

ratio requirements for Medicare Advantage organizations, financial penalties and sanctions against MA organizations when minimum medical loss ratios are not achieved by MA organizations, and release of medical loss ratio data to entities outside of CMS.

[81 FR 80557, Nov. 15, 2016]

#### § 422.2401 Definitions.

*Non-claims costs* means those expenses for administrative services that are not—

(1) Incurred claims (as provided in § 422.2420(b)(2) through (4));

(2) Expenditures on quality improving activities (as provided in § 422.2430);

(3) Licensing and regulatory fees (as provided in § 422.2420(c)(2)(i));

(4) State and Federal taxes and assessments (as provided in § 422.2420(c)(2)(ii) and (iii)).

[78 FR 31307, May 23, 2013; 78 FR 43821, July 22, 2013]

#### § 422.2410 General requirements.

(a) For contracts beginning in 2014 or later, an MA organization (defined at § 422.2) is required to report the information required under § 422.2460 for each contract under this part for each contract year.

(b) *MLR requirement.* If CMS determines for a contract year that an MA organization has an MLR for a contract that is less than 0.85, the MA organization has not met the MLR requirement and must remit to CMS an amount equal to the product of the following:

(1) The total revenue of the MA contract for the contract year.

(2) The difference between 0.85 and the MLR for the contract year.

(c) If CMS determines that an MA organization has an MLR for a contract that is less than 0.85 for 3 or more consecutive contract years, CMS does not permit the enrollment of new enrollees under the contract for coverage during the second succeeding contract year.

(d) If CMS determines that an MA organization has an MLR for a contract that is less than 0.85 for 5 consecutive contract years, CMS terminates the contract per § 422.510(b)(1) and (d) effective

as of the second succeeding contract year.

[78 FR 31307, May 23, 2013, as amended at 83 FR 16736, Apr. 16, 2018]

#### § 422.2420 Calculation of the medical loss ratio.

(a) *Determination of MLR.* (1) The MLR for each contract under this part is the ratio of the numerator (as defined in paragraph (b) of this section) to the denominator (as defined in paragraph (c) of this section). An MLR may be increased by a credibility adjustment according to the rules at § 422.2440, or subject to an adjustment determined by CMS to be warranted based on exceptional circumstances for areas outside the 50 states and the District of Columbia.

(2) The MLR for an MA contract—

(i) Not offering Medicare prescription drug benefits must only reflect costs and revenues related to the benefits defined at § 422.100(c); and

(ii) That includes MA-PD plans (defined at § 422.2) must also reflect costs and revenues for benefits described at § 423.104(d) through (f) of this chapter.

(b) *Determining the MLR numerator.*

(1) For a contract year, the numerator of the MLR for an MA contract (other than an MSA contract) must equal the sum of paragraphs (b)(1)(i) through (iii) of this section, and the numerator of the MLR for an MSA contract must equal the sum of paragraphs (b)(1)(i), (iii), and (iv) of this section. The numerator must be determined in accordance with paragraphs (b)(5) and (6) of this section.

(i) Incurred claims for all enrollees, as defined in paragraphs (b)(2) through (4) of this section.

(ii) The amount of the reduction, if any, in the Part B premium for all MA plan enrollees under the contract for the contract year.

(iii) The expenditures under the contract for activities that improve health care quality, as defined in § 422.2430.

(iv) The amount of the annual deposit into the medical savings account described at § 422.4(a)(2).

(2) *Incurred claims for clinical services and prescription drug costs.* Incurred claims must include the following:

(i) Amounts that the MA organization pays (including under capitation