



# Medical Loss Ratio Written Assurance Form

The Affordable Care Act (ACA) established Medical Loss Ratio (MLR) standards for health insurers.

Generally, MLR is the percentage of earned premiums that an insurer spends on health care services and reports as quality improvement activity expenses. If an insurer's MLR is less than ACA's MLR standard for a market in a state, the insurer may provide rebates in that market.

To provide a rebate to a policyholder that sponsors a church plan, the MLR regulations require that an insurer obtain a written assurance from the policyholder that any rebate will be used for the benefit of subscribers as described in the MLR regulations (45 C.F.R. 158.242(b)(3)). **If the written assurance is not provided, the MLR regulations require that an insurer distribute any rebate directly to certain subscribers of the plan (rather than to the policyholder).**

Does the policyholder listed below sponsor a church plan in connection with the policyholder's Blue Cross and Blue Shield of New Mexico (BCBSNM) coverage? "Church plan" has the meaning given the term in Internal Revenue Code Section 414(e).

☐ **No, the group health plan is NOT a church plan.**

**OR**

☐ **Yes, the group health plan is a church plan. If "yes" (check one of the following):**

☐ The policyholder WILL use any MLR rebate for the benefit of subscribers as described in the MLR regulations (45 C.F.R. 158.242(b)(3)).

☐ The policyholder WILL NOT use any MLR rebate for the benefit of subscribers as described above. I understand that, if this option is selected, BCBSIL **will** distribute any MLR rebate directly to certain subscribers of the plan.

If this Written Assurance Form is not completed, signed and received from a church account BCBSNM will provide any MLR rebate directly to certain subscribers of the plan.

By signing below, I:

- (1) Represent that I am a duly authorized representative of the employer and that the information contained in this form is true, accurate and complete;
- (2) Certify that should any of the answers or information I provided above change in any way, I will inform BCBSNM of such change as soon as I am able. I understand that failure to timely notify BCBSNM of such changes may impact the coverage/eligibility of the group, its members, or any other persons who now or who may then be eligible for coverage under such plan and/or may impact the compliance of the group with respect to specific state or federal requirements;
- (3) Understand and agree that the information contained in this form prospectively supersedes any prior information provided to BCBSNM (including for the purposes of 45 C.F.R. 158.242(b)(3)); and
- (4) Agree that the answers or information I provided above should be considered accurate and complete unless or until a subsequent MLR Written Assurance Form is submitted either in a subsequent calendar year or in the event of a change in such information.

Name: (please print) \_\_\_\_\_ Date: (mm/dd/yyyy) \_\_\_\_\_

Signature: \_\_\_\_\_ Position/Title: \_\_\_\_\_

**Please email the completed form to [data\\_collection@bcbsil.com](mailto:data_collection@bcbsil.com), or fax to 312-233-4244.**