Frequently Asked Questions about the Medical Loss Ratio

Below are answers to some Frequently Asked Questions about the Medical Loss Ratio requirement of the Affordable Care Act of 2010 and impact on selected enrollees in the Federal Employees Health Benefits Program.

What is a Medical Loss Ratio?
A medical loss ratio (MLR) is the proportion of health insurance premiums collected by a health insurer that is spent on clinical services and quality improvement. The MLR for each insurer is calculated by dividing the amount of health insurance premiums spent on clinical services and quality improvement by the total amount of health insurance premiums collected. The MLR is important because it requires health insurers to provide consumers with value for their premium payments.

What is the MLR requirement under ACA?
Starting in 2011, the ACA requires each large group health insurer to spend at least 85% of collected health insurance premiums on clinical services and quality improvement each year or provide a rebate. This is often explained as a plan spending a minimum of $0.85 of every $1.00 paid in health insurance premiums on clinical services and quality improvement, and a maximum of $0.15 of every $1.00 on administrative costs. Each health insurer must reimburse policyholders any difference between the MLR and the 85% minimum expenditure.

Will every Federal Employees Health Benefit (FEHB) plan issue a rebate?
No. Only health insurers failing to meet the minimum MLR will issue rebates to the policyholder. Although administrative costs in the FEHB Program are generally lower than other plans in the large group market, some insurers offering FEHB Plans will owe a rebate because the MLR for an insurer is calculated based on all of the insurer's business in each market within a state. The Office of Personnel Management (OPM) administers the FEHB Program, and is the policyholder for all plans within the FEHB Program. Health insurers for FEHB Plans that have met the MLR standard do not need to issue rebates. OPM will use these rebates to reduce future premiums, as described below.

Who receives the rebate?
OPM is the policyholder for all plans within the FEHB Program. Consistent the Federal Acquisition Regulation Section 31.201, any FEHB Program health insurer failing to meet the minimum MLR will issue rebates directly to OPM. These rebates will be used to reduce the cost of health insurance premiums for that insurer's FEHB Plan for the next plan year.

How will rebates be used?
Any rebates issued by health insurers participating in the FEHB Program will be sent to the Office of Personnel Management and will be deposited into the contingency reserve of the health plan offered by the insurer that paid the rebate and will be used to directly reduce the cost of the next year's health insurance premiums for employees in that insurer's FEHB Plan.

How will I know if my health insurer has issued a rebate?
Health insurers are required to mail notices to their enrollees notifying them if the insurer did or did not meet the MLR standard.

How much is the rebate?
The amount of the rebate depends on each health insurer's MLR. For example, the insurer for a large group plan that spent 80% of health insurance premiums on clinical services and quality improvement would reimburse each large group policyholder (i.e. OPM, for FEHB Plans) the 5% difference between actual expenses (80%) and the minimum requirement (85%). The total dollar amount varies by insurer.

Additional Information

For specific information about your FEHB Plan and the MLR requirement, please contact your health insurance plan.