Q&A | NATIONAL

Health care reform update – medical benefit ratio

As part of the Affordable Care Act (ACA), health plans are required to report their medical benefit ratios (MBRs) to the U.S. Department of Health and Human Services. An MBR (also known as a medical loss ratio) is the amount of premium revenue spent on medical care and services.

- For large groups, the mandated minimum amount is **85% of premium revenue.**
- For small groups, individuals, and student health plans, the minimum amount is **80% of premium revenue.**

Fully insured health plans that don't meet or exceed these amounts are required to issue rebates to customers (groups or individuals). Read the following Q&A for details about this health care reform requirement.

Q: What is a medical benefit ratio?

A: A medical benefit ratio – also called a medical loss ratio – is the percentage of premium revenue spent on health care expenses. It's sometimes seen as an indication of the value consumers get for each dollar they spend on their premium – the higher the percentage, the more of their premium is spent on health care.

Q: Why does Kaiser Permanente use the term "medical benefit ratio"?

A: Kaiser Permanente uses the term "medical benefit ratio" rather than "medical loss ratio" because we believe it more accurately describes the percentage of premiums a health plan spends on care and efforts to help improve quality. We don't consider funds spent on care for members a "loss."

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For more information about the MBR requirements, contact your Kaiser Permanente representative or visit the U.S. Department of Health and Human Services website at **hhs.gov**.

Q: What MBR thresholds do health plans need to meet?

A: For large groups, the minimum amount is 85% of premium revenue. For individuals and small groups, the minimum amount is 80% of premium revenue. Health plans that don't meet or exceed these minimum levels are required to issue rebates to customers.

Q: Do self-funded plans need to meet these thresholds?

A: No. These requirements don't apply to self-funded plans.

Q: How is the MBR calculated?

A: The MBR is calculated by dividing the medical claims or benefits purchased by a health plan by the amount of the premiums paid by all consumers or group customers in a market segment (large group, small group, individual, and student health):

$$\text{Medical benefit ratio} = \frac{\text{Medical benefits purchased by the health plan}}{\text{Premiums paid by all consumers or group customers}}$$

Please note that the MBR isn't calculated on a group-specific basis. Instead, for each market segment in each jurisdiction, the MBR is calculated using combined health plan data related to the costs incurred for covered services. Adjustments are also made to account for quality improvement initiatives and taxes paid to federal and state authorities, and three years of experience may be averaged.

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Q: What were the results of Kaiser Permanente's MBR filing?

A: In our July 31, 2019, final MBR filing for 2018, Kaiser Permanente's MBRs exceeded the required percentages in every jurisdiction and market segment.

Q: Are members being notified about MBR requirements?

A: Health plans that do not meet or exceed the MBR thresholds are required to notify subscribers about the rebate.

Q: Will Kaiser Permanente request more information from customers related to the MBR requirements?

A: If we determine that information is required, we'll request it from our customers and work with them to make sure they have a reasonable amount of time to supply the information.

Information may have changed since publication.

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