

News Release

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New Affordable Care Act rules give consumers better value for insurance premiums

New medical loss ratio regulations make insurance marketplace more transparent and require insurers to spend premium dollars on care

New regulations issued today by the Department of Health and Human Services (HHS) require health insurers to spend 80 to 85 percent of consumers' premiums on direct care for patients and efforts to improve care quality. This regulation, known as the "medical loss ratio" provision of the Affordable Care Act, will make the insurance marketplace more transparent and make it easier for consumers to purchase plans that provide better value for their money.

"Thanks to the Affordable Care Act, millions of Americans will get better value for their health insurance premium dollar," said HHS Secretary Kathleen Sebelius. "These new rules are an important step to hold insurance companies accountable and increase value for consumers."

Today, many insurance companies spend a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing. Thanks to the Affordable Care Act, consumers will receive more value for their premium dollar because insurance companies will be required to spend 80 to 85 percent of premium dollars on medical care and health care quality improvement, rather than on administrative costs, starting in 2011. If they don't, the insurance companies will be required to provide a rebate to their customers starting in 2012.

In 2011, the new rules will protect up to 74.8 million insured Americans and estimates indicate that up to 9 million Americans could be eligible for rebates starting in 2012 worth up to \$1.4 billion. Average rebates per person could total \$164 in the individual market. Important details regarding the new regulation are included below.

The medical loss ratio regulation outlines disclosure and reporting requirements, how insurance companies will calculate their medical loss ratio and provide rebates, and how

adjustments could be made to the medical loss ratio standard to guard against market destabilization.

Beginning in 2011, the law requires that insurance companies publicly report how they spend premium dollars, providing meaningful information to consumers. Also beginning in 2011, insurers are required to spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities. Insurance companies that are not meeting the medical loss ratio standard will be required to provide rebates to their consumers. Insurers will be required to make the first round of rebates to consumers in 2012.

“ These rules were carefully developed through a transparent and fair process with significant input from the public, the States, and other key stakeholders,” said Jay Angoff, Director of the Office of Consumer Information and Insurance Oversight at HHS. “ As we build a bridge to 2014, when better, more affordable options are available to consumers, these rules will help make health insurance fairer for consumers now.”

The Affordable Care Act required the National Association of Insurance Commissioners (NAIC) to develop uniform definitions and methodologies for calculating insurance companies’ medical loss ratios. Insurance commissioners in every State have a responsibility to protect the interests of the general public, policyholders, and enrollees within their respective States. Today’ s regulation certifies and adopts the recommendations submitted to the Secretary of HHS on October 27, 2010 by the NAIC. It also incorporates recommendations from a letter sent to the Secretary by the NAIC on October 13, 2010.

More information about the medical loss ratio is available at

http://www.healthcare.gov/news/factsheets/medical_loss_ratio.html. The regulation and

other technical information are available at <http://www.hhs.gov/ociio/regulations/index.html>.

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