Medicare Advantage Medical Loss Ratio Fact Sheet

June 2020

BETTER MEDICARE ALLIANCE

Key Facts:

- Medicare Advantage organizations and Part D sponsors are required to spend at least 85 percent of premiums on medical care and quality improvement activities.
- Statute requires that Medicare Advantage organizations and Part D sponsors are subject to financial penalties, and other enforcement actions if the 85 percent medical loss ratio (MLR) is not met.
- CMS has clearly defined criteria for services that qualify as medical care and quality improvement activities as opposed to administration and profit.
- The COVID-19 pandemic has had unexpected impact on the health care sector including lower than expected utilization of care in 2020.

BMA Recommendation:

BMA recommends that Congress act to modify the MLR requirements in response to the public health emergency by eliminating the year 2020 from the three-year enrollment penalty and the five-year date contracting penalty.

This action will help ensure predictability for Medicare Advantage and promote premium stability, high-quality care delivery, and continued innovation for millions of beneficiaries.

Medical Loss Ratio

Medical Loss Ratio (MLR) is the **proportion of premium revenues that a health insurer spends on medical care and quality improvement activities in contrast to administrative activities and profit.** The MLR is calculated at the Medicare Advantage organization contract level using a defined formula. The sum of incurred medical claims (including supplemental benefits) and activities that improve health care quality[1] is divided by the sum of earned premiums minus allowable deductions.

This requirement was established to promote transparency, beneficiary value, and greater efficiency of Medicare Advantage health plans. A higher MLR indicates a higher proportion of expenditures on direct patient care.

Medical Loss Ratio Rebates and Penalties

As of 2014, the Patient Protection and Affordable Care Act required a minimum MLR of 85 percent for Medicare Advantage organizations and Part D sponsors. These health plan sponsors are required to report their MLRs to the Centers for Medicare & Medicaid Services (CMS) on an annual basis and are subject to financial and other penalties for noncompliance. **Statute requires that organizations with contracts that result in an MLR lower than 85 percent in a given plan year must provide a financial rebate to CMS.**

Medicare Advantage organizations and Part D sponsors that do not meet the minimum MLR threshold for three consecutive years are subject to an enrollment penalty and are prohibited from accepting new beneficiaries. Organizations that do not meet the minimum MLR threshold for five consecutive years are subject to contract termination. These penalties are severe, and only once has CMS subjected a plan to such penalties due to noncompliance with the minimum MLR requirements. This demonstrates the attention paid by health plans to the MLR requirements and the value that has resulted for beneficiaries.

Impact of COVID-19 on Health Care Utilization

Due to the novel coronavirus (COVID-19) pandemic and the stay at home orders, Medicare Advantage health plans are experiencing a significant reduction in health care utilization. Early signs indicate that a return to normal rates of utilization of care will be slow. In addition, COVID-19 continues to require precautions to keep individuals, particularly older adults, safe and away from others. Health plans and providers have responded with increased access to telehealth, coverage for additional services, and lower cost sharing for beneficiaries. Yet, due to these almost universal impacts, **MLRs will likely be below the 85 percent standard in 2020 for many health plans.**

[1] Quality improvement activities must meet the criteria outlined by CMS. Specifically, the activity must be designed to: improve health quality; increase the likelihood of desired health outcomes in ways that can be objectively measured and produce verifiable results; 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; and be grounded in evidence-based medicine, clinical best practices, or criteria issued by recognized nationally recognized health care quality organizations.