



State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations (as of April 15, 2010)

Background: Medical loss ratios (MLRs) for comprehensive, major medical health insurance products have been employed for diverse purposes by a broad range of users, including insurance companies, managed care companies, legislators, regulators, investors, lenders, and consumer advocates.

- Some of the uses include the evaluation of an organization's performance by management and investors, providing consumers with information on the relative quality of competing health plans, projecting future earnings growth of health maintenance organizations (HMOs), and testing products against minimum loss ratio standards.
- Loss ratios have also been proposed as a method to compare and evaluate insurers and managed care organizations in a variety of ways. Proposed uses include health insurance illustration requirements, accounting standards, consumer quality measures, and solvency regulation.¹

Federal Health Care Reform: In 2010, President Obama signed into law the Patient Protection and Affordable Care Act, followed the Health Care and Education Reconciliation Act of 2010. The bills (as

enacted) amend the Public Health Service Act to require medical loss ratios of 85 percent for large group products and 80 percent for small group and individual products, effective January 1, 2011. The bill requires health insurance issuers failing to meet the requirement to provide rebates to policyholders, and permits the Secretary of Health and Human Services (in coordination with the National Association of Insurance Commissioners) to adopt standard definitions for calculating claims costs and non-claims costs.

NAIC model: In 1980, the National Association of Insurance Commissioners (NAIC) adopted the *Guidelines for Filing of Rates for Individual Health Insurance Forms (Guidelines)*. The Guidelines establish loss ratios as a standard for determining whether benefits under individual medical expense policies are reasonable in relation to premiums. Generally, the Guidelines use the following minimum loss ratios for new forms for purposes of deeming that premiums are reasonable for the indicated type of policy:

- optionally renewable (renewal is at the option of the insurance company) - 60%;
- conditionally renewable (renewal can be declined by class, by geographic area, or for stated reasons other than deterioration of health) - 55%;
- guaranteed renewable (renewal cannot be declined by the

¹ Excerpted from "Loss Ratios and Health Coverages," Loss Ratio Work Group, American Academy of Actuaries, November 1998.

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insurance company for any reason, but the company can revise rates on a class basis) - 55%; and

- non-cancelable (renewal cannot be declined and rates cannot be revised by the insurance company) - 50%.
- There are no similar NAIC Guidelines for small group products.

Reporting Requirements: Section 1(B) of the NAIC Guidelines requires that each rate submission include an actuarial memorandum describing the “anticipated loss ratio” for that rate and the method by which it was calculated.

- Section 1(C) of the NAIC Guidelines requires that each time a rate revision for a previously approved policy, rider or endorsement form is filed, the loss ratio be submitted with a history of the experience under the current rate.

Approaches: Thirty-four states (AZ, AR, CA, CO, CT, DE, FL, GA, IA, KS, KY, ME, MD, MA, MI, MN, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, SC, SD, TN, UT, VT, VA, WA, and WV) establish MLR guidelines, require the filing or reporting of loss ratio information with state regulators, or impose limitations on administrative expenses for comprehensive, major medical insurance.

MLR requirements in the Individual Market: Ten states (AZ, DE, IA, KS, MA, NC, SC, TN, UT, and VA) have adopted the NAIC Guidelines for use in their respective individual markets.

- MI, NH and SD have adopted loss ratio structures that are very similar to the NAIC Guidelines.
- Thirteen states impose specific MLR requirements for products sold in the individual market:
 - PA imposes an initial 50 percent MLR and a 60 percent renewal MLR;
 - ND requires a 55 percent MLR;
 - MD and WV mandate a 60 percent MLR;
 - CO, KY, and ME require a 65 percent MLR;
 - CA and VT mandate a 70 percent MLR;
 - MN establishes a general 72 percent MLR, with a reduction to

68 percent for companies assessed less than 3 percent of the total annual assessment by the state’s high-risk pool;

- WA establishes a general 74 percent MLR, with an increase up to 77 percent for organizations with a declination rate in the individual market of more than 8 percent;
- NM permits the Division of Insurance to set minimum MLR requirements, but establishes a floor of 75 percent beneath which the requirement may not go;
- NY requires a 75 percent MLR; and
- NJ establishes an 80 percent MLR.

MLR requirements in the Group Market²: Two states (AZ and UT) implemented the NAIC Guidelines for their entire group markets.

- DE extends the NAIC Guidelines for its small group market for employers with 24 or fewer employees.
- MI and NH adopted a loss ratio structure that is similar to the NAIC Guidelines for its small group market.
- Nine states (CO, KY, ME, MD, MN, NJ, NY, OK, and WV) impose mandatory MLR on small employer products sold in their respective states that range from 60 to 82 percent.
- Four states (CA, FL, ND, and SD) set minimum MLRs, ranging from 65 to 75 percent, across their entire group markets.
- CO also imposes an 85 percent MLR for products sold in the state’s large group market.
- NM imposes an 85 percent MLR for products sold in the state’s large and small group markets.

Other Approaches: Rather than establishing a minimum MLR requirement, laws in four states (CA, NJ, OH, and TN) require either HMOs or certain types of insurance companies to limit administrative expenses to a specified percentage of premiums.

² Unless otherwise noted, references to the small group market here conform to standards included in the Health Insurance Portability and Accountability Act (HIPAA) defining small groups as groups having between two and fifty eligible employees. For details regarding state-specific small group size, please see the entry included in this chart for the applicable state.

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- Two states set loss ratio requirements by type of organization – NJ health service corporations must meet a 75 percent MLR and NC HMOs must meet MLRs that range from 55 to 75 percent based on type of product.
- Four states mandate specific MLRs by type of product -- AR (point-of-service and minimum basic benefit plans), CA (mass-marketed policies), CT (special health care plans for small groups), and SD (short-term medical).

Filing and Reporting Requirements: Twelve states (DE, FL, MD, MN, NH, NJ, NY, OR, UT, VA, WA, and WV) generally require the submission of loss ratio data with rate filings.

- AR, CT, and GA require the filing of loss ratio guarantees for the individual market, while OR requires such a filing for both its individual and group markets.
- Six states (IA, KS, KY, MA, PA and TN) mandate the submission of an actuarial certification of the loss ratio with any rate filings in the individual market.
 - CA and MI impose a similar requirement for its individual and group markets.
 - KY requires an actuarial certification of the MLR for rate filings in the small group market.
- Some states (AR, CT, GA, NJ, OR, and WA) have specific filing or reporting requirements for certain products or entities that mandate the disclosure of MLR data without imposing an accompanying specific loss ratio requirement.

Premium Refunds, Dividends or Credits: MLR laws in six states – ME, NJ, NM, NY, NC and SC – require carriers to issue a dividend, credit or refund to policyholders for failure to comply with the requirements.

2010 state activity: To date, two states have adopted new MLR requirements in 2010 for comprehensive, major medical coverage:

- NH has adopted loss ratio requirements similar to the NAIC model based on product renewability, but has incorporated higher MLR thresholds.
- NM implemented loss ratio requirements of 85 percent (large and small group) and 75 percent (individual).

Chart: This chart contains detailed information on the NAIC guidelines and the thirty-two (34) state MLR or administrative cost requirements for comprehensive, major-medical type coverage offered in the individual and group markets. If the statute or regulation establishing the requirement also contains definitions of either MLR or administrative costs, those are also shown. The document also provides information on specific state filing and reporting requirements for MLRs or administrative costs, where applicable.

- This chart does not include state mandatory minimum MLR requirements for long-term care, Medicare supplement and/or disability income insurance. For state MLR laws for these supplemental health products, please see the companion document to this chart – *State Mandatory Medical Loss Ratios (MLRs) for Long-Term Care, Medicare Supplement, and Disability Income Insurance: Summary of State Laws and Regulations*.

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<p>“Patient Protection and Affordable Care Act” (Sec. 2718 of the Public Health Service Act)</p> <p>Enacted 2010 Effective 01/01/2011</p>	<p>Health insurers</p>	<p>Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—</p> <ul style="list-style-type: none"> • with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or • with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.³ 	<p>Directs the Secretary of the Department of Health and Human Services, in consultation with the National Association of Insurance Commissioners, to establish uniform definitions.</p>

³ § 1304(b)(2) of the Patient Protection and Affordable Care Act defines “*small employer*” to mean an employer who employed an average of at least one but not more than one hundred employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

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<p>NAIC <i>Guidelines for Filing of Rates for Individual Health Insurance Forms (Model 134)</i></p> <p>Adopted 1980</p>	<p>Individual</p>	<p>Establishes the following anticipated loss ratios as “safe harbors” for new policies for determining the reasonableness of benefits in relation to premiums:</p> <ul style="list-style-type: none"> • optionally renewable (renewal is at the option of the insurer) – 60%; • conditionally renewable (renewal can be declined by class, by geographic area, or for stated reasons other than deterioration of health) - 55%; • guaranteed renewable (renewal cannot be declined by the insurer for any reason, but the insurer can revise rates on a class basis) - 55%; and • non-cancelable (renewal cannot be declined and rates cannot be revised by the insurer) - 50%. <p>Requires each initial rate submission to include an actuarial memorandum describing the anticipated loss ratio and the method used to calculate the loss ratio.</p> <p>Requires the submission of loss ratio information, including a history of the experience under the current rate, with any rate revision request for a previously approved policy, rider or endorsement.</p>	<p><i>Anticipated loss ratio</i> means the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage.</p> <p>The NAIC annual statement blank defines <i>loss ratio</i> as “a measure of the relationship between accident and health (A & H) claims and premiums.”</p>
<p>Arizona <i>Ariz. Admin. Code R20-6-604; and R20-6-607</i></p> <p>Enacted 1981</p>	<p>Individual and group</p>	<p>Follows the NAIC Model for policies with annual premiums of at least \$200.</p> <ul style="list-style-type: none"> • For policies with annual premiums between \$100 and \$200 subtract 5% from allowable MLRs. • For policies with annual premiums less than \$100 and subtract 10% from allowable MLRs. <p>Requires that each rate submission include an actuarial certification of the loss ratio and the method of calculation.</p>	<p><i>Actual loss ratio</i> means incurred claims divided by earned premiums at rates in use.</p>

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<p>Arkansas <i>Ark. Code Ann. §23-98-102; §23-98-110; and Regulation 52</i></p> <p>Enacted 1991, 1991, and 1992</p>	Minimum basic benefit policies	<p>Establishes MLRs of no less than:</p> <ul style="list-style-type: none"> • 65% for individual policies and group policies issued to qualified trusts; and • 75% for all other group policies. <p>Prohibits rates from being approved without a statement certifying the reasonableness of benefits in relation to premiums.</p>	<p>“<i>Loss ratio</i>” means the percentage derived by dividing incurred claims, both reported and not reported, by total premiums earned.</p>
<p>Arkansas <i>Ark. Code Ann. §23-79-110</i></p> <p>Enacted 1991 Amended 2001</p>	Individual	<p>No specific MLR requirement.</p> <p>Requires rate filings to contain a loss ratio guarantee in order for the benefits of the policy to be deemed reasonable in relation to premiums.</p>	<p>“<i>Loss ratio</i>” means the ratio of incurred claims to earned premium by number of years of policy duration, for all combined durations.</p>
<p>Arkansas <i>Ark. Code Ann. §23-86-404</i></p> <p>Enacted 1999</p>	HMOs	<p>Establishes an MLR of no less than 80% for point of service (POS) plans.</p>	No definitions.
<p>California <i>Cal. Health & Safety Code §1378 and Cal. Code Regs. Tit. 28, §1300.78</i></p> <p>Enacted 1976</p>	HMOs (health care service plans)	<p>No specific MLR requirement.</p> <p>Prohibits excessive administrative costs and considers them reasonable if they do not exceed 25% during the development phase or 15% in all other circumstances.</p>	<p>Administrative costs include:</p> <ul style="list-style-type: none"> • salaries, bonuses, and benefits paid or incurred with respect to the officers, directors, partners, trustees, or other principal management of the plan; • the cost of soliciting and enrolling subscribers and enrollees; • the cost of receiving, processing, and paying claims, excluding the actual amount paid on

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			<p>such claims;</p> <ul style="list-style-type: none"> • legal and accounting fees and expenses; • the premium on the fidelity and surety bonds, and any statutorily required insurance, excluding medical liability insurance; • all costs associated with the establishment and maintenance of provider agreements and the cost of reviewing utilization of health care services on a referral basis; and • the direct or pro rata portion of all expenses incurred in the operation of the plan which are not essential to the provision of health care services, including but not limited to office supplies and equipment, clerical services, interest expense, insurance, dues and subscriptions, licenses (other than licenses for medical facilities, equipment or personnel), utilities, telephone, travel, rent, repairs and maintenance, depreciation of facilities and equipment, and charitable or other contributions.
<p>California <i>Cal. Code Regs. Tit. 10, §2222.10 to §2222.12, and §2222.19</i></p> <p>Enacted 1961 Amended 2006</p>	<p>Individual and group mass-marketed policies</p>	<p>Establishes a 70% MLR.</p> <p>Requires that a company shall, by April 1st of each year, submit a statement from a qualified actuary certifying the loss ratio for each policy the company provides.</p>	<p>No definitions.</p>
<p>Colorado <i>Colo. Rev. Stat. §10-</i></p>	<p>Individual and group</p>	<p>Establishes the following MLRs:</p> <ul style="list-style-type: none"> • 65% for individual; 	<p>“<i>Benefits ratio</i>” means the ratio of the value of the actual benefits, not including dividends, to the</p>

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<p><i>16-102; §10-16-107, as amended by H.B. 1389 (2008); and 3 Colo. Regs. §702-4</i></p> <p>Enacted 1992 Amended 2008</p>		<ul style="list-style-type: none"> • 80% for small group (1 to 50); and • 85% for large group. <p>Rate filings must contain an expected benefit ratio guarantee for the benefits of the policy to be deemed reasonable in relation to premiums.</p>	<p>value of the actual premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage.</p> <p><i>“Targeted loss ratio”</i> means the ratio of the expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage to the expected earned premium over the same period.</p>
<p>Connecticut <i>Conn. Agencies Regs §38a-478u-5 and Conn. Gen. Stat. §38a-478c and §38a-478g</i></p> <p>Enacted 1996, 1997, and 1997</p>	Managed care organizations (MCOs)	<p>No specific MLR requirement.</p> <p>On or before May 1st of each year, requires each insurer to submit, among other things, information necessary for the commissioner to assess plans, including loss ratios.</p>	<p><i>“Medical loss ratio”</i> is defined as the percentage of the total premium revenues spent on medical care compared to administrative costs and plan marketing, and how it compensates health care providers at its premium level.</p>
<p>Connecticut <i>Conn. Gen. Stat. §38a- 481</i></p> <p>Enacted 1990</p>	Individual	<p>No specific MLR requirement.</p> <p>Filing of premium rates shall include a loss ratio guarantee including anticipated loss ratios.</p>	<p><i>“Medical loss ratio”</i> means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.</p>
<p>Connecticut <i>Conn. Gen. Stat. §38a-570</i></p>	Small group – special health care plans	<p>Establishes an 80 percent MLR for special health care plans issued through the Health Reinsurance Association (HRA) to small employers (defined as employers with 10 or fewer eligible employees with the majority of the eligible</p>	No definitions.

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Enacted 1990 Amended 2008 ⁴		employees low-income workers).	
Delaware <i>Code Del. Regs. 18 1300, 1305</i> Enacted 1991	Individual and small groups of 24 or fewer persons	Follows the NAIC Model. Requires each individual policy or plan to have its loss ratio filed with the commissioner’s office. Requires rate revisions to be accompanied by expected and actual loss ratios for the current rate, as well as the expected loss ratios underlying the proposed change.	No definitions.
Florida <i>Fla. Stat. chs. 627.410, 627.411 and 627.6561</i> Enacted 1988, 1988, and 1992 Amended 2003	Individual and group	Establishes a 65% MLR. Requires loss ratios to be filed with initial policy filing as well as renewals.	<p>“Loss ratio” means incurred claims to earned premium.</p> <p>“Claims” include scheduled benefit payments or services provided by a provider or through a provider network for dental, vision, disability, and similar health benefits.</p> <ul style="list-style-type: none"> • Claims do not include state assessments, taxes, company expenses, or any expense incurred by the company for the cost of adjusting and settling a claim, including the review, qualification, oversight, management, or monitoring of a claim or incentives or compensation to providers for other than the provisions of health care services. • Companies can include in claims costs items that are demonstrated to reduce claims, such as fraud intervention programs or case management costs, which are identified in each

⁴ Connecticut S.B. 310 (2008) amended the requirements for the state’s small group special health care plans, including the repeal of the 75 percent MLR imposed under §38a-565 for special health care plans issued by carriers in the small group market.

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			filing, are demonstrated to reduce claims costs, and do not result in increasing the experience period loss ratio by more than 5%.
<p>Georgia <i>Ga. Code Ann. §33-29-19</i></p> <p>Enacted 1992 Amended 1993</p>	Individual	<p>No specific MLR requirement.</p> <p>Establishes procedures for filing of optional loss ratio guarantee.</p>	“ <i>Loss ratio</i> ” means the rate of incurred claims to earned premiums.
<p>Iowa <i>Iowa Admin. Code §§191-36.09(2) and 191-36.10(514D)</i></p> <p>Enacted 1981 Amended 1998</p>	Individual	<p>Follows the NAIC Model for policies with annual premiums of at least \$200.</p> <ul style="list-style-type: none"> • For policies with annual premiums between \$100 and \$200 subtract 5% from allowable MLRs. • For policies with annual premiums less than \$100 subtract 10% from allowable MLRs. <p>Requires that each rate submission include an actuarial certification of the loss ratio and the method of calculation.</p>	No definitions.
<p>Kansas <i>Kan. Admin. Regs. 40-4-1</i></p> <p>Enacted 1981 Amended 2003</p>	Individual	<p>Follows the NAIC Model for policies with annual premiums of at least \$200.</p> <ul style="list-style-type: none"> • For policies with annual premiums between \$100 and \$200 subtract 5% from allowable MLRs. • For policies with annual premiums less than \$100 subtract 10% from allowable MLRs. <p>Requires that each rate submission include an actuarial certification of the loss ratio and the method of calculation.</p>	“ <i>Loss ratio</i> ” means a measure of the relationship between A&H claims and premiums.

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<p>Kentucky <i>Ky. Rev. Stat. Ann. §304.17A-095 and 806 Ky. Admin. Regs. 17:150</i></p> <p>Enacted 1996 Amended 2005 and 2007</p>	Individual and small group health benefit plans	<p>Establishes the following MLRs:</p> <ul style="list-style-type: none"> • 65% for individual; • 70% for small group (2–10); and • 75% for small group (11–50).⁵ <p>Requires that each rate submission include an actuarial certification of the loss ratio and the method of calculation.</p>	<p>“Loss ratio” means the ratio of the sums of incurred losses and the change in policy reserves divided by the premiums.</p>
<p>Maine <i>Me. Rev. Stat. Ann. Tit. 24-A, §2736-C</i></p> <p>Enacted 1993 Amended 2005</p>	Individual	Establishes a 65% MLR.	No definitions.
<p>Maine <i>Me. Rev. Stat. Ann. Tit. 24-A, §2808-B</i></p> <p>Enacted 1991 Amended 2008</p>	Small group	<p>Establishes a 75% MLR.</p> <ul style="list-style-type: none"> • Carriers may opt to file for purely informational purposes with a guaranteed loss ratio requirement. In this situation, a refund to policyholders must be issued for failure to meet a 78% loss ratio over a 36-month period. The refund must be distributed in an amount reasonably calculated to correspond to the aggregate experience of all policyholders having similar benefits. 	No definitions.
<p>Maryland <i>Md. Code Ann. Ins.</i></p>	Individual and small group	Permits the commissioner to require filing of new rates if loss ratios are less than:	<p>“Loss ratio” means the ratio of incurred claims to premiums earned.</p>

⁵ New policies without credible experience have to meet no less than a minimum of 60% of the required loss ratios specified in three months, and by six months must meet the guaranteed minimum loss ratio of the policy (*806 Ky. Admin. R. § 8(2)(a)*).

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<p>§15- 605</p> <p>Enacted 1997 Amended 2005</p>		<ul style="list-style-type: none"> • 60% for individual; and • 75% for small group. <p>Requires that new and annual submissions contain the anticipated and actual loss ratios.</p>	
<p>Massachusetts <i>Mass. Regs. Code tit. 211, §42.04, §42.06</i></p> <p>Enacted 2003</p>	Individual	<p>Follows the NAIC Model.</p> <p>Requires that each rate submission include an actuarial certification of the loss ratio and the method of calculation.</p>	<p><i>“Anticipated loss ratio”</i> means the present value of the expected future benefits divided by the present value of expected future premiums, using a reasonable interest rate and assumptions as to the distribution of the policy.</p>
<p>Michigan <i>Mich. Admin. Code r.500.802, 500.803</i></p> <p>Enacted 1974</p>	Individual	<p>Establishes the following MLRs:</p> <ul style="list-style-type: none"> • collectively renewable - 60%; • optionally renewable - 60%; • guaranteed renewable - 55%; and • non-cancelable - 50%. <p>Requires that each rate submission include an actuarial certification of the loss ratio and the method of calculation.</p>	<p><i>“Anticipated loss ratio”</i> means the ratio of the present value of expected future benefits to the present value of future premiums.</p>
<p>Minnesota <i>Minn. Stat. §62A. 021 and §62L. 08</i></p> <p>Enacted 1992 Amended 2006</p>	Individual and small group	<p>Establishes the following MLRs:</p> <ul style="list-style-type: none"> • 72% for individual; and • 82% for small group. <p>Sets different ratios for companies assessed less than 3% of the total annual amount assessed by the state’s high risk pool as follows:</p>	<p>No definitions by statute or regulation.</p> <p>A Minnesota Department of Commerce report⁶ defines loss ratio as the ratio of incurred claims to earned premiums.</p> <ul style="list-style-type: none"> • The report defines incurred claims as the paid-on- incurred claims for the year, plus a reserve

⁶ Minnesota Department of Commerce, *Report of 2008 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies, Nonprofit Health Service Plan Corporations and Health Maintenance Organizations* (June 2009).

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		<ul style="list-style-type: none"> • 68% for individual; • 71% for small groups with less than 10 employees; and • 75% all other small groups. <p>All filings of rates and rating schedules are required to demonstrate that actual claims to actual premiums comply with MLR requirements.</p> <p>Filings for rate revisions should show that the loss ratio for the entire time for which the rate is computed meets the requirements.</p>	<p>for claims incurred but not yet paid, plus the change in any other reserves held, plus the expenses incurred during the year for the following items, where expenses for a functional area should include allocated costs such as data processing equipment, office space, management, overhead, etc.</p>
<p>New Hampshire <i>New Hamp. Code Admin. R. § 4102</i></p> <p>Adopted 2010 Effective 04/09/2010</p>	<p>Expense based individual health insurance policies, riders, or endorsement forms, except long term care insurance, Medicare supplement insurance, credit insurance, or disability income insurance.</p>	<p>For new policies, requires submissions to include anticipated loss ratio, including a description of how it was calculated and anticipated durational loss ratio assumptions when applicable. For rate revisions, requires filings to include the anticipated future loss ratio and a description of how it was calculated, along with the anticipated loss ratio that combines past and future experience, and a description of how it was calculated.</p> <p>With respect to new forms that are neither low average premium forms nor high average premium forms, benefits shall be deemed reasonable provided that the anticipated loss ratio is at least as great as:</p> <ul style="list-style-type: none"> • Seventy-five percent for optionally renewable, medical expense coverage; • Seventy percent for conditionally renewable medical expense coverage; • Sixty-five percent for guaranteed renewable medical expense coverage; • Sixty-five percent for non-cancelable medical expense coverage; 	<p><i>“Anticipated durational loss ratio”</i> means the ratio of the expected benefits to the expected premiums calculated for a specific policy year.</p> <p><i>“Anticipated loss ratio”</i> means the ratio of the present value of the expected benefits to the present value of the expected premiums calculated over the lesser of 20 years or the lifetime of the policy.</p>

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		<p>With respect to low average premium forms, benefits shall be deemed reasonable if the anticipated loss ratio is at least as great as the appropriate loss ratio above multiplied by the ratio of (1) the sum of I times 500 plus the expected average annual premium for the policy form over I times 750; and (2) an anticipated loss ratio of not less than fifty percent.</p> <p>With respect to high average premium forms, benefits shall be deemed reasonable provided that the anticipated loss ratio is at least as great as either the appropriate loss ratio from above plus five percentage points or the appropriate loss ratio from above multiplied by the ratio of (1) the sum of I times 4000 and the expected average annual premium for the policy form over I times 5500, and (2) an anticipated loss ratio of not more than eighty-five percent.</p> <p>For rate revisions, if the policy forms constitute an open block that is still being actively marketed, benefits shall be deemed reasonable provided the revised rates meet the following standards derived from the previously approved rate filing for the form or forms:</p> <ul style="list-style-type: none"> • The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage shall be at least as great as the anticipated loss ratio calculated over the entire future period using the durational loss ratios from the previously approved rate filing; and • The anticipated loss ratio shall be at least as great as the anticipated loss ratio from the previously approved filing where the anticipated loss ratio shall be computed by dividing (a) the sum of the accumulated benefits from the original effective date of the form to the effective date of the revision, and the present value of 	

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		future benefits, and (b) the sum of the accumulated premiums from the original effective date of the form to the effective date of the revision, and the present value of future premiums.	
<p>New Hampshire <i>New Hamp. Code Admin. R. § 4103</i></p> <p>Adopted 2010 Effective 04/09/2010</p>	Small employer group health insurance (1 to 50)	<p>With respect to forms that are neither low average premium forms nor high average premium forms, benefits shall be deemed reasonable in relation to the proposed premiums provided the anticipated loss ratio is at least as great as eighty percent.</p> <p>With respect to low average premium forms, benefits shall be deemed reasonable in relation to the premiums provided the anticipated loss ratio is at least as great as the appropriate loss ratio from above multiplied by the ratio of (1) the sum of I times 500 plus the expected average annual premium for the policy form over I times 750, and (2) an anticipated loss ratio of not less than fifty percent.</p> <p>With respect to high average premium forms, benefits shall be deemed reasonable in relation to the premiums provided the anticipated loss ratio is at least as great as either the appropriate loss ratio plus five percentage points or the appropriate loss ratio multiplied by the ratio of (1) the sum of I times 4000 and the expected average annual premium for the policy form over I times 5500, and (2) an anticipated loss ratio of not more than 85 percent.</p>	<p>“<i>Anticipated durational loss ratio</i>” means the ratio of the expected benefits to the expected premiums calculated for a specific policy year.</p> <p>“<i>Anticipated loss ratio</i>” means the ratio of the present value of the expected benefits to the present value of the expected premiums calculated over the lesser of 20 years or the lifetime of the policy.</p> <p>“<i>Carrier</i>” means any entity that provides health insurance in this state, including insurance companies, health service corporations, health maintenance organizations, fraternal benefit societies, and other benefits subject to state insurance regulation.</p> <p>“<i>Small employer</i>” means any person, firm, corporation, partnership or group of affiliated companies eligible to file a combined tax return and that is actively engaged in business that, on at least fifty percent of the working days during the preceding calendar year, employed at least one employee and no more than fifty employees, the majority of whom are employed within this state.</p>
<p>New Hampshire <i>New Hamp. Code Admin. R. § 4104</i></p>	Large employer group health insurance	Requires supporting documentation for rate filings to included paid loss ratio for each previous calendar year.	“ <i>Anticipated durational loss ratio</i> ” means the ratio of the expected benefits to the expected premiums calculated for a specific policy year.

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<p>Adopted 2010 Effective 04/09/2010</p>		<p>For new policy forms that are neither low average premium forms nor high average premium forms, benefits shall be deemed reasonable provided the anticipated loss ratio is at least as great as eighty percent.</p> <p>With respect to low average premium forms, benefits shall be deemed reasonable provided the anticipated loss ratio is at least as great as the appropriate loss ratio multiplied by the ratio of (1) the sum of I times 500 plus the expected average annual premium for the policy form over I times 750, and (2) an anticipated loss ratio not less than fifty percent.</p> <p>With respect to high average premium forms, benefits shall be deemed reasonable in relation to premiums provided that the anticipated loss ratio is at least as great as either the appropriate loss ratio plus five percentage points or the appropriate loss ratio multiplied by the ratio of (1) the sum of I times 4000 and the expected average annual premium for the policy form over I times 5000, and (2) an anticipated loss ratio of not more than 85 percent.</p>	<p>“<i>Anticipated loss ratio</i>” means the ratio of the present value of the expected benefits to the present value of the expected premiums calculated over the lesser of 20 years or the lifetime of the policy.</p> <p>“<i>Large employer</i>” means any person, firm, corporation, or partnership that is actively engaged in business that, on at least fifty percent of working days during the preceding calendar year, employs at least 51 employees who are eligible for employer sponsored coverage, and the majority of whom are employed within this state.</p>
<p>New Jersey <i>N.J. Stat. Ann.</i> §17B:27A-25 and §17B:27A-9</p> <p>Enacted 1992 Amended 2008</p> <p><i>N.J. Admin. Code</i> 11:20-7.4 and 11:21-7A.2</p>	<p>Individual and small group (standard and non-standard policies)</p>	<p>Establishes an 80% MLR.</p> <ul style="list-style-type: none"> • A dividend or credit towards future premiums for all policyholders must be issued for failure to comply. <p>Requires carriers to annually report by August 1st of each year, the calculated loss ratio for the previous year.</p>	<p>No definitions.</p>

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<p>New Mexico TBD (HB 2010-0012)</p> <p>Enacted 2010 Effective TBD (ninety days after adjournment)</p>	<p>Health insurance</p>	<p>For group health insurance:</p> <ul style="list-style-type: none"> • Requires insurers to make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines. <p>For individually underwritten health care policies, plans or contracts:</p> <ul style="list-style-type: none"> • Directs the superintendent to establish the level of reimbursement for direct services as a percent of premiums. • In setting the level, requires the superintendent to consider costs associated with individual marketing and medical underwriting of policies at a level not less than seventy-five percent of premiums. <p>Insurers failing to comply with the reimbursement requirements shall issue a dividend or credit against future premiums in an amount sufficient to assure that the benefits paid during the preceding three calendar years plus the amount of dividends or credits are equal to the required direct services reimbursement.</p>	<p>“<i>Direct services</i>” means services rendered to an individual by a health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of assessment that covers services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act. provided, however, that ‘direct services’ does not include care coordination, utilization review or management, or any other activity designed to manage utilization or services.</p> <p>“<i>Health insurer</i>” means a person duly authorized to transact the business of health insurance but does not include a person that only issues a limited-benefit policy intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income.</p> <p>“<i>Premium</i>” means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from third parties or other insurers and interests less any premium tax paid and fees associated with participating in a health insurance exchange that</p>

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			serves as a clearinghouse for insurance.
<p>New Mexico TBD (HB 2010-0012)</p> <p>Enacted 03/09/2010 Effective TBD (ninety days after adjournment)</p>	Small group	<p>Directs insurers to make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines over the preceding three calendar years as determined by reports filed with the insurance division.</p> <p>Insurers failing to comply with the eighty-five percent reimbursement requirement shall issue a dividend or credit against future premiums to all policyholders in an amount sufficient to assure that the benefits paid in the preceding three calendar years plus the amount of dividends or credits equal eighty-five percent of premiums collected in the preceding three calendar years.</p>	<p>“<i>Direct services</i>” means services rendered to an individual by a health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of assessment that covers services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act. Provided, however, that ‘direct services’ does not include care coordination, utilization review or management or any other activity designed to manage utilization or services.</p> <p>“<i>Health insurer</i>” means a person duly authorized to transact the business of health insurance but does not include a person that only issues a limited-benefit policy intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income.</p> <p>“<i>Premium</i>” means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from third parties or other insurers and interests less any premium tax paid and fees associated with</p>

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			<p>participating in a health insurance exchange that serves as a clearinghouse for insurance.</p> <p><i>“Small employer”</i> means any person, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent of its working days during either of the two preceding years, employed no less than two and no more than fifty eligible employees, provided that (1) in determining the number of eligible employees, the spouse or dependent of an employee may, at the employer’s discretion, be counted as a separate employee, (2) companies that are affiliated or that are eligible to file a combined tax return shall be considered one employer, and (3) in the case of an employer that was not in existence throughout a preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on working days in the current calendar year (<i>N.M. Stat. §59A-23C-3</i>).</p>
<p>New Mexico TBD (HB 2010-0012)</p> <p>Enacted 03/09/2010 Effective TBD (ninety days after adjournment)</p>	<p>Health maintenance organizations and nonprofit health care plans</p>	<p>An HMO or health care plan shall make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines, except individually underwritten. Reimbursement shall be made for direct services provided over the preceding three calendar years, but not earlier than calendar year 2010.</p> <p>For individuall underwritten health care policies, plans or contracts, the superintendent shall establish the level for direct services as a percent of premiums. In establishing the level, the superintendent shall consider the costs associated</p>	<p><i>“Direct Services”</i> means services rendered to an individual by an HMO or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of an assessment that covers services rather than administration and for which an insurer does receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act; provided, however, that ‘direct</p>

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		<p>with the individual marketing, and medical underwriting, of these policies, plans or contracts at a level not less than seventy-five percent of premiums.</p> <p>An HMO or health care plan that fails to comply with the reimbursement requirements shall issue a credit or dividend against future premiums to all policy or contract holders in an amount sufficient to assure that the benefits paid in the preceding three calendar years plus the amount of the dividends or credits are equal to the require direct services reimbursement level.</p>	<p>services’ does not include care coordination, utilization review or management, or any other activity designed to manage utilization or services.</p> <p>“<i>Health maintenance organization</i>” means any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles, but does not include a person that only issues a limited-benefit policy or contact intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only or hospital-indemnity only insurance policies, or that only issues policies for long-term care or disability income.</p> <p>“<i>Health care plan</i>” means a nonprofit corporation authorized by the superintendent to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles, but does not include a person that only issues a limited-benefit policy or contact intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only or hospital-indemnity only insurance policies, or that only issues policies for long-term care or disability income.</p> <p>“<i>Premium</i>” means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from</p>

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			third parties or other insurers and interest less any premium tax paid and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance.
<p>New York <i>N.Y. Ins. Law §3231</i></p> <p>Enacted 1992 Amended 2006</p>	Individual and small group	<p>Establishes a 75% MLR.</p> <p>Requires a dividend or credit towards future premiums for all policyholders to be issued for failure to comply. The credit is required to be prorated based on the direct premium earned for the year among all policy holders eligible to receive a dividend or credit. For former policyholders, carriers are required to make a reasonable effort to identify the location of the policyholder and issue the dividend or credit. If the former policyholder cannot be located, the carrier has the option of prospectively adjusting premium rates by the amount of the dividends or credits, issuing the amount to existing policyholders, depositing the amount in the fund for standardized individual enrollee direct payment contracts, or utilizing any other method which offsets the amount of the dividends or credits.</p> <p>Requires carriers to annually report the calculated loss ratio for the previous year.</p>	No definitions.
<p>New York <i>N.Y. Ins. Law §4308</i></p> <p>Enacted 1995 Amended 2009</p>	Non-profit medical and dental indemnity, or health and hospital service corporations (2 to 50)	<p>Requires corporations to return in the form of aggregate benefits incurred for each contract the following amounts:</p> <ul style="list-style-type: none"> • 80% for individual direct payment contracts; or • 75% for small group <p>Requires carriers failing to comply with the minimum loss ratio to issue a dividend or credit against future premiums sufficient to ensure that the aggregate benefits in the previous year plus the amount of dividends or credits equals</p>	No definitions.

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		<p>the required loss ratio. The credit is required to be prorated based on the direct premium earned for the year among all policy holders eligible to receive a dividend or credit. For former policyholders, carriers are required to make a reasonable effort to identify the location of the policyholder and issue the dividend or credit. If the former policyholder cannot be located, the carrier has the option of prospectively adjusting premium rates by the amount of the dividends or credits, issuing the amount to existing policyholders, depositing the amount in the fund for standardized individual enrollee direct payment contracts, or utilizing any other method which offsets the amount of the dividends or credits.</p>	
<p>North Carolina <i>N.C. Admin. Code r. 11.16.0201 and 11.16.0401</i></p> <p>Enacted 1992 and 1994 Amended 2006 and 1994</p>	<p>Individual</p>	<p>Follows the NAIC Model.</p> <p>A premium refund, premium decrease or other actuarial action must be taken for failure to comply.</p>	<p>“<i>Loss ratio</i>” means the percentage of premium that is expected to be used to pay losses. It is calculated by subtracting the expense loss ratio from the number one.</p> <p>“<i>Expense loss ratio</i>” means the ratio of the insurer's operating expenses for a class of business and plan of insurance to its earned premium for that class of business and plan of insurance.</p> <p>“<i>Operating expenses</i>” include:</p> <ul style="list-style-type: none"> • commissions; • other acquisitions; • general administration; • taxes, licenses, and fees; and • profit and contingency margin.
<p>North Carolina <i>N.C. Admin. Code r.</i></p>	<p>HMOs</p>	<p>Establishes MLRs as follows:</p> <ul style="list-style-type: none"> • 75% for full-service products issued on a group basis; 	<p>No definitions.</p>

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<p><i>11.16.0607</i></p> <p>Enacted 1995</p>		<ul style="list-style-type: none"> • 65% for single-service products issued on a group basis; • 65% for full-service products issued on an individual basis; and • 55% for single-service products issued on an individual basis. 	
<p>North Dakota <i>N.D. Cent. Code §26.1-36-3 7.2</i></p> <p>Enacted 1993 Amended 2007</p>	Individual and group	<p>Establishes MLRs of no less than:</p> <ul style="list-style-type: none"> • 55% for individual policies; and • 70% for group policies. 	<p><i>“Loss ratio”</i> means incurred claims divided by earned premiums.</p>
<p>Ohio <i>Ohio Rev. Code Ann. §3923.022 and §3923.333</i></p> <p>Enacted 1992 and 1997</p>	Individual and group	<p>Prohibits administrative expenses in excess of 20% of premium received.</p>	<p><i>“Administrative expense”</i> means the amount resulting from the following:</p> <ul style="list-style-type: none"> • the amount of premiums received minus the sum of the amount of claims for losses paid; • the amount of losses incurred but not reported; • the amount paid for state fees, federal and state taxes, and reinsurance; and • the costs and expenses related, either directly or indirectly, to the payment of commissions, measures to control fraud, and managed care. <p><i>“Administrative expenses”</i> does not include any amounts collected, or administrative expenses incurred, by an insurer for the administration of an employee health benefit plan subject to regulation by ERISA.</p>
Ohio	Mutual insurance	Subsequent to the first calendar year after organization,	No definitions.

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<p><i>Ohio Rev. Code Ann. §3941.14</i></p> <p>Enacted 1953</p>	companies	prohibits the expense of management of any domestic mutual company from exceeding in any one calendar year 40% of its premium income in such year.	
<p>Oklahoma <i>Okla. Stat. tit 36, §6515</i></p> <p>Enacted 1992 Amended 1998</p>	Small group (1 to 50)	Establishes a 60% MLR.	No definitions.
<p>Oregon <i>Or. Admin. R. 836-053-1400</i></p> <p>Enacted 2006 Amended 2007</p>	Individual and group	<p>No specific MLR requirement.</p> <p>Requires an annual submission stating the MLR for that year.</p>	<p><i>“Medical loss ratio”</i> means the total cost of medical claims divided by the total premiums earned.</p> <p><i>“Total amount of costs for claims”</i> means incurred claims as reported by the carrier on the exhibit of premiums, enrollment and utilization in its annual statement. If the annual statement blank used by a carrier does not include an exhibit of premiums, enrollment and utilization, the carrier shall derive the answer from its records, using the instructions for the exhibit of premiums, enrollment and utilization for reporting the information.</p> <p><i>“Total amount of premiums”</i> means earned premium as reported by the carrier on the exhibit of premiums, enrollment and utilization in its annual statement. If the annual statement blank used by a carrier does not include an exhibit of premiums, enrollment and utilization, the carrier shall derive the answer from its records, using the instructions for the exhibit of premiums, enrollment and</p>

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			utilization for reporting the information.
<p>Pennsylvania <i>31 Pa. Admin. Code §89.83</i> Enacted 1975</p>	Individual	<p>With regard to rates for policies which are initially filed for approval, finds unacceptable anticipated loss ratios which are lower than the following:</p> <ul style="list-style-type: none"> • industrial policies⁷ - 45%; and • all other policies - 50%. <p>With regard to rate revision, requires the use of the following minimum loss ratios:</p> <ul style="list-style-type: none"> • industrial policies - 50%; and • all other policies - 60%. <p>Requires both new filings and rate revisions to include actuarial certification of loss ratio.</p>	No definitions.
<p>South Carolina <i>S.C. Code Ann. §38-71-310(E)</i> Enacted 1976 Amended 2001</p>	Individual	<p>Follows the NAIC Model.</p> <ul style="list-style-type: none"> • A premium refund of \$5.00 or more must be issued to all South Carolina policyholders for failure to comply with guaranteed loss ratio (if applicable). <p>Loss ratio guarantee requires filing of anticipated loss ratio.</p> <p>Also requires that the company conduct an independent audit at their own expense to verify the loss ratio for the year in question.</p>	“ <i>Loss ratio</i> ” means the ratio of incurred losses to earned premium by number of years of policy duration, for all combined durations.
<p>South Dakota</p>	Individual	Creates a statutory loss ratio requirement of 65%, while	No definitions.

⁷ Industrial policies are low cost and low value policies that were sold and delivered, with premium collected (usually weekly or monthly) by the agent. These types of policies do not currently exist in the marketplace.

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<p><i>S.D. Codified Laws §58-17-64 and S.D. Admin. R. 20:06:22:02</i></p> <p>Enacted 1994 and 1990 Amended 1997</p>		<p>allowing the Director of the Division of Insurance to promulgate rules that modify the requirement based on the specific design of the product.</p> <p>Modifies statutory loss ratio by regulation as follows:</p> <ul style="list-style-type: none"> • For policies with annual premiums of \$250 or greater: <ul style="list-style-type: none"> ○ optionally renewable - 70%; ○ conditionally renewable - 65%; ○ guaranteed renewable - 65%; and ○ non-cancellable - 60%. • For policies with annual premiums between \$150 and \$250 subtract 5% from allowable MLRs. • For policies with annual premiums less than \$150 subtract 10% from allowable MLRs. 	
<p>South Dakota <i>S.D. Admin. R. 20:06:22:02</i></p> <p>Enacted 1990 Amended 1997</p>	Short-term medical	Establishes a 60% MLR.	No definitions.
<p>South Dakota <i>S.D. Codified Laws §58-18-63, §58-38-36, and §58-40-33</i></p> <p>Enacted 1994</p>	Group	Establishes a 75% MLR.	No definitions.
<p>Tennessee <i>Tenn. Code Ann.</i></p>	Medical service corporations	Limits acquisition and administrative expenses to 25% of total net premium income.	<i>“Administrative expenses”</i> include all expenditures except payments for subscribers’ claims.

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§56-2 7-114 Enacted 1945			<ul style="list-style-type: none"> Requires claim service expense to be included in administrative expense.
Tennessee <i>Tenn. Comp. R. & Regs. tit. 0780, ch. 1-20-06(1)</i> Enacted 1974 Amended 1980	Individual	Follows the NAIC Model for policies with annual premiums of at least \$200. <ul style="list-style-type: none"> For policies with annual premiums between \$100 and \$200 subtract 5% from allowable MLRs. For policies with annual premiums less than \$100 subtract 10% from allowable MLRs. Requires each rate submission and request for rate revision to include an actuarial certification of the loss ratio.	No definitions.
Utah <i>Utah Admin. Code R590-85-5(1)(a) and R590-85-4</i> Enacted 2003 Amended 2007	Individual and group	Follows the NAIC Model for policies with annual premiums of at least \$200. <ul style="list-style-type: none"> For policies with annual premiums between \$100 and \$200 subtract 5% from allowable MLRs. For policies with annual premiums less than \$100 subtract 10% from allowable MLRs. Requires all rate filings for new policies to include the anticipated loss ratio and all requests for rate revisions shall include the incurred loss ratio, cumulative loss ratio, and anticipated loss ratio for the revised rate.	No definitions.
Vermont <i>Vt. Stat. Ann. tit. 8, §4080b</i> Enacted 1991 Amended 2005	Individual	Establishes a 70% MLR.	<i>“Anticipated loss ratio”</i> means a comparison of earned premiums to losses incurred plus a factor for industry trend where the methodology for calculating trend shall be determined by the commissioner by rule.

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<p>Virginia 14 Va. Admin. Code §5-130-40 and §5-130-60</p> <p>Enacted 1981</p>	Individual	<p>Follows the NAIC Model for policies with annual premiums of at least \$200 but less than \$1000.</p> <ul style="list-style-type: none"> • For policies with annual premiums between \$100 and \$200 subtract 5% from allowable MLRs. • For policies with annual premiums less than \$100 subtract 10% from allowable MLRs. • For policies with annual premiums of \$1000 or more add 10% to the allowable MLRs. <p>Rate submissions shall include the anticipated loss ratio and a description of the method by which it was calculated.</p>	<p><i>"Anticipated loss ratio"</i> is the present value of future benefits to the present value of the future premiums of a policy over the entire period for which rates are computed to find coverage.</p>
<p>Washington Wash. Rev. Code §48.20.025); §48.44.017; and §48.46.062</p> <p>Enacted 2003, 2001, and 2001 Amended 2008</p>	Individual health benefit plans, health care service contractors, and HMOs	<p>Establishes a 74% MLR, minus the premium tax rate applicable to the insurer's individual health benefit plans.</p> <p>Increases the MLR based on the insurer's actual declination rate in the individual market in the preceding year (minus the applicable premium tax rate), as follows:</p> <ul style="list-style-type: none"> • 74% MLR when the declination rate is under 6%; • 75% MLR when the declination rate is more than 6% but less than 7%; • 76% MLR when the declination rate is 7% or more but less than 8%; and • 77% MLR when the declination rate is 8% or more 	<p><i>"Declination rate"</i> for an insurer means the percentage of the total number of applicants for individual health benefit plans in the aggregate in the applicable year which are not accepted for enrollment based on the results of the standard health questionnaire administered pursuant to state law.</p> <p><i>"Loss ratio"</i> means incurred claims expense as a percentage of earned premiums.</p>

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Washington <i>Wash. Admin. Code § 284-60-050</i> Enacted 1983	Individual disability (health) ⁸	Benefits shall be deemed reasonable in relation to premiums if the overall loss ratio is at least sixty percent over a calculating period chosen by the insurer and satisfactory to the commissioner.	No definitions.
Washington <i>Wash. Admin. Code §§284-43-910, §284-43-945 and §284-43-950</i> Enacted 1998 Amended 2005	Individual, small group, and group	No specific MLR requirement. Requires rate submissions required to include statement of anticipated or experienced loss ratio.	“ <i>Anticipated loss ratio</i> ” means the projected incurred claims divided by the project earned premium. “ <i>Loss ratio</i> ” means incurred claims as a division of earned premiums before any deductions.
Washington <i>Wash. Admin. Code § 284-60-060</i> Enacted 1983	Group disability (health)	Group disability (health) insurance, other than specified disease, as to which the insureds pay all or substantially all of the premium shall generate loss ratios no lower than the following (based on the number of certificate holders at issue, renewal or rating): <ul style="list-style-type: none"> • Nine or less—60%; • Ten to twenty-four—65%; • Twenty-five to forty-nine—70% • Fifty to ninety-nine—75% • One-hundred or more—80%. 	No definitions.

⁸ Note that Washington statutory law defines disability insurance broadly to include insurance against bodily injury, disablement, or death by accident, against disablement resulting from sickness, and every insurance related insurance, including stop loss insurance (Wash. Rev. Code § 48.11.030). Separate loss ratio requirements exist for ‘health benefit plans’, which are defined more restrictively to exclude supplemental products.

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<p>West Virginia <i>W. Va. Code, §33-6C-1, §33-6C-2; §33-24-4; §33-25-6; §33-25A-24; §33-25D-26; and W. Va. Code St. R. §114-31-3.1</i></p> <p>Enacted 1991, 1991, 1957, 1964, 1977, 1999 and 1992 Amended 1993, 1993, 2006, 2003, 2005, and 2003</p>	<p>Individual</p>	<p>Establishes a 60% MLR.</p> <p>Initial filing of loss ratio guarantee shall include target lifetime loss ratio and a statement of expected loss ratio.</p> <p>Filings for rate revision shall include cumulative loss ratio and expected lifetime loss ratio.</p>	<p>“Loss ratio” means the ratio of incurred claims to earned premium.</p>
<p>West Virginia <i>W. Va. Code §33-16D-5 and §33-16D-16</i></p> <p>Enacted 1991 and 2004 Amended 1997 and 2004</p>	<p>Small group</p>	<p>Establishes MLRs as follows:</p> <ul style="list-style-type: none"> • 77% for uninsured health benefit plans⁹; and • 73% for all other small group plans 	<p>No definitions.</p>

⁹ Section 33-16D-16 establishes requirements for a voluntary program under which health insurance carriers in the small group market provide coverage to small employers who have not had health insurance coverage for the previous 12 months. Among other things, this program requires employers to contribute 50 percent of the employee’s premium and exempts the coverage from state premium tax obligations.