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 services or supplies covered by the policy. In addition, the report must include claim reserves associated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the 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 withholds 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.

(b) *Adjustments to incurred claims.* (1) Adjustments that must be deducted from incurred claims:

(i)(A) For MLR reporting years before 2022, prescription drug rebates received by the issuer;

(B) Beginning with the 2022 MLR reporting year, prescription drug rebates and other price concessions received and retained by the issuer, and prescription drug rebates and other price concessions that are received and retained by an entity providing pharmacy benefit management services to the issuer and are associated with administering the issuer's prescription drug benefits.

(ii) Overpayment recoveries received from providers.

(iii) Cost-sharing reduction payments received by the issuer to the extent not reimbursed to the provider furnishing the item or service.

(2) Adjustments that must be included in incurred claims:

(i) Market stabilization payments or receipts by issuers that are directly tied to claims incurred and other claims based or census based assessments.

(ii) State subsidies based on a stop-loss payment methodology.

(iii) The amount of 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.

(iv) The amount of claims payments recovered through fraud reduction efforts not to exceed the amount of fraud reduction expenses.

(3) Adjustments that must not be included in incurred claims:

(i) Amounts paid to third party vendors for secondary network savings.

(ii) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management. For example, if an issuer contracts with a behavioral health, chiropractic network, or high technology radiology vendor, or a pharmacy benefit manager, and the vendor reimburses the provider at one amount but bills the issuer a higher amount to cover its network development, utilization management costs, and profits, then the amount that exceeds the reimbursement to the provider must not be included in incurred claims.

(iii) 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. For example, medical record copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks must not be included in incurred claims.

(iv) 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.

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

(i) 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.

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

(5) Other adjustments to incurred claims:

(i) 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 that must be defined by the issuer prior to January 1 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.

(ii) [Reserved]

[75 FR 74921, Dec. 1, 2010, as amended at 75 FR 82278, Dec. 30, 2010; 77 FR 16469, Mar. 21, 2012; 77 FR 28790, May 16, 2012; 78 FR 15539, Mar. 11, 2013; 79 FR 13842, Mar. 11, 2014; 80 FR 10876, Feb. 27, 2015; 85 FR 29262, May 14, 2020; 87 FR 27393, May 6, 2022]

§ 158.150 Activities that improve health care quality.

(a) *General requirements.* The report required in § 158.110 must include expenditures directly related to activities that improve health care quality, as such activities are described in this section.

(b) *Activity requirements.* Activities conducted by an issuer to improve quality must meet the following requirements:

(1) The activity must be designed to:

(i) Improve health quality.

(ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(iii) 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.

(iv) 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.

(2) The activity must be primarily designed to:

(i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.

(A) Examples include the direct interaction of the issuer (including those services delegated by contract for which the issuer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:

(*1*) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in section 3502 of the Affordable Care Act.

(*2*) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.

(*3*) Quality reporting and documentation of care in non-electronic format.

(*4*) Health information technology to support these activities.

(*5*) Accreditation fees directly related to quality of care activities.

(*6*) Commencing with the 2012 reporting year and extending through the first reporting year in which the Secretary requires ICD–10 as the standard medical data code set, implementing ICD–10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in § 158.130.

(B) [Reserved]

(ii) Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

(A) Comprehensive discharge planning (for example, 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;

(B) Patient-centered education and counseling.

(C) Personalized post-discharge reinforcement and counseling by an appropriate health care professional.

(D) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.

(E) Health information technology to support these activities.

(iii) Improve patient safety, reduce medical errors, and lower infection and mortality rates.