(b) *Notice of rebates to subscribers in the individual market.* For each MLR reporting year, at the time any rebate of premium is provided to a subscriber in the individual market in accordance with this part, an issuer must provide each subscriber that is receiving the rebate the following information in a form prescribed by the Secretary:

(1) A general description of the concept of an MLR;

(2) The purpose of setting an MLR standard;

(3) The applicable MLR standard;

(4) The issuer's MLR, adjusted in accordance with the provisions of this subpart;

(5) The issuer's aggregate premium revenue as reported in accordance with §158.130 of this part, minus any Federal and State taxes and licensing and regulatory fees that may be excluded from premium revenue as described in §158.162(a)(1) and (b)(1) of this part; and

(6) The rebate percentage and amount owed to enrollees based upon the difference between the issuer's MLR and the applicable MLR standard.

[76 FR 76593, Dec. 7, 2011]

§158.251 Notice of MLR information.

(a) *Notice of MLR information when the MLR standard is met or exceeded*—(1) *General requirement.* Except as provided in paragraph (b) of this section, for the 2011 MLR reporting year, an issuer whose MLR meets or exceeds the applicable MLR standard required by §158.210 or §158.211 must provide each policyholder and subscriber of a group health plan, and each subscriber in the individual market, a notice in accordance with the requirements of this section.

(2) *Timing.* An issuer must provide the notice required in this paragraph (a) with the first plan document that the issuer provides to enrollees on or after July 1, 2012.

(3) *Form and appearance.* The notice must be prominently displayed in clear, conspicuous 14-point bold type on the front of the plan document or as a separate notice. The notice may be provided electronically, if the requirements for electronic disclosure under section 2715 of the Public Health Service Act are met.

(4) *Language.* The following language must be used to satisfy the notice requirement of this paragraph (a):

Medical Loss Ratio Information—The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and your health insurer's Medical Loss Ratio, visit *www.HealthCare.gov*.''

(b) *Exceptions.* The requirements of paragraph (a) of this section do not apply to an issuer that reports its experience separately under §158.120(d)(3) or (d)(4), or to an issuer whose experience is non-credible as defined in §158.230(c)(3) and determined in accordance with §158.231.

[77 FR 28797, May 16, 2012]

§158.260 Reporting of rebates.

(a) *General requirement.* For each MLR reporting year, an issuer must submit to the Secretary a report concerning the rebates provided to and on behalf of enrollees pursuant to this subpart.

(b) *Aggregation of information in the report.* The information in the report must be aggregated in the same manner as required by §158.120.

(c) *Information to report.* The report required by this section must include the total:

(1) Number of subscribers in the individual, small group and large group markets to whom the issuer paid a rebate directly, and number of small group and large group policyholders receiving a rebate on behalf of enrollees;

(2) Amount of rebates provided as premium credit;

(3) Amount of rebates provided as lump sum payment regardless of whether in cash, reimbursement to an enrollee's credit card, or direct payment to an enrollee's bank account;

(4) Amount of rebates that were de minimis as provided in §158.243 of this subpart and the number of enrollees who did not receive a rebate because it was de minimis; and

(5) Amount of unclaimed rebates, a description of the methods used to locate the applicable enrollees, and a description of how the unclaimed rebates were disbursed.

(d) *Timing and form of report.* The data required by paragraphs (c)(1) through (4) of this section must be submitted with the report under §158.110, on a form and in the manner prescribed by the Secretary. The data required by paragraph (c)(5) of this section must be submitted with the report under §158.110 for the subsequent MLR reporting year.

[75 FR 74921, Dec. 1, 2010, as amended at 76 FR 76594, Dec. 7, 2011]

§158.270 Effect of rebate payments on solvency.

(a) If a State's insurance commissioner, superintendent, or other responsible official determines that the payment of rebates by a domestic issuer in that State will cause the issuer's risk based capital (RBC) level to fall below the Company Action Level RBC, as defined in the NAIC's Risk Based Capital (RBC) for Insurers Model Act, the commissioner, superintendent, or other responsible official must notify the Secretary. In such a circumstance, the commissioner, superintendent, or other responsible official may request that the Secretary defer all or a portion of the rebate payments owed by the issuer.

(b) In the event an insurance commissioner, superintendent, or other responsible official makes the request set forth in paragraph (a) of this section, the following should be provided to the Secretary along with the notification:

(1) The domestic issuer's RBC reports for the current calendar year and the 2 preceding calendar years; and

(2) A calculation of the amount of rebates that would be owed by the domestic issuer pursuant to this part.

(c) Upon receipt of the notification under paragraph (a), the Secretary will examine the information provided by the insurance commissioner, superintendent, or other responsible official along with any other information the Secretary may request from the issuer, and determine whether the payment of rebates by the issuer will cause its RBC level to fall below the Company Action Level RBC.

(d) When the Secretary determines that the payment of rebates by an issuer will cause its RBC level to fall below the Company Action Level RBC, the Secretary may permit a deferral of all or a portion of the rebates owed, but only for a period determined by the Secretary in consultation with the State. The Secretary will require that the issuer must pay these rebates with interest in a future year in which payment of the rebates would not cause the issuer's RBC level to fall below the Company Action Level RBC.

Subpart C—Potential Adjustment to the MLR for a State's Individual Market

§158.301 Standard for adjustment to the medical loss ratio.

The Secretary may adjust the MLR standard that must be met by issuers offering coverage in the individual market in a State, as defined in section 2791 of the PHS Act, for a given MLR reporting year if, in the Secretary's discretion, the Secretary determines that there is a reasonable likelihood that an adjustment to the 80 percent MLR standard of section 2718(b)(1)(A)(ii) of the Public Health Service Act will help stabilize the individual market in that State.

[83 FR 17070, Apr. 17, 2018]