

§ 158.120

MLR reporting year that was prior to the purchase.

[75 FR 74921, Dec. 1, 2010, as amended at 76 FR 76592, Dec. 7, 2011; 78 FR 15539, Mar. 11, 2013; 85 FR 29262, May 14, 2020]

§ 158.120 Aggregate reporting.

(a) *General requirements.* For purposes of submitting the report required in § 158.110 of this subpart, the issuer must submit a report for each State in which it is licensed to issue health insurance coverage that includes the experience of all policies issued in the State during the MLR reporting year covered by the report. The report must aggregate data for each entity licensed within a State, aggregated separately for the large group market, the small group market and the individual market. Experience with respect to each policy must be included on the report submitted with respect to the State where the contract was issued, except as specified in § 158.120(d) of this subpart.

(b) *Group Health Insurance Coverage in Multiple States.* Group coverage issued by a single issuer that covers employees in multiple States must be attributed to the applicable State based on the situs of the contract. Group coverage issued by multiple affiliated issuers that covers employees in multiple States must be attributed by each issuer to each State based on the situs of the contract.

(c) *Group Health Insurance Coverage With Dual Contracts.* Where a group health plan involves health insurance coverage obtained from two affiliated issuers, one providing in-network coverage only and the second providing out-of-network coverage only, solely for the purpose of providing a group health plan that offers both in-network and out-of-network benefits, experience may be treated as if it were all related to the contract provided by the in-network issuer. However, if the issuer chooses this method of aggregation, it must apply it for a minimum of 3 MLR reporting years.

(d) *Exceptions.* (1) For individual market business sold through an association or trust, the experience of the issuer must be included in the State report for the issue State of the certificate of coverage.

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(2) For employer business issued through a group trust or multiple employer welfare association (MEWA), the experience of the issuer must be included in the State report for the State where the employer (if sold through a trust) or the MEWA (if the MEWA is the policyholder) has its principal place of business.

(3) An issuer with policies that have a total annual limit of \$250,000 or less must report the experience from such policies separately from other policies.

(4) An issuer with group policies that provide coverage to employees, substantially all of whom are: 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, must aggregate and report the experience from these policies on a national basis, separately for the large group market and small group market, and separately from other policies.

(5) An issuer in the student market must aggregate and report the experience from these policies on a national basis, separately from other policies.

[75 FR 74921, Dec. 1, 2010, as amended at 75 FR 82278, Dec. 30, 2010; 76 FR 76592, Dec. 7, 2011; 77 FR 16469, Mar. 21, 2012; 77 FR 28790, May 16, 2012]

§ 158.121 Newer experience.

If, for any aggregation as defined in § 158.120, 50 percent or more of the total earned premium for an MLR reporting year is attributable to policies newly issued in that MLR reporting year, then the experience of these policies may be excluded from the report required under § 158.110 for that same MLR reporting year. If an issuer chooses to defer reporting of newer business as provided in this section, then the excluded experience must be added to the experience reported in the following MLR reporting year.

[81 FR 94183, Dec. 22, 2016]

§ 158.130 Premium revenue.

(a) *General requirements.* An issuer must report to the Secretary earned premium for each MLR reporting year. Earned premium means all monies paid by a policyholder or subscriber as a

condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan.

(1) Earned premium is to be reported on a direct basis except as provided in paragraph (b) of this section.

(2) All earned premium for policies issued by one issuer and later assumed by another issuer must be reported by the assuming issuer for the entire MLR reporting year during which the policies were assumed and no earned premium for that MLR reporting year must be reported by the ceding issuer.

(3) Reinsured earned premium for a block of business that was subject to indemnity reinsurance and administrative agreements effective prior to March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

(b) *Adjustments.* Earned premium must include adjustments to:

(1) Account for assessments paid to or subsidies received from Federal and State high risk pools.

(2) Account for portions of premiums associated with group conversion charges.

(3) Account for any experience rating refunds incurred, excluding any rebate paid based upon an issuer's MLR.

(4) Account for unearned premium.

(5) Account for the net payments or receipts related to the risk adjustment, risk corridors (using an adjustment percentage, as described in §153.500 of this subchapter, equal to zero percent), and reinsurance programs under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18061, 18062, 18063.

[75 FR 74921, Dec. 1, 2010, as amended at 77 FR 28790, May 16, 2012; 78 FR 15539, Mar. 11, 2013; 79 FR 13842, Mar. 11, 2014]

§ 158.140 Reimbursement for clinical services provided to enrollees.

(a) *General requirements.* The report required in §158.110 must include direct claims paid to or received by providers, including under capitation contracts with physicians, whose services are covered by the policy for clinical serv-

ices or supplies covered by the policy. In addition, the report must include claim reserves associated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the medical claim portion of lawsuits, and any incurred experience rating refunds. Reimbursement for clinical services, as defined in this section, is referred to as "incurred claims." All components of and adjustments to incurred claims, with the exception of contract reserves, must be calculated based on claims incurred only during the MLR reporting year and paid through March 31st of the following year. Contract reserves must be calculated as of December 31st of the applicable year.

(1) If there are any group conversion charges for a health plan, the conversion charges must be subtracted from the incurred claims for the aggregation that includes the conversion policies and this same amount must be added to the incurred claims for the aggregation that provides coverage that is intended to be replaced by the conversion policies. If an issuer transfers portions of earned premium associated with group conversion privileges between group and individual lines of business in its Annual Statement accounting, these amounts must be added to or subtracted from incurred claims.

(2) Incurred claims must include the current year's unpaid claims reserves, including claims reported in the process of adjustment, percentage withheld from payments made to contracted providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.

(3) Incurred claims must include claims incurred but not reported based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.

(4) Incurred claims must include changes in other claims-related reserves.

(5) Incurred claims must include incurred experience rating refunds and exclude rebates paid as required by §158.240 based upon prior MLR reporting year experience.