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Health Insurance Premium Rate Review Regulation: Case Studies to Inform California

Prepared for
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April 17, 2012

Acknowledgements: The authors are grateful to the officials from state agencies that regulate insurance and the senior actuaries and executives from health insurance carriers that participated in interviews for this study, and provided comments on a draft of this study. Each provided valuable information. The authors thank Gilbert Ojeda, Director, California Program on Access to Care, School of Public Health, University of California, Berkeley, for his extensive comments on multiple drafts of this study. The authors thank the following individuals for their comments on a draft of this study: Gerald F. Kominski, Professor, Department of Health Services, School of Public Health, University of California, Los Angeles; Albert Lowey-Ball, Health Economics and Medicaid Advisor, California Program on Access to Care; and Ann C. Munoz, Program Manager, California Program on Access to Care. This study was funded by the California Program on Access to Care, School of Public Health, University of California, Berkeley.

Executive Summary

The objective of this study is to examine health insurance rate review regulation in Minnesota and Massachusetts, to inform California policy-makers regarding evidence on prior approval authority. This evidence is intended to inform California's proposed change from file-and-use to prior-approval authority, based on AB 52 "Health Care Coverage: Rate Approval." The methods included reviewing the literature on rate review regulation, interviewing officials from state agencies that approve rates, and interviewing senior actuaries and executives from health insurance carriers. Three interviews were conducted on Minnesota, three interviews were conducted on Massachusetts, and two interviews were conducted on California. Minnesota was selected because it has exercised its prior approval authority for at least 15 years, which provides a long period of time to analyze. Massachusetts was selected because it only began exercising its prior approval authority—technically prior review and disapproval authority—in April 2010, providing an example of a state just starting prior approval rate review.

Prior approval authority has the potential to moderate rate increases, but there is also the potential that it could lead to higher rates. The literature does not contain a quantitative study with a strong research design that estimates its impact on health insurance premium growth. In a state with prior approval regulation, it will likely be more difficult for a health insurance carrier with market power to charge higher rates than are actuarially justified. Moreover, rate review regulation has the potential to increase market information about rates and premiums, allowing consumers and employers to more easily compare premiums. On the other hand, carriers may be able to reduce the impact of the regulation and still earn excess profits or surpluses, by changing more

difficult-to-measure dimensions, such as customer service. Prior approval authority may cause some carriers to exit the market and may cause others to not enter the market, due to increased market uncertainty, both of which could reduce competition and lead to higher rates. However, this potential has not been well studied.

We think there are three key lessons that California can learn from Minnesota and Massachusetts. First, if prior approval authority is sought, California should establish guidelines that are as clear and objective as possible, such as actuarially based criteria. For example, Massachusetts uses three actuarial criteria for presumptive disapproval, but the remaining criteria are based on the reportedly undefined standards requiring that rates not be "excessive, inadequate or unreasonable in relation to the benefits provided." The interpretation of these standards has changed over time and has been subject to litigation. Even with relatively objective criteria, the criteria need to accommodate a variety of situations. For example, the medical loss ratio is often a key criterion used by states for rate approval, and states vary on how they distinguish medical from non-medical costs, particularly in the areas of quality-improvement initiatives (Haberkorn, 2010).

Second, any California prior approval legislation should be designed to correct market failures in the health insurance industry, realizing other legislation and regulations may be needed to correct market failures in the health care sector more broadly. The economic justification for regulation stems from a market failure, such as market power and imperfect information. Market failure can exist in the insurance sector, including market power in some localities, as well as information asymmetries between consumers and carriers, leading to adverse selection. Prior approval authority can prevent excessive rates from being charged where carriers are exerting market power. Although market

failures in the health insurance industry contribute to health insurance premium growth, the principal driver of growth is rapidly evolving health care technology that makes new treatments available (Newhouse, 1992). In addition, health care is being delivered by providers with significant market power—many of which operate with poor incentives to deliver high-quality care at a low cost (Arrow et al., 2009). The regulation of the provider market power may deserve separate legislation executed by a state's antitrust division, because antitrust regulation is inherently different from actuarially based regulation.

Third, both Minnesota and Massachusetts emphasized the need for regulators to employ sufficient staff with actuarial expertise or have the ability to contract with outside consultants. The California Department of Finance estimates the annual costs of AB 52 would be $27.5 million for 181 additional staff for the California Department of Managed Health Care and California Department of Insurance to review and monitor activities related to rate approval (Hill, 2011). The cost to conduct rate review and approve or disapprove rates in Minnesota and Massachusetts appears to be far lower, even considering that they are smaller states and neither actively reviews rates in the large group market. In Minnesota, the annual total cost to review medical health insurance rates in the individual and small group markets is approximately $81,000, which covers two DOC employees: 15% of an actuary's time and 50% of a non-actuary's time (Minnesota Department of Commerce, 2011). In Massachusetts, the annual total cost to review medical insurance rates is approximately $300,000, which covers a portion of one actuary's and the Deputy Commissioner's time as well as three actuarial consultants. However, AB 52 proposes to also regulate the large group market. Minnesota's prior

approval authority does not extend to the large group market, and Massachusetts's prior review and disapproval authority does not concentrate on the large group market.

To help California policy-makers determine the best policies to moderate health insurance premium increases, the following additional areas of research should be pursued. This research would also be helpful if California implements prior-approval authority. The proposed research will mitigate a key limitation of this study, in that our findings are based only on contacting a limited number of experts in Minnesota, Massachusetts, and California. First, California's health care sector needs to be studied, including health insurance carriers, technology, providers, and payment systems, to determine which areas are most responsible for health insurance premium increases and which warrant regulation. Second, research should investigate whether the Affordable Care Act's minimum medical loss ratio and California's required rate review and certification by an independent actuary are sufficient to prevent excessive rates. Third, additional states should be studied in more detail to learn which criteria are most important to use to determine whether rates are excessive (or inadequate or discriminatory). In March 2012, the authors of this study, through their affiliation with the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health, University of California-Berkeley, were awarded a two-year grant titled "Impact of State Rate Review Regulation on Health Insurance Premiums" by the Robert Wood Johnson Foundation. That study will estimate the impact of state rate review regulation on health insurance premiums, which will include identifying which, if any, criteria had the largest impact on reducing health insurance premium increases. Fourth, the costs of prior approval authority should be investigated in more detail, because the

California Department of Finance estimate appears to be much higher than Minnesota's and Massachusetts's costs, even considering that they are smaller states and neither actively reviews rates in the large group market. This research will enable California to better understand how best to moderate health insurance premium increases, and if prior approval authority is determined to be prudent, then the proposed research will help it most effectively implement that authority.

Introduction

The mean annual health insurance premium in the United States for employer-sponsored family coverage was $13,770 in 2010, an increase of 114%—more than four times the rate of inflation—over the past decade (Claxton et al., 2010). Policy attempts at the state level to regulate soaring premiums in the individual and small group markets take two main forms: “file and use” and “prior approval” rate review regulation. For either type, health insurance carriers are required to file an actuarial justification for a rate increase, demonstrating that the premiums are reasonable in relation to the benefits. Under file-and-use, carriers are able to apply the increase without the state’s approval; under prior approval, carriers cannot apply the increase until it has been approved by the state or the deeming period, typically 30 or 60 days, has passed.

As of 2010, 34 states in the individual market and 29 states in the small group market had prior approval authority, and 14 states in the individual market and 20 states in the small group market had a file-and-use requirement (Corlette & Lundy, 2010). Currently, states vary in exercising their legal authority (Corlette & Lundy, 2010), as was the case ten years ago (Kirk & Chollet, 2002). For example, Massachusetts did not strongly exercise its prior review and rate disapproval authority until April 2010, after a period of double-digit rate increases. The degree to which a state actively uses its authority is based on political priorities, an insurance commissioner’s priorities, and staff resources to review rates, as well as health insurance carriers’ political power. States and insurance commissioners have been facing increased political pressure from their constituents, including large purchasers, to moderate health insurance premium increases.

The Affordable Care Act (ACA) includes two major provisions that seek to address the rate of growth of health insurance premiums. First, it requires the U.S. Department of Health and Human Services (DHHS) to work with state insurance departments to conduct an annual review of "unreasonable increases in premiums." States are required to review rate increases at or above 10% for non-grandfathered plans in the individual and small group markets. A grandfathered plan is an individual or group plan that existed on March 23, 2010, when the Patient Protection and Affordable Care Act was signed. If a state lacks the resources or authority to conduct rate reviews, DHHS will conduct the reviews or partner with the state to conduct the reviews. As of August 22, 2011, DHHS identified six states (Alabama, Arizona, Louisiana, Missouri, Montana, and Wyoming) where DHHS will conduct rate reviews, and identified two states (Pennsylvania and Virginia) where DHHS will partner with the states to conduct rate reviews (Center for Consumer Information & Insurance Oversight, 2011).

Congress appropriated $250 million to DHHS to award grants to state insurance departments to enhance their rate review process. In August 2010, DHHS awarded $43 million to 42 states and the District of Columbia ($1 million to each) under the grant titled: "Grants to States for Health Insurance Premium Review-Cycle I" (DHHS, 2011; DHHS, 2010). California and Massachusetts received $1 million each; however, Minnesota was one of the few states not to apply for this grant, because former Governor Tim Pawlenty's executive order directed state agencies to decline all discretionary participation in the Affordable Care Act (Pacquet, 2010). However, Minnesota continued to exercise its prior approval authority. In September 2011, DHHS awarded $109 million to 28 states under the grant titled: "Grants to Support States in Health Insurance Rate

Review-Cycle II," including California Department of Insurance ($2.2 million), California Department of Managed Health Care ($2.2 million), Minnesota Department of Commerce ($3.9 million), and Massachusetts Department of Insurance ($3.4 million). Minnesota now participates in the discretionary elements of the ACA under Governor Mark Dayton. Grants to additional states are likely to still be awarded for Cycle II.

Second, the ACA requires health insurance carriers to have a medical loss ratio (MLR) of at least 80% in the individual and small group markets and at least 85% in the large group market, beginning January, 2011. The MLR is the proportion of the premium that is spent on patient care and certain quality improvement activities (Haberkorn, 2010). If the MLR falls short of the threshold, plans are required to provide rebates to enrollees the following year.

The objective of this study is to examine health insurance rate review regulation in Minnesota and Massachusetts, to inform California policy-makers regarding evidence on prior approval authority. This evidence is intended to inform California's proposed change from file-and-use to prior-approval authority, based on AB 52 "Health Care Coverage: Rate Approval." The Assembly passed AB 52 in June 2011, but the bill was not voted on by the full Senate, because of a lack of support. We collected information on the criteria used by states to determine reasonableness of a rate increase; information that needs to be collected from health plans to conduct a thorough rate review; and best practices and lessons learned. Minnesota was selected because it has exercised its prior approval authority for at least 15 years, which provides a long period of time to analyze. Massachusetts was selected because it only began exercising its prior approval

authority—technically prior review and disapproval authority—in April 2010, providing an example of a state just starting its prior review and disapproval authority.[1]

Methods

The methods included reviewing the literature on rate review regulation, interviewing officials from state agencies that approve rates, and interviewing senior actuaries and executives from health insurance carriers. Three interviews were conducted on Minnesota, three interviews were conducted on Massachusetts, and two interviews were conducted on California. The interviewees provided reports and other material on rate review for their states, including regulatory bulletins, recent and pending legislation, and background reports. Each interviewee was sent a draft of this study, and all but one provided comments.

Results

Literature Review

Since the passage of the ACA, rate review regulation has generated significant interest. Three recent studies surveyed each state's rate review regulations, including the Congressional Research Service (Newsom and Fernandez, 2011), the U.S. Government Accountability Office (GAO, 2011), and the Kaiser Family Foundation (Corlette & Lundy, 2010). A fourth study surveyed states' rate review regulations in 2001 (Kirk & Chollet, 2002).

[1] Massachusetts distinguishes prior approval from prior disapproval authority. In prior approval, the health insurance carrier has the burden of proof that it has met the review standards. In prior disapproval, the regulator must state the reasons for disapproval, and those reasons are the items that are reviewed in any subsequent hearing.

The state surveys found that a state's rate review regulation authority may differ from its actual practice. For example, Ohio has a file-and-use rate review regulation in the small group market, but its review amounts to prior approval authority (Corlette & Lundy, 2010). Second, the surveys found that states use similar categories to determine whether rates are reasonable (e.g., medical trend, rate history, MLR); however, the precise thresholds vary. For example, the minimum MLR varies, from 50-60% in states that use *National Association of Insurance Commissioners Guidelines for Filing of Rates for Individual Health Insurance Forms*, to 88% in Massachusetts (America's Health Insurance Plans [AHIP], 2011). However, to our knowledge, no study has systematically estimated the impact of rate review authority on health insurance premiums.

Table 1 shows each state's rate review regulation authority (Corlette & Lundy, 2010); the minimum medical loss ratio (America's Health Insurance Plans, 2011); whether the state reported sufficient capacity and resources to review rates (GAO, 2011); the percent of reviewed filings that were disapproved, withdrawn, or resulted in lower rates (GAO, 2011); whether filings and a list of filings were available via the Internet (Philips, 2010b); and the types of opportunities for consumers to become involved in the rate review process (GAO, 2011). As of June 2010, 34 states in the individual market and 29 states in the small group market had prior approval authority (Corlette & Lundy, 2010). As of February 2011, 30 states in the individual market and 26 states in the small group market had a minimum MLR requirement (AHIP, 2011). The minimum MLR varied from 50-88% in the individual and small group markets. In Minnesota, the minimum MLR for most plans was 72% in the individual market and was 82% in the

small group market.[2] In Massachusetts, the minimum MLR was 88% (the highest of all the states) in the merged individual and small group markets. Thirty-three states reported having sufficient capacity and resources to review rates, including Minnesota and Massachusetts, but 15 states reported insufficient capacity and resources, including California (GAO, 2011). In 2010, states varied in the percent of reviewed filings that were disapproved, withdrawn, or resulted in lower rates (GAO, 2011). In the individual market, the median percentage was 24%, and Utah had the highest percentage (77%). In the small group market, the median percentage was 7%, and New York had the highest percentage (83%). Minnesota's percentages in the individual and small group markets were 23% and 5%, respectively. For Massachusetts's merged individual and small group markets, the percentage was 40%. As of June 2010, 12 states provided public access to rates and rate filings via the Internet, which did not include Minnesota or Massachusetts (Philips, 2010b). This increased transparency may reduce the ability of health insurance carriers to increase rates. In 2010, 14 states provided consumers opportunities to become involved in the rate review process, such as rate hearings, public comment periods, and consumer advisory boards (GAO, 2011). Neither Minnesota nor Massachusetts reported these official mechanisms for consumer involvement.

[2] Minnesota's minimum MLR is lower for HMOs and nonprofit health plan service corporations assessed less than 3% of the total assessed by the state's high risk pool, which assesses based on earned premiums. For these entities, the minimum MLR is 68% in individual market and is between 71% and 75% in the small group market.

Table 1: Rate Review Regulation Authority and Attributes by State

State	Rate Review Regulation, June 2010 (1)		Minimum Medical Loss Ratio, February 2011 (2)		Sufficient Capacity and Resources to Review Rates, 2010 (3)	Reviewed Filings Disapproved, Withdrawn, or Resulted in Lower Rates, 2010 (4)		Access to Filings or List via Internet, June 2010 (5)	Opportunities for Consumer Involvement in Rate Review Process, 2010 (6)
	Individual Market	Small Group Market	Individual Market	Small Group Market		Individual Market	Small Group Market		
Alabama	File and use	File and use			Yes	33%	22%		
Alaska	File and use	File and use			Yes	50%	0%		
Arizona	File and use	File and use	50-60%	50-60%	No	0%			
Arkansas	Prior approval	Prior approval	80%#	80%#	No	17%	0%		
California	File and use	File and use	70-85%	70-85%#	No	6%			Other
Colorado	Prior approval	Prior approval	65%	70%	Yes	54%	31%	Yes	
Connecticut	Prior approval	Prior approval^		80%#	Yes	73%	53%	Yes, if hearing	Hearings/Comments
Delaware	Prior approval	Prior approval	50-60%	50-60%	Yes	64%	19%		
District of Columbia	Prior approval	Prior approval			No				
Florida	Prior approval	Prior approval	65%	65%	Yes	5%	5%	Yes	
Georgia	None	None			Yes	5%	5%		
Hawaii	Prior approval^	Prior approval^			Yes	17%	0%		
Idaho	File and use	File and use			No	0%	0%		
Illinois	File and use	None			N/AV			Yes, individual	
Indiana	Prior approval	File and use			N/AV				
Iowa	Prior approval	Prior approval	50-60%		Yes	55%			Hearings/Comments
Kansas	Prior approval	Prior approval	50-60%		Yes	55%	0%		
Kentucky	Prior approval	Prior approval	65%	70-75%	Yes	11%	0%		
Louisiana	File and use	File and use			N/AV				
Maine	Prior approval	Prior approval^^	65%	78%*	Yes	21%	0%	Yes	Hearings/Comments
Maryland	Prior approval	Prior approval	60%	75%	Yes	33%	15%		
Massachusetts	Prior approval	Prior approval	88%	88%	Yes	40%	40%		
Michigan	Prior approval^	Prior approval^	50-60%	80%	Yes				Hearings/Comments
Minnesota	Prior approval	Prior approval	72%	82%	Yes	23%	5%		
Mississippi	File and use	File and use			Yes				
Missouri	None	File and use			No				
Montana	None	File and use			Yes				
Nebraska	Prior approval	File and use			Yes			Yes	
Nevada	Prior approval	Prior approval^			No	10%	0%		
New Hampshire	Prior approval	Prior approval	65-75%	50-85%	Yes	55%	33%		
New Jersey	File and use	Prior approval	80%*	80%*	Yes	15%	0%	Yes, individual	
New Mexico	Prior approval	Prior approval	75%*	85%*	Yes	32%	14%		Hearings
New York	Prior approval	Prior approval	82%*	82%*	Yes	43%	83%		Comments
North Carolina	Prior approval	Prior approval	50-65%*	65-75%#	Yes	3%	0%	Yes	
North Dakota	Prior approval	Prior approval	55%	70%	Yes				
Ohio	Prior approval	File and use	60-80%	60-80%	Yes	37%	15%	Yes	
Oklahoma	Prior approval^	Prior approval		60%	Yes				
Oregon	Prior approval	Prior approval			No	37%	50%	Yes	Comments
Pennsylvania	Prior approval	Prior approval^	45-60%		No	55%	15%	Yes	Comments
Rhode Island	Prior approval	Prior approval			No				Hearings/Comments/Other
South Carolina	Prior approval	File and use	50-60%		No				
South Dakota	File and use	File and use	80%*	80%*	Yes	47%			
Tennessee	Prior approval	File and use	50-75%	75%#	No	19%			
Texas	File and use	File and use			Yes	5%	7%		Other
Utah	File and use	File and use	50-60%	50-60%	No	77%	54%		
Vermont	Prior approval	Prior approval	70%		Yes	24%	43%		
Virginia	Prior approval	File and use	50-65%		No				
Washington	Prior approval	Prior approval	74-77%*	74-77%#	Yes	57%	14%		Other
West Virginia	Prior approval	Prior approval	60%*	73-77%	Yes	10%	0%		Other
Wisconsin	File and use	File and use			No	0%		Yes, individual	Other
Wyoming	File and use	File and use			Yes	0%	0%		

Data sources and notes: (1) Corlette & Lundy (2010); ^prior approval for health maintenance organizations and/or Blue Cross Blue Shield plans only; ^^prior approval unless carrier elects 78% guaranteed loss ratio option. (2) America's Health Insurance Plans (2011); #MLR applies to HMO or health care service corporations only; *rebate required if health insurance carrier exceeds the minimum MLR. (3) Government Accountability Office (2011). (4) Government Accountability Office (2011) and authors' research (Massachusetts). Chapter 58 of the Acts of 2006, "Providing Affordable, Quality, and Accountable Health Care" merged Massachusetts's individual market into the small group market. A very small number of individuals (<1%) have not entered the merged market. Government Accountability Office (2011) reported that 0% of filings reviewed for those policies were disapproved, withdrawn, or resulted in lower rates in 2010. (5) Philips (2010b). (6) Government Accountability Office (2011); "N/AV" not available; "comments" include public comment periods; and "other" includes establishing consumer advisory boards and making rate filings more accessible to the public.

California

In California, the Department of Managed Health Care (DMHC) regulates health care service plans (i.e., HMOs and some PPOs), and the California Department of Insurance (CDI) regulates health insurance carriers (i.e., traditional fee-for-service insurers, most PPOs, and Medicare supplemental coverage). DMHC oversaw carriers that cover 21.6 million enrollees in 2009, and CDI oversaw carriers that cover 2.4 million enrollees in 2008, including 52% of the individual market (California HealthCare Foundation, 2010).

California is classified as a file-and-use state for health insurance rate review. Health insurance carriers are required to file specified rate information at least 60 days prior to the effective date of any rate change, but DMHC and CDI do not have the authority to disapprove a rate increase. California's file-and-use authority was modified and strengthened last year. In September 2010, California enacted Senate Bill 1163 "Health care coverage: denials: premium rates." As of January 1, 2011, all proposed health insurance rate increases are required to be reviewed and certified by an independent actuary, including health insurance regulated by either DMHC or CDI in the individual, small group, and large group markets. DMHC and CDI report that their rate review has saved consumers $100.5 million in health insurance premiums, including $13.5 million by DMHC in the third quarter of 2011 and $87 million by CDI since January 3, 2011 (Barnhart, 2011; Jones, 2012). To increase transparency, rate increases will be posted on the websites of DMHC, CDI, and carriers.

Furthermore, in October 2011, California enacted Senate Bill 51 "Health care coverage." The main provision of the law was to align California's minimum MLR

requirements with ACA's MLR requirements: at least 80% in the individual and small group markets and at least 85% in the large group market.

If AB 52 "Health Care Coverage: Rate Approval" had been enacted, it would have given DMHC and CDI prior approval authority. AB 52 would have prohibited DMHC and CDI from approving any rate or rate change in the individual, small group, and large group markets that was found to be "excessive, inadequate, or unfairly discriminatory." The bill did not clearly define the criteria that would be used to determine whether a rate was excessive, inadequate, or unfairly discriminatory. The bill stated that "the review shall consider, but not be limited to, medical expenses and all nonmedical expenses, including, but not limited to, the rate of return, overhead, and administration, and surplus, reserves, investment income, and any information submitted under Section 1385.004 or 1385.005." The California Assembly passed AB 52 on June 2, 2011, and Senate Committee on Health approved the bill on July 6. The bill did not come before the full Senate because of a lack of support, in part because Governor Jerry Brown's Department of Finance raised concerns over the cost of implementing prior approval authority (Hill, 2011). Moreover, the Health Benefit Exchange Board has cautioned that the bill could interfere with the Health Benefit Exchange in California regarding its negotiation of rates with participating health plans (Capitol Alert, 2011). The bill will likely be debated again in the 2012 legislative session.

Consumer Watchdog Campaign is currently collecting signatures for a California ballot measure "Approval of Healthcare Insurance Rate Changes," which is substantively similar to AB 52, except that prior approval would not apply to the large group market (Consumer Watchdog Campaign, undated). The authority to approve rates would be

vested in the CDI, including the rates for health care service plans that DMHC otherwise regulates.

Minnesota

The major health insurance carriers by membership market share in Minnesota's individual market in 2010 included Blue Cross Blue Shield of Minnesota (63%), Medica (12%), HealthPartners (10%), and Assurant Health (10%) (Minnesota Department of Commerce, 2011).[3] The major carriers in Minnesota's small group market in 2010 included Blue Cross Blue Shield of Minnesota (39%), HealthPartners (27%), Medica (23%), and PreferredOne (7%). Each of these carriers operates as a non-profit.

The Minnesota Department of Health (MDH) licenses and regulates health maintenance organizations (HMOs), whose members comprise approximately 2% of the individual market and 29% of the small group market (Minnesota Department of Commerce, 2011). The Office of Insurance Commissioner, which is part of the Minnesota Department of Commerce (DOC), regulates other health insurance carriers and Blue Cross and Blue Shield of Minnesota. MDH contracts with the DOC to review health insurance rate filings for the plans that it regulates. Yet, MDH retains final decision authority on approving rates for the plans it regulates.

Minnesota has had prior approval authority in the individual and small group markets for at least 15 years. The law states that a rate must not be approved unless the DOC or MDH has determined the rate to be reasonable. A key criterion to determine

[3] Companies with common ownership were treated as one entity. Health insurance carriers with premium volume of less than $200,000 were not included in the cited report.

whether a rate increase is reasonable is whether the rate meets the minimum MLR.[4] For major HMOs and nonprofit health service plan corporations, the minimum MLR is 72% in the individual market, and is 82% in the small group market (Minnesota Department of Commerce, 2011).[5] The MLR requirement is prospective, meaning that the projected MLR has to meet the relevant threshold, but if the realized MLR is less than the threshold, individuals and small employers do not receive rebates. A second key criterion to determine whether a rate increase is reasonable is whether it involves a higher-than-usual rate increase. For example, when utilization was higher than anticipated for high deductible health plans, the actuarially justified rate increase could not be immediately implemented, but had to be phased in over several years. This phase-in policy delicately balances consumer protection from steep increases, on the one hand, and carriers' solvency requirements, on the other.

The health insurance market is reported to be fairly competitive in Minnesota. However, the provider market is concentrated in certain areas of the state, resulting in higher costs in those areas. Carriers reported that prior approval regulation does not seem to help moderate provider cost increases.

To review proposed rates, the DOC stipulates that filings need to include a description of the policy, benefits, and marketing methods as well as the scope and reason

[4] In the 1990s, judgments about the reasonableness of a rate increase included consideration of cost containment goals. For example, for calendar year 1998, the cost containment goal was for health care spending to not exceed the change in the regional consumer price index for urban consumers for calendar year 1997 plus 2.6 percentage points. Because of cost increases associated with new health care technology and treatments, it became evident that health insurance carriers would not meet these goals and remain solvent. Before a financial penalty was about to assessed in the late 1990s, the state legislature removed the financial penalty for not meeting the goals.

[5] The ACA's minimum MLR is 80% in both the individual and small group markets. Minnesota has not raised its individual market minimum MLR to 80%. This is partly because Minnesota's methodology used to calculate the MLR results in a lower MLR, as compared to the MLR calculated using the ACA methodology. The ACA methodology subtracts premium taxes and assessments from earned premiums.

for the rate revision, including the maximum increase a policyholder or employer would experience (Philips, 2010a). The filing needs to document premium and claims experience for the past five years, as well as the rate increase history. Support for the anticipated cost trend and expected future loss ratio must be included, along with a certification by an actuary employed or retained by the health insurance carrier that the premiums are reasonable in relation to the benefits.

In order to review and approve rates, DOC employs one health care actuary, and that person reviews medical insurance rates and other health-related insurance rates, such as dental, Medicare supplemental, and long-term care insurance. The total annual cost to review and approve medical insurance rates in the individual and small group markets is approximately $81,000, which covers two DOC employees: 15% of an actuary's time and 50% of a non-actuary's time (Minnesota Department of Commerce, 2011). The costs are low because the filing requirements are relatively clear. In addition, most of the insurance carriers are Minnesota-only carriers, so they can focus on Minnesota's filing requirements, resulting in fewer filing errors.

Carriers bear costs to file rates with the state; however, a majority of the effort to prepare filings involves work that the carrier would have done, even if filings were not required. For example, the carrier would still do an actuarial analysis to estimate the medical and non-medical costs for each product, as part of its process to set premiums. The additional annual effort for a carrier to file its individual and small group products and to respond to questions involves approximately one full-time-equivalent person for five to six weeks.

The carriers and the DOC have a working relationship where expectations are fairly well known. The actuarial review, minimum MLR, and premium restrictions are well understood by both parties. However, new situations arise, and DOC's interpretation of a rule may not be documented quickly enough to avoid the need for carriers to revise their filings. For example, carriers recently had to meet the ACA's requirement to offer coverage to dependent children up to age 26. Because of lack of prior data regarding average claim cost of dependents, the increase in premiums for the requirement ranged from 2-70% across the carriers. Therefore, the DOC needed to do significant analyses and comparisons across carriers, which required more information from the carriers, in order to determine what increase was reasonable. The DOC required filings to be revised to state whether the actuarial analysis assumed 1, 2, or 3 or more dependent children, while in the past, this level of detail was not required. Finally, although DOC completes rate approvals for the plans that the Department of Health regulates, the agencies sometimes interpret laws differently, which adds work for the carriers.

Massachusetts

In 2008, the major HMOs by membership market share in the merged individual and small group market included Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. (54.3%), Harvard Pilgrim Health Care, Inc. (17.6%), and Tufts Associated Health Maintenance Organization, Inc. (15.1%) (Murphy, 2010a). All of these HMOs operate as non-profits. HMO enrollees represent 87% of the merged market.

In 2006, Massachusetts passed a major health reform law, Chapter 58 of the Acts of 2006, "Providing Affordable, Quality, and Accountable Health Care." The reform included expanding MassHealth (Massachusetts's Medicaid program); merging the

individual market into the small group market; establishing the Commonwealth Health Insurance Connector Authority ("Connector"), an exchange for the merged individual and small group markets; and mandating that residents have health insurance coverage.

In February 2010, Governor Deval Patrick directed the Commissioner of Insurance to issue an emergency regulation and bulletin that required HMOs and Blue Cross and Blue Shield of Massachusetts, Inc. (BCBSMA) health plans, which cover approximately 95% of the people insured through the merged market, to file rate increases 30 days prior to their effective date, and to include more detailed actuarial information to justify the rate increase than previously had been required (Massachusetts Division of Insurance, 2010; Murphy, 2010b).[6] The emergency regulation and bulletin applied to rate increases that were to be effective April 1, 2010. Following the final promulgation of this regulation, the timeline to file rate increases changed to 90 days prior their effective date, for rate increases that were to be effective October 1, 2010. Since 1976, the Division of Insurance (DOI) had prior review and disapproval authority for all rates, but did not exercise it, partially because carriers were only required to file on or near the rate's effective date, giving regulators little opportunity to review the filing.[7] The governor's direction for the state to exercise its authority was prompted by a period of double-digit rate increases.

In addition to the actuarial justification for the rate increase, if an HMO or BCBSMA intended to pay similarly situated providers different rates of reimbursement, it had to provide a detailed description of the basis for the different rates including, but not

[6] The emergency regulation and bulletin apply to the large group market, but the DOI does not expend as much effort reviewing those filings, as compared to the filings in the merged market.
[7] Prior to 1996, DOI had prior approval authority for BCBSMA's guaranteed issue plans and exercised that authority. They served as plans of last resort for people with pre-existing conditions who could not otherwise obtain coverage.

limited to: (1) quality of care delivered; (2) mix of patients; (3) geographic location at which care is provided; and (4) intensity of services provided. The intent of this provision was to try to limit providers from exercising their market power. The governor stated that any proposed increases greater than medical inflation, which was 3.2%, would be challenged. For the filings that were to become effective April 1, 2010, the commissioner did not approve the rate increase for 235 of the 274 filings.

The major carriers challenged DOI's disapprovals, stating that it had impermissibly disapproved the submitted rate increases based on a predetermined, arbitrary and inadequate rate cap, which was insufficient, given provider reimbursement increases in the state. Harvard Pilgrim Health Care, Inc. was the first carrier to be granted an administrative hearing at the DOI. On June 24, 2010, the hearing officers reversed the DOI's disapproval and ruled that there are reasons beyond the four factors identified for which provider reimbursements could justifiably vary, particularly the relative market power of providers (Cornell, 2011). A Massachusetts Attorney General report found that provider reimbursement varied substantially among providers, and the variation was primarily linked to market power, not quality or case mix (Coakley, 2011; Coakley, 2010). Almost all remaining carriers reached settlements with the DOI, agreeing to not retroactively apply rate increases, and to limit increases for the remainder of the year to between 7 and 13 percent.

In August 2010, shortly after the hearing officers reversed DOI's disapproval of Harvard Pilgrim Health Care, Chapter 288 of the Acts of 2010 was signed into law, which applied to carriers in the merged market. It required the following: (1) projected

weighted-average MLR for a carrier's plans to be at least 88% in 2011 and 90% in 2012;[8] (2) projected increases in administrative expenses to not exceed the New England medical CPI; and (3) contributions-to-surplus level to not exceed 1.9% (Cornell, 2011). If a carrier does not meet these criteria, the statute requires that a rate increase be presumptively disapproved and subject to a mandatory rate hearing. If a carrier meets the criteria, then DOI will consider the reasonableness of the rate in relation to the benefits provided, and will consider whether rate increases are based on unreasonable increases in the rates paid to contracting providers. Governor Deval Patrick is advocating for a bill that would allow the state to regulate what carriers are paying providers, particularly hospitals. This proposed legislation is H1849 "An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments." The legislative committee is currently working on their version of the bill. The Special Commission on Provider Price Reform, created by Chapter 288 of the Acts of 2010, issued its recommendations, including one to create an independent panel that would determine whether a provider's price—if it is above the market-based median and is rejected by the insurer—is justified based on the demonstrated quality of the service (Special Commission on Provider Price Reform, 2011). The Commission's representative from the Massachusetts Hospital Association cast the only vote against this recommendation, stating that the factors driving price variation need to be better understood to determine whether they are justified (Nicholas, 2011).

In Massachusetts, the DOI's Health Care Access Bureau employs approximately seven staff, but only one actuary and the Deputy Commissioner are involved in prior

[8] The 2012 MLR applies for coverage issued or renewed through September 30, 2012, after which, the requirement would sunset, unless future legislation extends it.

review and disapproval of medical insurance rates. DOI contracts with three actuarial consultants to assist. The total annual cost is approximately $300,000, including $100,000 for DOI staff plus $200,000 for actuarial consultant costs. These costs do not include DOI's costs to review other health-related insurance rates, such as dental, Medicare supplemental, and long-term care insurance.

Carriers bear costs to file rates with the state; however, a majority of the effort to prepare filings involves work that the carrier would have done, even if filings were not required. For example, the carrier would still do an actuarial analysis to estimate the medical and non-medical costs for each product, as part of its process to set premiums. The additional annual effort for a carrier to file its merged market products and to respond to questions involves approximately one full-time-equivalent person for six months, or approximately 1.5 months per quarter.

The working relationship between carriers and DOI is still in transition, because DOI has only been exercising its prior review and disapproval authority for a little over a year and a half. The presumptive disapproval criteria are relatively objective and clear, but DOI's other criteria are less objective, can change, and may be subject to different interpretations, such as when DOI considers how well carriers negotiated provider reimbursements. Because DOI has pushed for lower rates, carrier actuaries have stated in some of their filings that the approved rate was inadequate to pay expected claims and cover administration costs.

Discussion

The objective of this study is to examine health insurance rate review regulation in Minnesota and Massachusetts, to inform California policy-makers regarding evidence

on prior approval authority. During 2011, California considered legislation “Health Care Coverage: Rate Approval” (AB 52) to give the California Department of Managed Health Care and the California Department of Insurance the authority to disapprove health insurance rates. The bill passed the Assembly but ultimately failed to pass in the Senate. The bill will likely be debated again in the 2012 legislative session.

Prior approval authority has the potential to moderate rate increases, but there is also the potential that it could lead to higher rates. The literature does not contain a quantitative study with a strong research design that estimates its impact on health insurance premium growth. In a state with prior approval regulation, it will likely be more difficult for a health insurance carrier with market power to charge higher rates than are actuarially justified. Moreover, rate review regulation has the potential to increase market information about rates and premiums, allowing consumers and employers to more easily compare premiums. On the other hand, carriers may be able to reduce the impact of the regulation and still earn excess profits or surpluses, by changing more difficult-to-measure dimensions, such as customer service. Other important dimensions that may also be difficult to measure, such as claims processing times and the comprehensiveness and quality of their provider network, are regulated by the California Department of Managed Health Care, but fewer consumer protections exist for health plans regulated by the California Department of Insurance. Prior approval authority may cause some carriers to exit the market and may cause others to not enter the market, due to increased market uncertainty, both of which could reduce competition and lead to higher rates. However, this potential has not been well studied.

We think there are three key lessons that California can learn from Minnesota and Massachusetts. First, if prior approval authority is sought, California should establish guidelines that are as clear and objective as possible, such as actuarially based criteria. For example, Massachusetts uses three actuarial criteria for presumptive disapproval, but the remaining criteria are based on reportedly undefined standards requiring that rates not be "excessive, inadequate or unreasonable in relation to the benefits provided." The interpretation of these standards has changed over time and has been subject to litigation.

Even with relatively objective criteria, the criteria need to accommodate a variety of situations. For example, even if a rate is considered to be actuarially justified, it is important to consider the financial health of the overall firm in determining whether a rate is excessive or inadequate. In addition, the medical loss ratio is often a key criterion used by states for rate approval, and states vary on how they distinguish medical from non-medical costs, particularly in the areas of quality-improvement initiatives (Haberkorn, 2010). Robinson (1997) emphasizes the limitations of the medical loss ratio, and notes that the MLR will be lower for an HMO that administratively manages care, versus a preferred provider organization or indemnity insurance plan where care management is shifted to providers and is treated as a medical expense. In addition, the MLR does not incorporate important dimensions, such as customer service, claims processing times, and the comprehensiveness of the provider network.

Second, any California prior approval legislation should be designed to correct market failures in the health insurance industry, realizing other legislation and regulations may be needed to correct market failures in the health care sector more broadly. The economic justification for regulation stems from a market failure, such as market power

and imperfect information. Market failure can exist in the insurance sector, including market power in some localities, as well as information asymmetries between consumers and carriers, leading to adverse selection. Prior approval authority can prevent excessive rates from being charged where carriers are exerting market power. This authority can also prevent excessive rates being charged to enrollees in closed products. If a health insurance carrier effectively closes a product by no longer marketing it, the remaining enrollees will likely become less healthy over time, because the relatively more healthy enrollees can more easily purchase another product. The closed product can face steep increases in premiums that would still meet a minimum MLR. If carriers raise premiums based on the closed product alone—not on a larger pool of similar open products—this will hurt their reputation. However, because consumers do not know which products will eventually be closed, and because the time period between the initial purchase of a product and it being closed may be ten years or more, prior approval authority may be needed to prevent soaring premiums for closed products.

Although market failures in the health insurance industry contribute to health insurance premium growth, the principal driver of growth is rapidly evolving health care technology that makes new treatments available (Newhouse, 1992). In addition, health care is being delivered by providers with significant market power—many of which operate with poor incentives to deliver high-quality care at a low cost (Arrow et al., 2009). In light of this situation, rate regulators in Massachusetts have extended their regulatory authority to include examining provider reimbursements, because increasing provider reimbursements appear to be contributing to increasing health insurance premiums (Coakley, 2011; Coakley, 2010). Setting a minimum MLR, which is often used

in prior approval states, is not, by itself, sufficient to hold down premiums when medical costs are increasing.

The regulation of the provider market power in California may deserve separate legislation executed by a state's antitrust division, because antitrust regulation is inherently different from actuarially based regulation. Hospital and physician group market power is particularly strong in Massachusetts and is related to high provider reimbursement levels (Coakley, 2011; Coakley, 2010). In California, hospital and medical group consolidation during the late 1990s and early 2000s has strengthened their negotiating power with health insurance carriers (Berenson et al., 2010). Another California study found greater physician organization concentration was associated with higher physician prices, but greater health insurance carrier concentration was not associated with higher premiums (Schneider et al., 2008). To help mitigate the adverse effects of provider market power, California SB 751 "Health care coverage: provider contracts" is under consideration and would prohibit hospital-imposed contract clauses that restrict carriers from furnishing information to enrollees on the cost and quality of procedures at a hospital.

Third, both Minnesota and Massachusetts emphasized the need for regulators to employ sufficient staff with actuarial expertise or have the ability to contract with outside consultants. Both states reported having sufficient capacity and resources to review rates (GAO, 2011). In Massachusetts, filings are now required 90 days in advance of a rate increase, and the state has 45 days to approve or disapprove the increase. This leaves individuals and employers only 45 days to compare rates, which carriers thought was an insufficient amount of time for them to market their plans. In California, if AB 52 had

passed, carriers were concerned that rates may not be approved in a timely manner, because of the number of staff DMHC and CDI would need to hire. A delay could significantly impact a carrier operating with thin margins. For example, if a carrier is negotiating a rate increase with a regulator of between 6% and 8%, during the negotiation period, no rate increase will likely be implemented (not even the lower one). In addition, AB 52 included a provision where consumer representatives (intervenors) could call for rate hearings, which could extend the approval process. Carriers would incur the cost of intervenors. This provision is modeled after California's Proposition 103, passed in 1988, which regulates automobile, homeowners, and other property-casualty insurance rates (California Department of Insurance, 2011).

The California Department of Finance estimated the annual costs of AB 52 would be $27.5 million for 181 additional staff for DMHC and CDI to review and monitor activities related to rate approval (Hill, 2011). The cost to conduct rate review and approve or disapprove rates in Minnesota and Massachusetts appears to be far lower, even considering that they are smaller states and neither actively reviews rates in the large group market. However, AB 52 proposed to regulate the large group market. Minnesota's prior approval authority does not extend to the large group market, and Massachusetts's prior review and disapproval authority does not concentrate on the large group market. But notably, California was one of the 15 states that reported insufficient capacity and resources to review rates, so it may be currently understaffed (GAO, 2011). In Minnesota, the annual cost to review medical health insurance rates in the individual and small group markets is approximately $81,000, which covers two DOC employees: 15% of an actuary's time and 50% of a non-actuary's time (Minnesota Department of

Commerce, 2011). In Massachusetts, the annual cost to review medical insurance rates is approximately $300,000, which covers a portion of one actuary's and the Deputy Commissioner's time as well as three actuarial consultants.

To help California policy-makers determine the best policies to moderate health insurance premium increases, the following additional areas of research should be pursued. This research would also be helpful if California implements prior-approval authority. The proposed research will mitigate a key limitation of this study, in that our findings are based on only contacting a limited number of experts in Minnesota, Massachusetts, and California. First, California's health care sector needs to be studied, including health insurance carriers, technology, providers, and payment systems, to determine which areas are most responsible for health insurance premium increases and which warrant regulation. Second, research should investigate whether the Affordable Care Act's minimum medical loss ratio and California's required rate review and certification by an independent actuary are sufficient to prevent excessive rates. Third, additional states should be studied in more detail to learn which criteria are most important to use to determine whether rates are excessive (or inadequate or discriminatory). In March 2012, the authors of this study, through their affiliation with the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health, University of California-Berkeley, were awarded a two-year grant titled "Impact of State Rate Review Regulation on Health Insurance Premiums" by the Robert Wood Johnson Foundation. That study will estimate the impact of state rate review regulation on health insurance premiums, which will include identifying which, if any, criteria had the largest impact on reducing health insurance premium increases. Fourth,

the costs of prior approval authority should be investigated in more detail, because the California Department of Finance estimate appears to be much higher than Minnesota's and Massachusetts's costs, even considering that they are smaller states and neither actively reviews rates in the large group market. This research will enable California to better understand how best to moderate health insurance premium increases, and if prior approval authority is determined to be prudent, then the proposed research will help it most effectively implement that authority.

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