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New Rules Tell Insurers: Spend More on Care

By ROBERT PEAR

WASHINGTON — The Obama administration issued new federal rules on Monday that will require many health insurance companies to spend more on medical care and allocate less to profits, executive compensation, marketing and overhead expenses.

The rules, intended to benefit consumers, vastly expand federal authority to direct the use of premiums collected by companies like Aetna, Humana, UnitedHealth and WellPoint. While some states have had such requirements, Monday's announcement is the first such mandate by the federal government and grows out of the new national health care law.

"Millions of Americans will get better value for their health insurance premium dollar," Kathleen Sebelius, the secretary of health and human services, said in issuing the rules.

Ms. Sebelius said the rules would protect nearly 75 million people: 10.6 million with individual policies, 24.2 million with small-group coverage and 40 million covered by large employers.

Starting next year, she said, insurers in the individual and small-group markets must spend at least 80 percent of their premium revenues on medical care and activities to improve the quality of care. Insurers in the large-group market must spend at least 85 percent of premium dollars for those purposes.

Insurers that do not meet the standards next year will have to pay rebates to consumers, starting in 2012. Ms. Sebelius estimated that up to nine million people could get rebates worth up to $1.4 billion. About 45 percent of people with individually purchased insurance are in health plans that do not meet the new standards, known as medical loss ratios, federal officials said.

At a news conference on Monday, administration officials repeatedly refused to respond to Republican attacks on the health care law. Nor would they discuss Republican calls to repeal the law, a centerpiece of President Obama's domestic agenda.

"We are just trying to implement this regulation," said Jay Angoff, the rules' chief author. He is director of the Department of Health and Human Services' Office of Consumer Information and Insurance Oversight.

He said most insurers should be able to meet the standards because "their profitability and reserves are at an all-time high."

However, state officials said the standards could destabilize insurance markets in some states. Specifically, they said they feared that some carriers would withdraw from the market in some states, resulting in fewer choices and less competition.

Under the rules, federal officials can lower the standard for up to three years in states where "there is a reasonable likelihood that market destabilization, and thus harm to consumers, will occur."

Mr. Angoff said that Georgia, Iowa, Maine and South Carolina had asked for such adjustments.

Joshua R. Raskin, a senior analyst at Barclays Capital, an investment bank, said, "With these rules, the federal government will, for the first time, hold health insurance companies accountable for putting a minimum amount of premiums toward medical expenses."

The rules allow special treatment for health plans that provide limited benefits at a more affordable price. At least 1.4 million people are enrolled in such "mini-med" plans, which may cap coverage for

one or more benefits at $5,000 or $10,000 a year — or perhaps $25,000.

Employers offering such coverage had said they might end it because they could not meet the 80 percent standard next year.

Premiums are usually lower for mini-med plans than for regular insurance, and administrative costs may be high because these plans often cover employees with high turnover rates. As a result, administrative costs account for a higher share of premium revenues.

In addition, some consumer groups said mini-med plans had higher profit margins than traditional insurance.

“The administration has made a wise accommodation that will temporarily preserve this coverage, which is very important to many employees in the retail and restaurant industries,” said E. Neil Trautwein, a vice president of the National Retail Federation.

The dispensation for mini-med plans is for one year. The government will collect data on these plans next year and decide how to proceed in 2012 and 2013. “In 2014, we anticipate that these mini-med policies will disappear and be replaced by more comprehensive health plans,” said Steven B. Larsen, a federal insurance regulator.

The rules generally follow recommendations from the National Association of Insurance Commissioners, which represents state regulators.

However, “we have a difference of opinion” on one point, said Jane L. Cline, the insurance commissioner of West Virginia and president of the association.

State officials said Mr. Obama should allow states to phase in the requirements over several years, to avoid disruption of the individual or small-group insurance market. The White House said, “The law allows adjustments of the medical loss ratio for the individual market in a state and does not apply to the small-group market.”

Consumers Union, the American Heart Association and Democratic members of Congress praised the rules.

Representative George Miller, Democrat of California, said the rules showed the folly of efforts to repeal the health care law.

“If Republicans succeed,” Mr. Miller said, “they will be taking money right out of the pockets of millions of average Americans.”

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