfront payments, goods in kinds, or similar benefits, to the extent the value of these items is not passed on to the enrollee, and excluding bona fide service fees. This includes amounts received by the issuer, as well as amounts received by an entity providing pharmacy benefit management services (including drug price negotiation services) to the issuer to the extent the amounts are associated with administering the issuer's prescription drug benefits.
- Market stabilization receipts by issuers that are directly tied to claims incurred and other claims based or census based assessments
- Payment 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 deducted from incurred claims

Line 2.2 – Direct claim liability (MLR reporting year)

2.2a – 12/31 Column – liability as of 12/31 of MLR reporting year for all claims regardless of incurred date.

2.2b – 3/31 Column – liability based on claims incurred only during the MLR reporting year, and unpaid as of 3/31 of the following year.

Include:

- Unpaid claims, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, recoverable for anticipated coordination of benefits (COB) and subrogation (including third party liability)
- Incurred but not reported – report claims incurred only during the MLR reporting year and not reported by 3/31 of the following year. Except where inapplicable, the reserve included in these lines should be based on past experience, modified to reflect current conditions, such as changes in exposure

Line 2.3 – Direct claim liability prior year (year preceding the MLR reporting year)

12/31 Column – liability as of 12/31 of the year preceding the MLR reporting year, as reported to the regulatory authority in the issuer's State of domicile or as reported on the NAIC SHCE filing for the year preceding the MLR reporting year.

Line 2.4 – Direct claim reserves (MLR reporting year)

2.4a – 12/31 Column – reserves as of 12/31 of MLR reporting year for all claims regardless of incurred date.

2.4b – 3/31 Column – reserves based on experience incurred only in the MLR reporting year, calculated as of 3/31 of the following year.

Report reserves related to healthcare services for present value of amounts not yet due on claims.

Line 2.5 – Direct claim reserves prior year (year preceding the MLR reporting year)

12/31 Column – reserves as of 12/31 of the year preceding the MLR reporting year, as reported to the regulatory authority in the issuer's State of domicile or as reported on the NAIC SHCE filing for the year preceding the MLR reporting year.

Line 2.6 – Direct contract reserve (MLR reporting year)

Report the amount of reserves required when, due to the gross premium structure, the future benefits exceed the future net premium. Contract reserves are in addition to claim liabilities and claim reserves.

Include: Contract reserves and other claims related reserves.

Exclude: Premium deficiency reserves.
Reserves for expected MLR rebates.

2.6a – 12/31 Column – reserves as of 12/31 of the MLR reporting year, as reported to the regulatory authority in the issuer's State of domicile or as reported on the NAIC SHCE filing for the MLR reporting year.

2.6b – 3/31 Column – for policies issued prior to 2011, contract reserves may only be used in the MLR calculation if such reserves were held prior to 2011, and may include reserves used for the purpose of leveling policy duration-based variation in claims experience only if durational contract reserves were held for such policies prior to 2011. Reported contract reserves may not exceed contract reserves calculated using the applicable product pricing assumptions. Calculate as of 12/31 of the MLR reporting year.

Line 2.7 – Direct contract reserves prior year (year preceding the MLR reporting year)

12/31 Column – amount reported as of 12/31 of the year preceding the MLR reporting year.

3/31 Column – amount reported on Line 2.6b in the 3/31 Column of the MLR Form for the preceding year.

Line 2.8 – Experience rating refunds (rate credits) paid or received

2.8a – 12/31 Column – report all refunds paid or received through 12/31 of the MLR reporting year.

2.8b – 3/31 Column – report refunds associated only with claims incurred during the MLR reporting year, paid or received through 3/31 of the following year.

Include: Experience rating refunds and State premium refunds paid or received during the MLR reporting year. Experience rating refund is the return of a portion of premium pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention, and margin are less than earned premium.

Exclude: Federal and State MLR rebates, and risk corridors payments or charges.

Line 2.9 – Reserves for experience rating refunds (MLR reporting year)

2.9a – 12/31 Column – all refunds unpaid as of 12/31 of the MLR reporting year.

2.9b – 3/31 Column – refunds associated only with claims incurred during the MLR reporting year, not paid or received as of 3/31 of the following year.

Include: Reserves for experience rating refunds, plus reserves for State premium refunds.

Exclude: Reserves for Federal and State MLR rebates, premium stabilization reserves, and risk corridors reserves or accruals.

Deduct: Amounts receivable under retrospectively rated funding arrangements.

Line 2.10 – Reserves for experience rating refunds (year preceding the MLR reporting year)

12/31 Column – as of 12/31 of the year preceding the MLR reporting year.

See instructions for Line 2.9.

Line 2.11 – Incurred medical incentive pools and bonuses

12/31 Column – based on all payments or receipts through 12/31 of the MLR reporting year.

3/31 Column – based on amounts incurred only for the MLR reporting year and paid or received through 3/31 of the following year.

Include: Arrangements with providers and other risk sharing arrangements whereby the reporting entity agrees to either share savings or make incentive payments or receipts to providers. Include only incentive and bonus payments made to providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers.

2.11a – Paid or received medical incentive pools and bonuses for the MLR reporting year.

2.11b – Accrued medical incentive pools and bonuses for the MLR reporting year. Exclude amounts recorded on Line 2.11a, include only the amount of medical incentive and bonus pool payments or receipts that are estimated to be owed but not yet paid or received for the MLR reporting year.

2.11c – Accrued medical incentive pools and bonuses for the year preceding the MLR reporting year.

Line 2.12 – Net healthcare receivables

12/31 Column – receivables reported as of 12/31 of the MLR reporting year.

3/31 Column – receivables incurred during the MLR reporting year and that remain outstanding as of 3/31 of the following year.

2.12a – Healthcare receivables (MLR reporting year).

2.12b – Healthcare receivables (year preceding the MLR reporting year).

The amounts on these lines are the gross healthcare receivable assets, not just the admitted portion. These amounts should not include those healthcare receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider. These amounts should include prescription drug rebates and other price concessions receivables.

Line 2.13 – Contingent benefit and lawsuit reserves for claims incurred in the MLR reporting year

12/31 Column – reserves as of 12/31 of the MLR reporting year.
If not separately reported in annual financial filings to the issuer's regulatory authority, the issuer does not need to separately report this element in this column.

3/31 Column – reserves related to claims incurred during the MLR reporting year and unpaid as of 3/31 of the following year.
Issuer must separately report this data element in the 3/31 column as provided in 45 CFR Part 158 and as noted in the General Instructions.

Include: The claims-related portion of reserves for contingent benefits and lawsuits.

Exclude: Reserves related to costs associated with claims lawsuits within Line 2.13; e.g., legal fees, court costs, pain and suffering damages, punitive damages, etc.

Line 2.14 – Group conversion charges

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.

If an issuer has only group lines of business and no other individual market experience, the issuer may choose to report the experience of the group conversion policies in the columns for the applicable group market, rather than the individual market columns, and leave this line blank.

Line 2.15 – Blended rate adjustment

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 the issuer defined prior to the beginning of the MLR reporting year, 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. From the date an issuer ***chooses*** to use such an adjustment, it must be used for a minimum of three consecutive MLR reporting years. Affiliated issuers that choose to make such an adjustment must do so for all policies with blended rates in the applicable State market.

Line 2.16 – State Reinsurance Program Payments

Include: Expected Receipts from State Reinsurance Programs[3]

NOTE: Report contributions to State Reinsurance Programs, regardless of the form of contribution, in Part 1, Line 3.2a

Line 2.17 – Total incurred claims

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[3] For example, receipts from the Alaska Reinsurance Program, Colorado Health Insurance Affordability Enterprise, Connecticut Small Employer Health Reinsurance Pool, Delaware Health Insurance Individual Market Stabilization Reinsurance Program & Fund, Georgia Reinsurance Program, Idaho Individual High Risk Reinsurance Pool, Maine Guaranteed Access Reinsurance Association, Maryland Reinsurance Program, Minnesota Premium Security Plan, Montana Reinsurance Program, New Hampshire Reinsurance Program, New Jersey Reinsurance Program, Reinsurance Association of North Dakota, Oregon Reinsurance Program, Pennsylvania Commonwealth Health Insurance Reinsurance Program, Rhode Island Reinsurance Program, Virginia Commonwealth Health Reinsurance Program, Wisconsin Healthcare Stability Plan, and receipts from other State reinsurance programs, including those established under Section 1332 of the Patient Protection and Affordable Care Act.

12/31 Column – Part 2, Lines 2.1a + 2.2a – 2.3 + 2.4a – 2.5 + 2.6a – 2.7 + 2.8a + 2.9a – 2.10 + 2.11a + 2.11b – 2.11c – 2.12a + 2.12b + 2.13 + 2.14 + 2.15 – 2.16

3/31 Column – Part 2, Lines 2.1b + 2.2b + 2.4b + 2.6b – 2.7 + 2.8b + 2.9b + 2.11a + 2.11b – 2.12a + 2.13 + 2.14 + 2.15 – 2.16

(Note: Allowable fraud reduction expenses are added to Incurred Claims in the calculation of Adjusted Incurred Claims in Part 3, Line 1.2.)

Line 2.18 – Allowable claims recovered through fraud reduction efforts

Report the amount of claims payments recovered through fraud reduction efforts not to exceed the amount of fraud reduction expenses.

This amount is limited to the lesser of the total fraud reduction expenses reported on Line 2.18a or the actual fraud recoveries collected on paid claims on Line 2.18b. If either Line 2.18a or Line 2.18b is equal to zero (0) then the allowable amount is equal to zero (0).

2.18a – Total fraud reduction expense.

2.18b – Total fraud recoveries that reduced PAID claims in Part 2, Line 2.1.
Include collected fraud recoveries on paid claims only.

Line 2.19 – Reconciled Payments of Cost-sharing Reductions

Include: Total reconciled cost-sharing reductions amount for the MLR reporting year, including from State CSR programs

Instructions for MLR Annual Reporting Form – Part 3
(MLR and Rebate Calculation)

These MLR Form Filing Instructions apply to the 2023 MLR reporting year and its reporting requirements. These Filing Instructions may be revised to reflect changes that apply to the filing years subsequent to 2023.

No data should be entered in any of the cells shaded grey.

COLUMN DEFINITIONS – PART 3

Columns 1, 5, 9, 13, 17, 21, 33 – **PY2**

Report the information for the MLR reporting year that is 2 years prior to the MLR reporting year. Report corrected amounts if reported in error in prior MLR Form submissions. All elements should be reported in accordance with the applicable reporting year's instructions. Exception: Line 1.1 should be reported as originally submitted.

Columns 2, 6, 10, 14, 18, 22, 34 – **PY1**

Report the information for the MLR reporting year that is 1 year prior to the MLR reporting year. Report corrected amounts if reported in error in prior MLR Form submissions. All elements should be reported in accordance with the applicable reporting year's instructions. Exception: Line 1.1 should be reported as originally submitted.

Columns 3, 7, 11, 15, 19, 23, 35 – **CY**

Report the information for the MLR reporting year.

Columns 4, 8, 12, 16, 20, 24, 36 – **Total**

For Sections 1 and 2 and Line 4.1, report the sum of the amounts in PY2, PY1, and CY columns, except for Lines 1.9 and 2.3. Otherwise, follow line instructions. The Total column is used to calculate the numerator and denominator of the MLR calculation. CY adjusted premium is used to calculate the issuer's rebate, if any.

<u>Column Groupings</u>

For the definitions for each of the following markets, see the Column Definitions at the beginning of these Filing Instructions.

Columns 1–4	–	Individual Market
Columns 5–8	–	Small Group Market
Columns 9–12	–	Large Group Market
Columns 13–16	–	Mini-Med plans – Individual Market
Columns 17–20	–	Mini-Med plans – Small Group Market
Columns 21–24	–	Mini-Med plans – Large Group Market
Columns 25–28	–	Expatriate plans – Small Group Market (Not applicable for 2023)
Columns 29–32	–	Expatriate plans – Large Group Market (Not applicable for 2023)

Columns 33–36 – Student Health plans – Individual Market (GT template only)

LINE INSTRUCTIONS – PART 3

Columns 1–24 are not applicable for the GT template and may be left blank.

<u>Section 1 – Medical Loss Ratio Numerator</u>

Line 1.1 – Adjusted incurred claims as reported on the MLR Form for prior year(s)

PY2 and PY1 Columns – 2021 and 2022 MLR Forms, respectively, Part 3, Line 1.2, Column CY

Line 1.2 – Adjusted incurred claims as of 3/31 of the year following the MLR reporting year

Report corrected amounts if prior year's information was reported inaccurately.

PY2 Column – enter the amount of adjusted incurred claims reported on Part 3, Line 1.2, Column CY of the MLR Form 2 years prior to the MLR reporting year, restated as of 3/31 of the year following the MLR reporting year. For example, for reporting year 2023, the issuer would enter 2021 adjusted incurred claims restated as of 3/31/2024. (This is also known as claims incurred in 12 months and paid in 39 months.) Restate all applicable elements of adjusted incurred claims, including reserves and the allowable claims recovered through fraud reduction efforts, in accordance with the Filing Instructions from 2 years prior to the MLR reporting year.

PY1 Column – enter the amount of adjusted incurred claims reported on Part 3, Line 1.2, Column CY of the MLR Form for the preceding MLR reporting year, restated as of 3/31 of the year following the MLR reporting year. (This is also known as claims incurred in 12 months and paid in 27 months). Restate all applicable elements of adjusted incurred claims, including reserves and the allowable claims recovered through fraud reduction efforts, in accordance with the Filing Instructions from the year preceding the MLR reporting year.

CY Column – Part 1, Lines 2.1 + 2.11, Columns 3/31 + Deferred PY1 – Deferred CY (Note that adjusted incurred claims in the Deferred PY1 columns on Parts 1 and 2 should have been restated as of 3/31 of the year following the MLR reporting year.)

Line 1.3 – Improving Health Care Quality Expenses

PY2 and PY1 Columns – 2021 and 2022 MLR Forms, respectively, Part 3, Line 1.3, Column CY

CY Column – Part 1, Line 4.6, Columns 3/31 + Deferred PY1 – Deferred CY

Line 1.4 – Reconciled Payments of Cost-Sharing Reductions

PY2 and PY1 Columns – Amount of reconciled cost-sharing reductions for 2021 and 2022, respectively.

CY Column – Part 2, Line 2.19, Columns 3/31 + Deferred PY1 – Deferred CY

Line 1.5 – Federal Transitional Reinsurance Program payments

PY2 and PY1 Columns – 2021 and 2022 MLR Forms, respectively, Part 3, Line 1.5, Column CY

CY Column – Part 2, Line 1.9, Columns 3/31 + Deferred PY1 – Deferred CY

Line 1.6 – Net Federal Risk Adjustment Program payments or charges

See instructions for Part 2, Line 1.10 for the mapping of the HHS-RADV adjustments and MLR reporting years.

PY2 and PY1 Columns – 2021 and 2022 MLR Forms, respectively, Part 3, Line 1.6, Column CY

CY Column – Part 2, Line 1.10, Columns 3/31 + Deferred PY1 – Deferred CY

Line 1.7 – Reserved

Line 1.8 – Shared Savings payments to enrollees

Shared savings payments made by the issuer to an enrollee as a result of the enrollee choosing to obtain health care from a lower-cost, higher-value provider.

Line 1.9 – MLR numerator

All Columns – Lines 1.2 + 1.3 – 1.4 – 1.5 – 1.6 + 1.8

In states with different MLR standards for the current reporting year or either of the two prior years, issuers may scale the experience included in the Total column for Line 1.9 to account for the change(s) in MLR standards. The scaling adjustment for the prior year is the current year standard minus the prior year standard, multiplied by the prior year adjusted premium. The scaling adjustment for two years prior is the current year standard minus the standard from two years prior, multiplied by the adjusted premium from two years prior. For example, an issuer subject to a 67% MLR standard in 2021, a 75% standard in 2022, and an 80% MLR standard in 2023, with adjusted premiums of $1,000,000, $1,200,000, and $1,300,000 in 2021, 2022, and 2023, respectively, would have an adjustment of (80% - 75%) * $1,200,000 and (80% - 67%) * $1,000,000 = $60,000 + $130,000 = $190,000 in 2023. Note that the scaling adjustment amount(s) should be added to the Total Column for Line 1.9, and not in the CY, PY1, or PY2 columns.

Issuers with health insurance coverage in both the individual and small group markets, who merge their markets in accordance with state law (such as in Massachusetts, Maine, and the District of Columbia), should combine Lines 1.2 + 1.3 – 1.4 – 1.5 – 1.6 + 1.8 for both markets and enter the combined amounts on Line 1.9 in the PY2, PY1, CY, and Total Columns for both markets (Columns 1-8). Please note that MLR numerator, denominator, and life-years to determine credibility are the only fields on the MLR Form where experience for the two markets can be combined.

Section 2 - Medical Loss Ratio Denominator

Line 2.1 – Premium earned including Federal and State high risk programs

PY2 and PY1 Columns – 2021 and 2022 MLR Forms, respectively, Part 3, Line 2.1, Column CY

CY Column – (Part 1, Lines 1.1 + 1.2 + 1.3, Columns 3/31 + Deferred PY1 – Deferred CY) – (Part 3, Lines 1.5 + 1.6, Column CY)

Line 2.2 – Federal and State taxes and licensing or regulatory fees

PY2 and PY1 Columns – 2021 and 2022 MLR Forms, respectively, Part 3, Line 2.2, Column CY

CY Column –

Federal tax-exempt issuers:
Part 1, Lines 3.1a + 3.1b + 3.1d + 3.2a + 3.2b + 3.2c + 3.3a + 3.3b, Columns 3/31 + Deferred PY1 – Deferred CY

Non Federal tax-exempt issuers:
Part 1, Lines 3.1a + 3.1b + 3.1d + 3.2a + (the higher of 3.2b or 3.2c) + 3.3a + 3.3b, Columns 3/31 + Deferred PY1 – Deferred CY

Note: If Line 3.2b is negative and Line 3.2c is zero or blank (or vice versa), zero may not be used as the higher of the two: only the negative amount may be used in the equation.

Line 2.3 – MLR denominator

All Columns – Lines 2.1 – 2.2

For Health Insurance Coverage and Mini-med plans respectively, issuers with experience in both the individual and small group markets who merge markets in accordance with state law (such as in Massachusetts, Maine, and the District of Columbia), should combine Lines 2.1 – 2.2 for both markets and enter the combined amounts on Line 2.3 in the PY2, PY1, CY, and Total Columns for both markets (Columns 1-8). Please note that MLR numerator, denominator, and life-years to determine credibility, are the only fields on the MLR Form where experience for the two markets may be combined.

Section 3 – Credibility Adjustment

Line 3.1 – Life-years

PY2 and PY1 Columns – 2021 and 2022 MLR Forms, respectively, Part 1, Line 7.5, Columns 3/31 + Deferred PY1 – Deferred CY

CY Column – Part 1, Line 7.5, Columns 3/31 + Deferred PY1 – Deferred CY

For Health Insurance Coverage and Mini-med plans respectively, issuers with experience in both the individual and small group markets who merge their markets in accordance with state law (such as in Massachusetts, Maine, and the District of Columbia), should combine Line 3.1 for both *markets and enter the combined amounts on Line 3.1 in the PY2, PY1, CY, and Total Columns for both markets (Columns 1-8). Please note that MLR numerator, denominator, and life-years to determine credibility are the only fields on the MLR Form where experience for the two markets may be combined.*

Line 3.2 – Base credibility factor

Non-credible experience: An issuer with aggregated life-years of less than 1,000 as reported in Line 3.1, Total Column for the relevant market is presumed to meet or exceed the applicable MLR standard and does not receive a credibility adjustment.

Fully credible experience: An issuer with 75,000 or more aggregated life-years as reported in Line 3.1, Total Column for the relevant market does not receive a credibility adjustment. Enter zero (0%) or leave blank.

Partially credible experience: An issuer with at least 1,000 but fewer than 75,000 aggregated life-years as reported in Line 3.1, Total Column for the relevant market may receive a base credibility factor calculated as follows:

Beginning with the 2013 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 preliminary 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.

Specifically, the base credibility factor is zero if all of the following conditions are met:

- Line 3.1, PY2 Column is at least 1,000; and
- Line 3.1, PY1 Column is at least 1,000; and
- Line 3.1, CY Column is at least 1,000; and
- Line 4.1, PY2 Column is less than Line 5.1, PY2 Column; and
- Line 4.1, PY1 Column is less than Line 5.1, PY1 Column; and
- Line 4.1, CY Column is less than Line 5.1, CY Column.

Otherwise, if the aggregated life-years as reported in Line 3.1, Total Column exactly matches a life-year category listed in Table 1 below, 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. **DO NOT ROUND.**

Table 1

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)

Line 3.3 – Average deductible

Issuers who choose to use a deductible factor of 1.0 can skip Steps 1 and 2, leave Line 3.3 blank, and enter 1.0 on Line 3.4.

Step 1: Calculate average deductibles separately for policies in force in PY2, PY1, and CY.

The per-person deductible for a policy that covers a subscriber and the subscriber's dependents shall be calculated as follows:

The lesser 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).

Issuers offering products with differing deductibles should use a weighted average based upon life-years for each deductible level of policies included in the aggregation.

Step 2: Calculate the weighted average (based upon life-years) of the PY2, PY1, and CY average deductibles computed in Step 1. Enter this three-year weighted average deductible on Line 3.3.

For Health Insurance Coverage and Mini-med plans respectively, issuers with experience in both the individual and small group markets who merge their markets in accordance with state law (such as in Massachusetts, Maine, and the District of Columbia), should calculate the averages across both markets such that the average deductible is the same for both markets (Columns 4 and 8).

Line 3.4 – Deductible factor

This amount is calculated based upon the average deductible reported in the Total Column for Line 3.3. The deductible factor ranges from 1.0 to 1.736 and is shown in Table 2 below and in the Tables tab of the MLR Form. When the average deductible used to determine the deductible factor exactly matches a deductible level listed in Table 2, the deductible factor associated with that average deductible level is the factor in Table 2. The deductible factor for a deductible level between the values shown in Table 2 is determined by linear interpolation (do not round).

Table 2

Health plan deductible	Deductible Factor
< $2,500	1.000
$2,500	1.164
$5,000	1.402
>= $10,000	1.736

Enter the amount from the table corresponding with the average deductible. Issuers with non-credible or fully credible experience do not have a deductible factor and can enter a value of 1.0.

Line 3.5 – Credibility adjustment

Lines 3.2 x 3.4 (DO NOT ROUND)

Issuers with non-credible or fully credible experience do not receive a credibility adjustment and should enter zero.

Section 4 – Medical Loss Ratio Calculation

Issuers with less than 1,000 aggregated life-years (Line 3.1, Total Column) are presumed to meet the MLR standard and may leave Section 4 blank.

Line 4.1 – Preliminary Medical Loss Ratio

All Columns – Line 1.9 / Line 2.3. Do not round.

Line 4.2 – Credibility adjustment

Line 3.5, Total Column.

Line 4.3 – MLR including credibility adjustment (if applicable)

Lines 4.1+ 4.2, Total Column. After adding, round to three decimal places, e.g. 0.801 or 80.1%.

Section 5 – MLR Rebate Calculation

Line 5.1 – MLR Standard

PY2 Column – 2021 MLR Form, Part 3, Line 5.1, Total Column

PY1 Column – 2022 MLR Form, Part 3, Line 5.1, Total Column

CY and Total Columns – The applicable MLR standard is based on one of the following:

- The statutory MLR standard for the relevant market (i.e., 80% for the individual market and small group market; and 85% for the large group market); or
- The HHS-approved adjusted MLR standard for a particular State's individual market; or
- The State MLR standard, if the State requires a higher percentage than the statutory MLR standard for the relevant market for rebate purposes. In 2023, the following States had higher MLR standards: MA – 88% (individual and small group markets); NY – 82% (individual and small group markets).

- If an issuer thinks a State's higher MLR standard does not apply to its MLR and rebate requirements under Federal law, please contact CCIIO at MLRQuestions@cms.hhs.gov.

Line 5.2 – Credibility-adjusted MLR

Line 4.3, Total Column

Line 5.3 – Adjusted earned premium

Lines 2.1 – 2.2, CY Column only

Line 5.4 – Rebate amount if credibility-adjusted MLR is less than the MLR standard

(Lines 5.1 – 5.2) x Line 5.3, Total Column

If Line 5.3 is negative, enter zero ($0) in Line 5.4.

Completing Lines 5.5-5.8 below is OPTIONAL for issuers. Completing these lines generally benefits new or rapidly growing issuers whose MLRs initially fall below the standard and increase over time. Electing to not complete Lines 5.5-5.8 on the current reporting year's MLR Form will not preclude an issuer from taking advantage of the rebate limiting provision in a future year; the issuer would pro-rate previously paid rebates in accordance with the alternative instructions for Line 5.6.

Line 5.5 – Single-year rebate liability

PY2 Column – Line 2.3, Column PY2 x (Line 5.1, Column PY2 – (Line 4.1, Column PY2 + Line 4.2, Column Total, rounded to three decimal places)). If the result is less than zero, enter zero.

PY1 Column – Line 2.3, Column PY1 x (Line 5.1, Column PY1 – (Line 4.1, Column PY1 + Line 4.2, Column Total, rounded to three decimal places)). If the result is less than zero, enter zero.

CY Column – Line 2.3, Column CY x (Line 5.1, Column CY – (Line 4.1, Column CY + Line 4.2, Column Total, rounded to three decimal places)). If the result is less than zero, enter zero.

Line 5.6 – Paid rebate liability

If Lines 5.6 and 5.8 were completed on the MLR Form for the preceding year:

PY2 Column – MLR Form for the preceding year, Part 3, Lines 5.6 + 5.8, Column PY1

PY1 Column – MLR Form for the preceding year, Part 3, Line 5.8, Column CY

Issuers with experience in both the individual and small group markets who merge markets in accordance with state law (such as in Massachusetts, Maine, and the District of Columbia), should combine Line 5.8 amounts from the preceding year's MLR Form for both markets and include the combined amount on Line 5.6 in the PY2 and PY1 Columns for both markets on the current year's MLR Form. Line 5.6 on the preceding year's MLR Form should already reflect a combined amount.

An issuer who paid a higher state than federal MLR rebate under a state MLR calculation that utilizes a single year of data rather than a multi-year average MLR or under a state calculation that utilizes multi-year data in both the MLR and rebate calculations (such as New Jersey and New Mexico) may substitute such higher state MLR rebate on Line 5.6.

If an issuer prepaid MLR rebates in advance of filing the MLR Form for a prior year, the issuer may include such prepaid amount on Line 5.6 even if it exceeds the rebate amount calculated on Line 5.4 of the MLR Form for the relevant prior year (to the extent not recouped from the enrollees).

Alternative instructions:
If Line 5.8 was not completed on the MLR Form for the preceding year, pro-rate non-zero prior year rebate amounts as shown below. For users' convenience, CMS will provide on its website[4] an Excel spreadsheet automating this calculation. In lieu of pro-rating using the formulas below, an issuer may choose to calculate the paid rebate liability for each of the previous years' MLR Forms using the formulas for Lines 5.5-5.8. All references to Line 3.5 below mean Line 3.5 in Column Total.

Step 1: Using the 2022 MLR Form, Part 3:

- 2021 paid rebate liability: Line 5.4, Column Total x [Lines 2.3 x (5.1 – 4.1 – 3.5), Column PY1] / [Lines 2.3 x (5.1 – 4.1 – 3.5), Column PY2 + Lines 2.3 x (5.1 – 4.1 – 3.5), Column PY1 + Lines 2.3 x (5.1 – 4.1 – 3.5), Column CY].
- 2022 paid rebate liability: Line 5.4, Column Total x [Lines 2.3 x (5.1 – 4.1 – 3.5), Column CY] / [Lines 2.3 x (5.1 – 4.1 – 3.5), Column PY2 + Lines 2.3 x (5.1 – 4.1 – 3.5), Column PY1 + Lines 2.3 x (5.1 – 4.1 – 3.5), Column CY]
- Note: If Line 2.3 is negative or blank for any column above, use $0 as the value for Line 2.3 in that column. If the result of Lines (5.1 – 4.1 – 3.5) is negative for any column, use 0% as the value for Lines (5.1 – 4.1 – 3.5) in that column. If Line 4.1 was blank for any column because the business in that column was non-credible, calculate the value for Line 4.1 by dividing Line 1.9 by Line 2.3.

For example, if on the 2022 MLR Form, Part 3, Individual market:

a) Line 2.3 shows $30,000 in Column PY2, $90,000 in Column PY1, and $100,000 in Column CY;
b) Line 3.5 shows 0% in Column Total;
c) Line 4.1 shows 60% in Column PY2, 70% in Column PY1, and 83% in Column CY;
d) Line 5.1 shows an 80% MLR standard in all columns;
e) Line 5.4 shows $5,500 in Column Total;

then the $5,500 rebate payment would be pro-rated as follows:

- 2021 paid rebate liability = $5,500 x $90,000 x (80% – 70% – 0%) / [$30,000 x (80% – 60% – 0%) + $90,000 x (80% – 70% – 0%) + $100,000 x 0% (*0% is used because 80% – 83% is less than zero*)] = $3,300;

[4] https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Medical_Loss_Ratio

- 2022 paid rebate liability = $5,500 x $100,000 x 0% (*0% is used because 80% – 83% is less than zero*) / [$30,000 x (80% – 60% – 0%) + $90,000 x (80% – 70% – 0%) + $100,000 x 0% (*0% is used because 80% – 83% is less than zero*)] = $0.

In this example, $3,300 would be included on the 2023 MLR Form, Part 3, Line 5.6, Column PY2; and $0 would be included on the 2023 MLR Form, Part 3, Line 5.6, Column PY1.

<u>Step 2</u>: Using the 2021 MLR Form, Part 3:

- 2021 paid rebate liability: Line 5.4, Column Total x [Lines 2.3 x (5.1 – 4.1 – 3.5), Column CY] / [Lines 2.3 x (5.1 – 4.1 – 3.5), Column PY2 + Lines 2.3 x (5.1 – 4.1 – 3.5), Column PY1 + Lines 2.3 x (5.1 – 4.1 – 3.5), Column CY]
- Note: If Line 2.3 is negative or blank for any column above, use $0 as the value for Line 2.3 in that column. If the result of Lines (5.1 – 4.1 – 3.5) is negative for any column, use 0% as the value for Lines (5.1 – 4.1 – 3.5) in that column. If Line 4.1 was blank for any column because the business in that column was non-credible, calculate the value for Line 4.1 by dividing Line 1.9 by Line 2.3.

For example, if on the 2021 MLR Form, Part 3, Individual market:

a) Line 2.3 shows $5,000 in Column PY2, $30,000 in Column PY1, and $90,000 in Column CY;
b) Line 3.5 shows 1.0% in Column Total;
c) Line 4.1 shows blank in Column PY2, 60% in Column PY1, and 70% in Column CY;
d) Line 1.9 shows $2,000 in Column PY2;
e) Line 5.1 shows an 80% MLR standard in all columns;
f) Line 5.4 shows $11,340 in Column Total;

then the $11,340 rebate payment would be pro-rated as follows:

- 2021 paid rebate liability = $11,340 x $90,000 x (80% – 70% – 1%) / [$5,000 x (80% – $2,000/$5,000 – 1%) (*$2,000/$5,000 is used because Line 4.1 is blank*) + $30,000 x (80% – 60% – 1%) + $90,000 x (80% – 70% – 1%)] = $5,832.

Include the result on the 2023 MLR Form, Part 3, Line 5.6, Column PY2 together with the 2021 amount obtained in Step 1.

Issuers with experience in both the individual and small group markets who merge markets in accordance with state law (such as in Massachusetts, Maine, and the District of Columbia), should combine the resulting prior year amounts for both markets and enter the combined amounts on Line 5.6 in the PY2 and PY1 Columns for both markets.

<u>Line 5.7 – Unpaid rebate liability</u>

Lines 5.5 – 5.6 (if less than zero, enter zero)

<u>Line 5.8 – Limited payable rebate amount</u>

PY2 Column – The lesser of Line 5.7, Column PY2 and Line 5.4, Column Total

PY1 Column – The lesser of Line 5.7, Column PY1 and (Line 5.4, Column Total – Line 5.8, Column PY2)

CY Column – The lesser of Line 5.7, Column CY and (Line 5.4, Column Total – Line 5.8, Column PY1 – Line 5.8, Column PY2)

Issuers with experience in both the individual and small group markets who merge markets in accordance with state law (such as in Massachusetts, Maine, and the District of Columbia), should adjust the formulas above by multiplying Line 5.7 by the ratio of Lines (2.1 – 2.2) / 2.3 in the respective columns.

Section 6 – Temporary Adjustments

Reserved

Instructions for MLR Annual Reporting Form – Part 4
(Rebate Disbursement)

These MLR Form Filing Instructions apply to the 2023 MLR reporting year and its reporting requirements. These Filing Instructions may be revised to reflect changes that apply to the filing years subsequent to 2023.

The Column Definitions, which immediately follow the General Instructions at the beginning of these Filing Instructions, apply to the markets to be reported in Columns 1 through 9 of Part 4.

Column 1	–	Individual Market
Column 2	–	Small Group Market
Column 3	–	Large Group Market
Column 4	–	Mini-Med plans – Individual Market
Column 5	–	Mini-Med plans – Small Group Market
Column 6	–	Mini-Med plans – Large Group Market
Column 7	–	Expatriate plans – Small Group Market (not applicable in 2023)
Column 8	–	Expatriate plans – Large Group Market (not applicable in 2023)
Column 9	–	Student Health plans – Individual Market

Additional definitions:

- **Group Policyholder** means any entity that has entered into a contract with an issuer to receive health insurance coverage. (Applicable only in the group markets.)

- **Subscriber** (Applicable in all markets.)
  - In the individual market, subscriber means the person who purchases an individual policy and who is responsible for the payment of premiums. This does not include the number of dependents and therefore does not correspond to the number of covered lives or life-years; rather, this corresponds to the number of individual policies.
  - In the group market, subscriber means the person, 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. This does not correspond to the number of group policyholders (e.g. employers). This also does not include the number of dependents and therefore does not correspond to the number of covered lives or life-years; rather, this corresponds to the number of certificates (e.g. number of employees).

Section/Line 1 – Number of policies/certificates (from Part 1, Line 7.1)

Section 2 – Number of policyholders/subscribers owed rebates

Line 2.a – Number of group policyholders who are being paid a rebate (only applicable in the group markets)

Include: All group policies (e.g. employers) within the respective group markets that are due a rebate and to whom the issuer is paying the rebate directly. This is a count of the groups, not a count of the certificates, covered lives, or life-years in the groups.

Exclude: Rebates being paid in the individual market and rebates in group markets which the issuer is paying directly to the group's subscribers rather than to the group policyholder.

Line 2.b – Number of subscribers being paid a rebate

- Individual market: All subscribers under individual policies that are due a rebate. This does not include dependents; consequently, this is not the number of covered lives or life-years.
- Small and large group markets: Those subscribers to whom the issuer is paying the rebate directly. This does not include subscribers where the issuer is paying the rebate to the group policyholder. This is not the number of employers, covered lives or life-years; typically, this is the number of employees (not including dependents).

Line 2.c – Number of group policyholders whose calculated rebate is *de minimis*

De Minimis –

- For a group policy for which the issuer distributes the rebate directly to the policyholder, if the total rebate owed to the policyholder and its subscribers combined is less than $20 for the MLR reporting year. This is not the number of certificates, covered lives or life-years; typically, this is the number of employers.

Line 2.d – Number of subscribers whose calculated rebate is *de minimis*

De Minimis –

- For a group policy for which the issuer distributes the rebate directly to the subscribers, if the total rebate owed to each subscriber is less than $5 for a given MLR reporting year. This is not the number of employers, covered lives or life-years; typically, this is the number of employees (not including dependents).
- For an individual policy, if the total rebate owed to each subscriber is less than $5 for a given MLR reporting year. This does not include dependents; consequently, this is not the number of covered lives or life-years.

Section 3 – Total amount of rebates

Line 3.a – Total amount of rebates (from Part 3, Line 5.4 or 5.8, as applicable)

Line 3.b – Total amount of *de minimis* rebates

Line 3.c – Amount of rebates being paid by premium credit

Line 3.d – Amount of rebates being paid by lump-sum reimbursement

Line 3.e – Amount of rebates prepaid in advance of filing the MLR Form

Section 4 – Prior MLR year rebates

Line 4.a – Total amount of rebates paid for the previous MLR reporting year

Line 4.b – Total amount of rebates still owed for the previous MLR reporting year

Line 4.c – Percentage of rebate notices timely sent to individual and group policyholders owed a rebate

Enter the percentage of notices sent by September 30 following the prior MLR reporting year.

Line 4.d – Percentage of notices timely sent to subscribers of group policies owed a rebate

Enter the percentage of notices sent by September 30 following the prior MLR reporting year.

Line 4.e – Percentage of rebate amounts timely paid to individual and group policyholders owed a rebate

Include:

- Rebate amounts paid as a lump-sum check or reimbursement to individual policyholders and directly to group policyholders (e.g., on the form filed for the 2023 MLR reporting year, this line would include rebates for the 2022 MLR reporting year that were disbursed as a lump sum by September 30, 2023)
- Rebate amounts that begun to be credited to individual policyholders and directly to group policyholders for the premium due no later than October 30 following the prior MLR reporting year (e.g., on the form filed for the 2023 MLR reporting year, this line would include the percentage of rebates based upon the 2022 MLR reporting year that were paid as premium credit beginning on or before October 30, 2023)

Exclude: Rebates in group markets which the issuer paid directly to the group's subscribers rather than to the group policyholder.

Line 4.f – Percentage of rebates amounts timely paid directly to subscribers of group policies owed a rebate

Enter the percentage of rebate amounts paid by September 30 following the prior MLR reporting year, for rebates which the issuer paid directly to the group's subscribers rather than to the group policyholder.

Line 4.g – Amount of unclaimed rebates from all prior MLR reporting years

Report rebate checks issued but not presented for payment. Report the amount of rebates owed based on the previous MLR reporting years which remain unpaid because the issuer was unable, after making a good faith effort, to locate a former policyholder or subscriber, and which have not yet been escheated or otherwise disbursed.

Line 4.h – Describe the methods used to locate policyholders/subscribers to distribute the prior MLR reporting years' unclaimed rebates

Line 4.i – Disbursement method of the prior MLR reporting years' unclaimed rebates

Describe the method used to disburse the prior MLR reporting years' unclaimed rebates.

Instructions for MLR Annual Reporting Form – Part 5 (Additional Responses)

These MLR Form Filing Instructions apply to the 2023 MLR reporting year and its reporting requirements. These Filing Instructions may be revised to reflect changes that apply to the filing years subsequent to 2023.

Line 1 – If the issuer reported amounts in Part 1, Line 3.2c, Community Benefit Expenditures, provide the state premium tax rate that was used in determining the reported amount (provide the actual tax rate rather than the flat 3% floor that may apply for some issuers exempt from Federal income tax). Complete on each State template and not on the GT template.

Line 2 – If the issuer reported amounts in Part 2, Line 2.15, Blended rate adjustment, provide the affiliate(s)' name(s) for which blended rate adjustments were made.

Line 3 – If the issuer reported amounts in the 3/31 Columns related to dual contract options with affiliates providing out-of-network coverage, provide the affiliate(s)' name(s) for which experience is being reported.

Line 4 – If the issuer entered into any 100% assumption reinsurance agreements (with a novation) during the MLR reporting year, provide the name(s) of the entity(ies) with which the agreement was (were) made and the effective date of the novation. Report only those agreements that are applicable to "health insurance coverage" as defined at the beginning of these Filing Instructions.

Line 5 – If the issuer sold any business in the MLR reporting year, and the novation was effective during the MLR reporting year, provide the name(s) of the entity(ies) to which the business was sold and the date of the sale or transfer.

Line 6 – If the issuer has any 100% 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 of business, provide name(s) of the entity(ies) that is (are) reporting the experience related to such business. Report only those agreements that are applicable to "health insurance coverage" as defined at the beginning of these Filing Instructions.

Instructions for MLR Annual Reporting Form – Part 6
(Expense Allocation Methodology)

These MLR Form Filing Instructions apply to the 2023 MLR reporting year and its reporting requirements. These Filing Instructions may be revised to reflect changes that apply to the filing years subsequent to 2023. Complete Part 6 only within the GT template.

Description of Methods to Allocate Expenses

Describe the methods used to allocate expenses, as reported on the MLR Form, 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 (e.g., individual, small group, large group, mini-med plans, expatriate plans, government program plans, other health business, and uninsured plans, each as defined in the Column Definitions at the beginning of these Filing Instructions) 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. (See instructions within Parts 1 and 2 for descriptions of the various expense elements.)

For a new initiative that otherwise meets the definition of quality improvement activities (QI) (see Filing Instructions for Part 1) but has not yet met the requirement that it be capable of being objectively measured and of producing verifiable results and achievements, note that it is "NEW" in the description of the QI and include the expected timeframe for the activity to meet this requirement.

Acceptable Bases for Allocation of Expenses

Allocation of each type of expense among health insurance markets should be based on a generally accepted accounting method that is expected to yield the most accurate results. If this is not feasible, the issuer should provide an explanation as to why it believes a more accurate result will be gained from its allocation of expenses, including pertinent factors or ratios, such as studies of employee activities, salary ratios or similar analyses.

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

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 to a specific entity or sub-set of entities, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by that specific entity or subset of entities and must not be apportioned to other entities within a group.

Line References

Line 1 – Incurred Claims (as reported on Part 2, Lines 2.1 through 2.16)

Line 2 – Federal and State Taxes and Licensing or Regulatory Fees (as reported on Part 1, Section 3)

Line 2.a – Federal taxes and assessments (as reported on Part 1, Lines 3.1a-d)

Line 2.b – State insurance, premium, and other taxes (as reported on Part 1, Lines 3.2a and 3.2b)
Line 2.c – Community benefit expenditures (as reported on Part 1, Line 3.2c)
Line 2.d – Regulatory authority licenses and fees (as reported on Part 1, Lines 3.3a and 3.3b)

Line 3 – Quality Improvement Expenses (as reported on Part 1, Section 4)

Line 3.a – Improve health outcomes (as reported on Part 1, Line 4.1)
Line 3.b – Activities to prevent hospital readmission (as reported on Part 1, Line 4.2)
Line 3.c – Improve patient safety and reduce medical errors (as reported on Part 1, Line 4.3)
Line 3.d – Wellness and health promotion activities (as reported on Part 1, Line 4.4)
Line 3.e – Health Information Technology (HIT) expenses related to health improvement (as reported on Part 1, Line 4.5)

Line 4 – Non-claims Costs (as reported on Part 1, Section 5)

Line 4.a – Cost containment expenses (as reported on Part 1, Line 5.1)
Line 4.b – All other claims adjustment expenses (as reported on Part 1, Line 5.2)
Line 4.c – Direct sales salaries and benefits (as reported on Part 1, Line 5.3)
Line 4.d – Agents and brokers fees and commissions (as reported on Part 1, Line 5.4)
Line 4.e – Other taxes (as reported on Part 1, Line 5.5a-c)
Line 4.f – Other general and administrative expenses (as reported on Part 1, Line 5.6)
Line 4.g – Community benefit expenditures (as reported on Part 1, Line 5.7)