

## Dept. of Health and Human Services

## § 158.170

(vii) Payments made by a Federal income tax exempt issuer for community benefit expenditures as defined in paragraph (c) of this section, limited to the highest of either:

(A) Three percent of earned premium; or

(B) The highest 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.

(viii) In lieu of reporting amounts described in paragraph (b)(1)(vi) of this section, an issuer that is not exempt from Federal income tax may choose to report payment for community benefit expenditures as described in paragraph (c) of this section, limited to the highest 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.

(2) State taxes and assessments not excluded from premium under subpart B which include:

(i) State sales taxes if the issuer does not exercise options of including such taxes with the cost of goods and services purchased.

(ii) Any portion of commissions or allowances on reinsurance assumed that represent specific reimbursement of premium taxes.

(iii) Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

(iv) State employment and similar taxes and assessments.

(c) *Community benefit expenditures.* Community benefit expenditures means expenditures 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 any of the following activities that:

(1) Are available broadly to the public and serve low-income consumers;

(2) Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);

(3) Address Federal, State or local public health priorities such as advancing

health care knowledge through education or research that benefits the public;

(4) Leverage or enhance public health department activities such as childhood immunization efforts; and

(5) Otherwise would become the responsibility of government or another tax-exempt organization.

[75 FR 74921, Dec. 1, 2010. Redesignated and amended at 75 FR 82279, Dec. 30, 2010; 76 FR 76593, Dec. 7, 2011; 78 FR 15540, Mar. 11, 2013; 80 FR 10876, Feb. 27, 2015]

### § 158.170 Allocation of expenses.

(a) *General requirements.* 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 types of expenses. Expenditures that benefit lines of business or products other than those being reported, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata share.

(b) *Description of the methods used to allocate expenses.* The report required in § 158.110 must include a detailed description of the methods used to allocate expenses, 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 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.

(1) Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the issuer should provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee

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activities, salary ratios or similar analyses.

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

(3) 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 solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

(c) *Disclosure of allocation methods.* The issuer must identify in the report required in § 158.110 of this subpart the specific basis used to allocate expenses reported under this part to States and, within States, to lines of business including the individual market, small group market, large group market, supplemental health insurance coverage, health insurance coverage offered to beneficiaries of public programs (such as Medicare and Medicaid), and group health plans as defined in § 145.103 of this chapter and administered by the issuer.

(d) *Maintenance of records.* The issuer must maintain and make available to the Secretary upon request the data used to allocate expenses reported under this part together with all supporting information required to determine that the methods identified and reported as required under paragraph (b) of this section were accurately implemented in preparing the report required in § 158.110 of this subpart.

[75 FR 74921, Dec. 1, 2010, as amended at 87 FR 27393, May 6, 2022]

### Subpart B—Calculating and Providing the Rebate

#### § 158.210 Minimum medical loss ratio.

Subject to the provisions of § 158.211 of this subpart:

## 45 CFR Subtitle A (10–1–23 Edition)

(a) *Large group market.* For all policies issued in the large group market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 85 percent, as determined in accordance with this part.

(b) *Small group market.* For all policies issued in the small group market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80 percent, as determined in accordance with this part.

(c) *Individual market.* For all policies issued in the individual market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80 percent, as determined in accordance with this part.

(d) *Adjustment by the Secretary.* If the Secretary has adjusted the percentage that issuers in the individual market in a specific State must meet, then the adjusted percentage determined by the Secretary in accordance with § 158.301 of this part *et seq.* must be substituted for 80 percent in paragraph (c) of this section.

#### § 158.211 Requirement in States with a higher medical loss ratio.

(a) *State option to set higher minimum loss ratio.* For coverage offered in a State whose law provides that issuers in the State must meet a higher MLR than that set forth in § 158.210, the State's higher percentage must be substituted for the percentage stated in § 158.210. If a State requires the small group market and individual market to be merged and also sets a higher MLR standard for the merged market, the State's higher percentage must be substituted for the percentage stated in § 158.210 for both the small group and individual markets.

(b) *Considerations in setting a higher minimum loss ratio.* In adopting a higher minimum loss ratio than that set forth in § 158.210, a State must seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums