Refunds for Excessive Health Insurance Premiums

Beginning in 2011, the Patient Protection and Affordable Care Act (ACA) required insurers to report to the federal government the percentage of a health insurance premium spent on administrative, quality improvement, and medical costs.

Starting in 2012, if an insurer directs less than 80 percent of an individual insurance or small group plan's premium and 85 percent of a large group plan's premium to clinical and quality care improvement costs, the insurer will be required to refund the difference to the enrollee. This provision intends to ensure efficient and proper use of enrollees' premiums.

Medical Loss Ratios

Not all of a health insurance premium is directed to providing an enrollee's health care. Health insurers devote premium payments to medical care as well as other costs, including marketing, claims processing, and profits. The amount of a premium that is used by an insurer to pay medical costs versus administrative and other expenses is called the medical loss ratio. Because some insurers, particularly those offering individual plans, direct up to 40 percent of a premium towards non-medical care costs, the ACA requires health insurers to pay no less than a specified percentage amount of a premium on clinical medical costs and health care quality activities. Beginning in 2011, health insurers – including plans offered before March 23, 2010 – are required to submit information documenting the amount of an enrollee's premium that is devoted to clinical, administrative, and quality care improvement costs.

How does the law define medical care and administrative costs?

In November 2010, the federal government released a rule defining medical, quality improvement, and administrative expenses. The rule was based on recommendation put forth by the National Association of Insurance Commissioners. The medical loss ratio has generated controversy, since insurers advocate that activities such as fraud prevention and disease management programs, which may improve quality tangentially, be considered as quality improvement cost.

The rule states that quality improvement activities may include:

- Comprehensive discharge planning
- Case management
- Care coordination
- Chronic disease management
- Health information technology expenses
- Public health education campaigns

Activities that would not be considered in the medical or quality improvement definition include:

- Fraud detection and prevention efforts
- Expenses related to the implementation of the International Classification of Disease code sets (ICD-10)
- Retrospective and concurrent utilization review
- Development and execution of provider contracts
- Provider credentialing
- Accreditation

- Marketing

How does this law affect insurers?

Some states, particularly those with small populations and few insurance options, requested a waiver from the federal government to stall the implementation of the medical loss ratio rule. States argued that the medical loss ratio requirement would undermine the individual insurance market, causing instability that may drive insurers out of the state. A number of states were granted waivers that staggered the implementation of the medical loss ratio rule although most of these waivers have since expired.

What happens if insurers fail to meet the medical loss ratio standard?

Starting in 2012, if insurers fail to meet the medical expense target they will be required to provide premium rebates to enrollees equal to the amount of non-medical expenses that exceed the target. In 2012, the first medical loss ratio rebates were issued to consumers. According to HHS, rebates were distributed to over 12 million individuals.

Additional Resources

- *Kaiser Family Foundation: Beyond Rebates: How Much Are Consumers Saving from the ACA's Medical Loss Provision*

  http://kff.org/health-reform/perspective/beyond-rebates-how-much-are-consumers-saving-from-the-acas-medical-loss-ratio-provision/