

**STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street
San Francisco, California 94105**

**NOTICE OF PROPOSED READOPTION OF EMERGENCY ACTION
PURSUANT TO INSURANCE CODE SECTION 10293 AND
GOVERNMENT CODE SECTION 11346.1(h)**

DATE: July 7, 2011

READOPTON OF PRIOR OAL FILE NUMBER: 2011-0112-01 E

CDI REGULATION FILE: ER-2011-00001

**LOSS RATIO REGULATION FOR
INDIVIDUAL HEALTH INSURANCE POLICIES**

**OPPORTUNITY FOR INTERESTED PARTIES TO SUBMIT COMMENTS TO THE
OFFICE OF ADMINISTRATIVE LAW**

Paragraph (a)(2) of Government Code section 11346.1 requires that, at least five working days prior to submission of the proposed emergency action to the Office of Administrative Law, the adopting agency provide a notice of the proposed emergency action to every person who has filed a request for notice of regulatory action with the agency. After submission of the proposed emergency to the Office of Administrative Law, the Office of Administrative Law shall allow interested persons five calendar days to submit comments on the proposed emergency regulations as set forth in Government Code section 11349.6.

This notice is for a readoption of the proposed emergency regulation, pursuant to Government Code section 11346.1(h). The emergency regulation, OAL file number 2011-0112-01 E, was filed with the Secretary of State on January 24, 2011. The Department of Insurance submitted an emergency rulemaking action to amend section 2222.12 of title 10 of the California Code of Regulations. This amendment was prompted by the enactment of the federal Affordable Care Act, a series of health market reforms, and the Interim Final Rule. 45 Code of Federal Regulations Part 158, which describes the factors, scope, and method used in the calculation of loss ratios. The federal rules provide, among other things, that beginning January 1, 2011, health insurers offering coverage in the individual market must achieve at least an 80% loss ratio. Those insurers that do not meet this standard will be required to provide a refund the following calendar year. As a result of this amendment, insurers in California will have to demonstrate both (1) compliance with the existing 70% lifetime anticipated loss ratio standard prescribed by section 2222.12, so that consumers are assured of receiving reasonable benefit value for their premium dollars on a policy-form basis, as well as (2) compliance with the 80% federal standard on a market-segment basis at the time of the Department's rate review, so that consumers can have the benefit of the federal medical loss ratio from the outset of the rate, rather than having to wait from eight to twenty months for a premium refund.

INCORPORATION OF PRIOR RULEMAKING RECORD BY REFERENCE

Pursuant to 1 California Code of Regulations § 52(c), the Department of Insurance incorporates by reference the rulemaking record of the initial emergency adoption, OAL file number 2011-0112-01 E.

STATEMENT OF SUBSTANTIAL PROGRESS AND DILIGENCE IN COMPLIANCE WITH GOVERNMENT CODE SECTION 11346.1(E) [1 CCR § 52 (B) (1)]

The Department of Insurance has made substantial progress and proceeded with diligence in compliance with Government Code section 11346.1(e). After considering the comments submitted by interested parties in response to the initial adoption of this emergency regulation, the Department held meetings with insurance companies and industry groups, and consumer groups, respectively, regarding implementation of these and other provisions of federal health reform. The emergency regulation incorporates the federal loss ratio described in the interim final rule entitled “Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act,” (45 C.F.R. §§ 158.220-158.232, 75 Fed. Reg. 74927-74928, (December 1, 2010)). However, on December 23, 2010, the federal government also promulgated another proposed rule regarding health insurance rates, “Rate Increase Disclosure and Review” (45 CFR 154). This latter proposed rule did not become a final rule until May 23, 2011. As the emergency regulation described in this notice involves incorporation of federal loss ratio rules into state regulation, the Department considered it prudent to wait for both federal rate regulations to come into their final form before proceeding with the permanent state rulemaking proceeding, in order to avoid incorporating potentially obsolete, superseded federal provisions into state law.

Notice of the regular, noticed rulemaking action to make the regulations permanent, CDI file number REG-2011-00005, will be submitted to the Office of Administrative Law on or before July 12, 2011 for publication in the July 22, 2011 Notice Register. The public hearing on the permanent rulemaking proceeding will be held on September 13, 2011 in the Department of Insurance San Francisco office.

EXPRESS FINDING OF EMERGENCY

Statement Regarding Unchanged Emergency Circumstances (1 CCR § 52 (b)(2))

The emergency circumstances are unchanged since the initial adoption of OAL file number 2011-0112-01 E.

AUTHORITY AND REFERENCE

The proposed regulations will implement, interpret and make specific the provisions of Insurance Code sections 10293. Insurance Code section 10293 provides authority for this rulemaking.

INFORMATIVE DIGEST; DESCRIPTION OF THE PROBLEM AND THE NECESSITY FOR THE REGULATION

Summary of Existing Law

Insurance Code section 10293, originally enacted during the 1961 legislative session, requires, among other provisions, that the Insurance Commissioner withdraw approval of individual or mass-marketed policies of disability insurance “if after consideration of all relevant factors the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged.”ⁱ The same Insurance Code section also requires that the Insurance Commissioner promulgate “such reasonable rules and regulations...as are necessary to establish the standard or standards by which the commissioner shall withdraw approval of any such policy.”ⁱⁱ As a result, on November 30, 1962, the Insurance Commissioner ordered that a new Article 1.9, consisting of sections 2222.10 to 2222.19, be added to the California Administrative Code.ⁱⁱⁱ This article adopted a 50% “loss ratio” as the means to determine whether the benefits provided by a policy were reasonable in relation to the premium charged. A “loss ratio” is a measure used to evaluate the reasonableness of the benefits provided by a hospital, medical or surgical policy. Here, the “loss ratio” is the ratio of incurred claims to earned premium. In 2006, section 2222.12 was amended to change the loss ratio standard to 70%, and to permit insurers to consider disease management expenses.

Policy Statement Overview

1) Federal Health Reform

The federal Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (Pub. L. 111-152) was enacted on March 30, 2010. Collectively, these two statutes are referred to as the Affordable Care Act (“ACA”). Among the health insurance market reforms of the ACA, section 2718 (42 USCS §300gg-18), entitled “Bringing Down the Cost of Health Care Coverage,” provides that, beginning January 1, 2011, health insurers offering coverage in the individual market must achieve at least an 80% loss ratio. Further, if the insurer does not meet the required minimum loss ratio, it must provide a refund the following calendar year. The Department of Health and Human Services subsequently issued an Interim Final Rule, 45 Code of Federal Regulations Part 158 (Dec. 1, 2010, with technical corrections issued Dec. 30, 2010) which described the factors, scope, and method used in the federal calculation. This Interim Final Rule provides that insurers must report their federal medical loss ratio outcome for a calendar year by June 1 of the following year (45 CFR § 158.110). Thus, for calendar year 2011, the report is not due until June 1, 2012, and premium rebates are not due until August 1, 2012 (45 CFR § 158.241).

The loss ratio calculation method used in the existing California regulation uses a different calculation method than the federal loss ratio. The 70% minimum loss ratio in existing section 2222.12 is a lifetime anticipated loss ratio, which involves projections into the future based on actuarial assumptions regarding factors involved in the ratio, including medical cost inflation, future claims, durational effects, and other factors. The 70% minimum loss ratio is determined at the level of specific policy forms. In contrast, the federal 80% minimum loss ratio involves

different factors, is retrospective in nature, and is determined based on an aggregation of the loss ratios for all of the insurer's individual health insurance forms. Further, the federal 80% minimum loss ratio includes factors, such as premium tax and HIPAA Guaranteed Issue business costs, which are not included in the California 70% loss ratio calculation. This amendment to the regulation conforms the California regulation to the requirements of federal health reform, while preserving the consumer protections of the existing loss ratio standard.

2) Purchasers of individual hospital, medical, or surgical policies lack expertise and market power

One of the most significant factors facing purchasers of individual hospital, medical, or surgical insurance is the disparity in expertise and market power between the purchaser and the insurer. While large purchasers of group health insurance have expertise in judging the level of benefit, and market power in negotiating benefits, small groups and individuals lack such expertise and market power. In part as a result of this disparity, the market for individual insurance does not function at full efficiency. This disparity in market knowledge and market power accounts, in part, for the fact that the amount of premium remaining after benefits and expenses is significantly higher for individual hospital, medical, or surgical insurance, as compared to group health insurance.^{iv}

3) Purchasers of individual hospital, medical, or surgical policies bear an increasing economic burden

Consumers who purchase individual hospital, medical, or surgical insurance policies face a growing economic burden, as both premium costs and out-of-pocket expenses have significantly increased. This economic burden is consistent with larger trends in health care costs. In the past decades, health care spending in the United States has outpaced the general rate of inflation.^v Nationally, the amount spent per person on health care increased 74 percent between 1994 and 2004.^{vi} In addition to the increase in health care costs, the nature of the expenses has changed over the past 20 years, shifting to areas for which the individual hospital, medical, or surgical insurance policyholder often must pay a significant portion of the expense. For example, between 1984 and 2004, the amounts paid for prescription drugs, as a percentage of national health expenditures, increased from 4.9% to 10.0%.^{vii} From 2001 through 2004, the average annual growth rate in national health care expenditures was 8.4 percent.^{viii} In the California individual hospital, medical, or surgical insurance market, premiums rose almost 40 percent between 1997 and 2002, in contrast to an approximately 12 percent rise in the prices of other goods and services, as measured by the Consumer Price Index, over the same period.^{ix} Since section 2222.12 was last amended in 2006, the disparity between the rate of increase of health insurance premiums and the overall rate of inflation has become even more dramatic: while cumulative overall inflation between 2006 and 2010 was 12%, the cumulative rate of premium increases for individual and group insurance over the same five years was 48%, four times the rate of overall inflation.^x

4) Purchasers of individual hospital, medical, or surgical policies are a vulnerable population

While this environment of rising costs poses challenges for purchasers of individual hospital, medical, or surgical insurance, additional factors make these purchasers particularly vulnerable.^{xi} First, the individual hospital, medical, or surgical insurance market is the last resort for many; California has a higher rate of persons without insurance and lower rates of employer-sponsored coverage than does the nation as a whole.^{xii} In addition, the need for individual hospital, medical, or surgical insurance has been increasing due to corporate downsizing.^{xiii} Those who are not fortunate enough to receive insurance through their workplace and are not eligible for public programs must attempt to obtain coverage in the individual market. Once covered by individual insurance, many consumers rely on maintaining that coverage for years. In California, the individual insurance market is an important source of long-term hospital, medical, or surgical insurance coverage for a sizable fraction of those who purchase it.^{xiv}

A second factor that confronts purchasers of individual hospital, medical, or surgical insurance policies is the fact that products in the individual market are difficult to qualify for because they are carefully underwritten to manage risk. A third factor is the rapidly increasing cost of individual insurance. High premiums and the low incomes of many of the potential purchasers of individual insurance make affordability a particular concern.^{xv} The increasing expense of individual hospital, medical, or surgical insurance reduces affordability, which in turn reduces availability for consumers who might otherwise be forced to go without vital hospital, medical, or surgical insurance coverage. Also, inadequate benefits in individual insurance coverage can be a major source of underinsurance, which affects 13-20 percent of the privately insured.^{xvi} On average, coverage in the individual hospital, medical, or surgical insurance market is less complete than coverage in the group market.^{xvii} Thus, purchasers of individual hospital, medical, or surgical insurance are faced with rapidly increasing health care costs in general, as well as even more rapidly increasing premiums for individual coverage. Because they have no realistic alternative to individual coverage, such persons are at risk of being priced out of the individual insurance market, and joining the large number of uninsured Californians.

5) Conclusion

The current 70% lifetime anticipated loss ratio standard, evaluated on a policy-form basis, protects California consumers by assuring that each policy form will return at least 70 cents of benefit for each premium dollar. The amendment reflected in this notice extends further protection to California consumers by conforming the California regulation to the requirements of federal health care reform while providing consumers with immediate access to the additional benefit of the federal 80% standard, on a market segment basis. This regulation applies the 80% standard to consumers' premium dollars from the outset, without the insured having to wait for up to twenty months for a premium refund. Under federal law, a consumer who pays a premium in excess of that justified under the federal loss ratio requirement would have to wait until August of the following year for a refund. This presents the consumer with an inflated premium for the entire year of coverage; for individuals and families in difficult economic circumstances, such a front-end excess premium can create a barrier to access to health coverage, making the coverage effectively unavailable. Applying both the California and Federal standards in a

complementary fashion through this amendment achieves the mandate of Insurance Code section 10293, that benefits under a policy be reasonable in relation to the premium charged, while also removing a barrier to access to coverage, therefore making this vital coverage more available to Californians.

Effect of Proposed Action

As a result of the proposed action, insurers will demonstrate both (1) compliance with the existing 70% lifetime anticipated loss ratio standard, so that consumers are assured of receiving reasonable benefit value for their premium dollars on a policy-form basis, as well as (2) compliance with the 80% federal standard on a market-segment basis at the time of the Department's rate review, so that consumers can have the benefit of the federal medical loss ratio from the outset of the rate, rather than having to wait from eight to twenty months for a premium refund.

Comparable Federal Law

As discussed above, there are existing federal statutes and a regulation that are comparable to the proposed regulation, specifically 42 USCS §300gg-18 and 45 Code of Federal Regulations Part 158.

MANDATES ON LOCAL AGENCIES OR SCHOOL DISTRICTS

The proposed regulations do not impose any mandate on local agencies or school districts. There are no costs to local agencies or school districts for which Part 7 (commencing with Section 17500) of Division 4 of the Government Code would require reimbursement.

COST OR SAVINGS TO STATE AGENCIES, LOCAL AGENCIES OR SCHOOL DISTRICTS OR IN FEDERAL FUNDING

The Commissioner has determined that the proposed regulations will result in no cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code, no other nondiscretionary cost or savings imposed on local agencies, and no cost or savings in federal funding to the State.

The Department of Insurance will not incur additional rate review costs as a consequence of this amendment, as review of compliance with the federal loss ratio standard is already a part of the Department's rate review process.

DESCRIPTION OF SPECIFIC FACTS DEMONSTRATING THE EXISTENCE OF AN
EMERGENCY AND THE NEED FOR IMMEDIATE ACTION; DESCRIPTION OF THE
JUSTIFICATION FOR ADOPTION OF THE REGULATION AS AN EMERGENCY
REGULATION

Over one million Californians are covered by individual insurance products regulated by the Department of Insurance (1,060,225 covered lives in 2008). The two largest providers of individual insurance comprise 77% of the market, representing 814,495 covered individuals. These two largest insurers had premium revenue in the individual market of over \$2 billion. The average of the loss ratios for these two insurers in the individual market segment in 2009 was approximately 71%. Adjustments to the loss ratio prescribed by federal regulations regarding minimum loss ratio calculations would raise this average loss ratio by an amount that is estimated to be approximately 4%, yielding an adjusted medical loss ratio of approximately 75% -- approximately 5% less than the federal 80% medical loss ratio standard. Therefore, going forward, the insureds of just the two largest insurers would face an excess premium of over \$100 million, or over \$123/insured. Although this excess premium might be refunded in the middle of the following calendar year, this excess premium could effectively prevent some individuals, and particularly families, from obtaining insurance coverage. Although the Department of Insurance will commence an ordinary rulemaking proceeding under Government Code section 11346.4, the months required for such a proceeding would enable insurers to proceed with rate increases relying on the rebate provisions of federal law, rather than complying from the outset with the 80% loss ratio limitation, as would be the case under this amended regulation. For these 814,495 current insureds, as well as prospective purchasers and those covered by the insurers in the remaining 23% of the market, such a large excess rate increase in the present year could bar them from affording, and obtaining, needed health coverage, presenting a situation calling for immediate action to avoid serious harm to the public peace, health, safety, or general welfare. This emergency regulation is therefore required to conform the California regulation to the requirements of federal health reform, while at the same time assuring that consumers will obtain reasonable benefit, in relationship to policy premium, from the outset of their coverage in order to make coverage accessible to Californians.

In a March 2010 Health Policy Research Brief, the UCLA Center for Health Policy Research found that the uninsured rate among adults jumped nearly six percentage points between 2007 and 2009, reaching a level of 29.5%, including a steep decline in individual insurance coverage.^{xviii} Thus, the recent severe recession has placed Californians at serious risk of losing their individually-purchased health insurance. Chernew, et al., in their study "Increasing Health Insurance Costs and the Decline in Insurance Coverage," found that a \$1,000 increase in premium is associated with a 3.9 percentage point decline in coverage.^{xix} Thus, the \$123/insured excess premium estimated to a result from the delay of the implementation of the 80% loss ratio without this emergency regulation would, based on the Chernew study, result in an approximately 0.4 percentage point decline in coverage. As a consequence, of the 1,060,225 Californians with individual health insurance, approximately 4,241 would lose their health insurance coverage during the pendency of an ordinary rulemaking process, in the absence of this emergency regulation. Wilper, et al., in a 2009 study, found that the uninsured have a 40% higher risk of death compared to the insured.^{xx} Therefore, without this emergency regulation, 4,241 Californians will lose their health coverage during the time involved in promulgating a

regulation through an ordinary, non-emergency procedure. This loss of insurance will needlessly expose these 4, 241 Californians to a 40% increased risk of death. This loss of insurance, and attendant significantly increased risk of death, is a specific harm calling for immediate action to avoid serious harm to the public health and general welfare.

STUDIES AND REPORTS REFERENCED IN FINDING OF EMERGENCY

The commissioner considered and relied on the following technical and empirical studies in developing this regulation and finding of emergency.

- 1) Buntin, et. al., *Trends and Variability in Individual Insurance Products in California*, Health Affairs, W3-449, Sept. 23, 2003, www.healthaffairs.org
- 2) *California Health Care Almanac: California Health Plans and Insurers*, October 2010, California HealthCare Foundation, www.chcf.org
- 3) Chernew, M., Cutler, D.M., Keenan, P.S., *Increasing Health Insurance Costs and the Decline in Insurance Coverage*, Health Services Research, August, 2005, p. 1031
- 4) “Health Insurance in California: Where Do Your Premium Dollars Go?” PowerPoint presentation by Department of Insurance staff at June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236).
- 5) Lavarreda, S.H., Brown, E.R., Cabezas, L., & Roby, D., *Number of Uninsured Jumped To More than Eight Million from 2007 to 2009*, UCLA Health Policy Research Brief, UCLA Center for Health Policy Research, March, 2010, p. 4.
- 6) Marquis, et al., *Consumer Decision Making in the Individual Health Insurance Market*, Health Affairs, W226, May 2, 2006, www.healthaffairs.org.
- 7) Survey of Loss Ratio Requirements in Other States for Individual Health Insurance Policies, July 22, 2006, prepared by Department of Insurance Staff.
- 8) *Snapshot: Health Care Costs 101, 2006 edition*, California Health Care Foundation, www.chcf.org, pp. 1,4,6,15,14.16.
- 9) Transcript of December 1, 2005 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314).
- 10) Transcript of June 1, 2006 “Health Insurance in California: Where Do Your Premium Dollars Go?” PowerPoint presentation by Department of Insurance staff at June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236).
- 11) Wilper, A.P, Woolhandler, S., Lasser, K., McCormick, D., Bohr, D., & Himmelstein, D., *Health Insurance and Mortality in US Adults*, American Journal of Public Health, v. 99, no. 12, December 2009, p. 2289, 2292.

TEXT OF PROPOSED AMENDMENT TO REGULATION

Amend Title 10, Section 2222.12 to read:

§ 2222.12. Standards of Reasonability.

The authority of the commissioner under Insurance Code Section 10293 being to withdraw approval of policy forms the benefits of which are not reasonable in relation to the premium charged, whether the approval of any form of an insurer should be withdrawn pursuant to said section shall be determined by an analysis of actual loss experience, giving due consideration to all factors relevant to the determination of how the past loss experience may be used to reasonably indicate the average loss experience which should develop. Some of such factors which will be considered by the commissioner are hereinafter in this article set forth, but their listing does not preclude an-insurer from urging any other factors which it considers relevant to the issue involved.

(a) Benefits provided by a hospital, medical or surgical policy shall be deemed to be reasonable in relation to premiums ~~if either~~ if both of the criteria in subdivisions (1) and (2), below, are satisfied:

(1) ~~(A)~~ (A) the lifetime anticipated loss ratio is not less than 70%, and ~~(2)~~ (B) in the case of a rate revision, the anticipated loss ratio over the future period for which the revised rates are computed to provide coverage is also not less than 70%, or, if the insurer chooses to include disease management expenses in determining compliance with these standards, ~~(3)~~ (C) the sum of the lifetime anticipated loss ratio and the lifetime anticipated disease management ratio is not less than 70%, and ~~(4)~~ (D) in the case of a rate revision, the sum of the anticipated loss ratio over the future period for which the revised rates are computed to provide coverage and the anticipated disease management ratio over the future period for which revised rates are computed to provide coverage is also not less than 70%~~;~~and;

(2) the insurer's projected medical loss ratios in the individual market, calculated using the method described in the interim final rule entitled "Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act," (45 C.F.R. §§ 158.220-158.232, 75 Fed. Reg. 74927-74928, (December 1, 2010)) and incorporated herein by reference, are not less than 80%.

(b) Benefits provided by a hospital, medical, or surgical policy delivered or issued for delivery to any person in this State prior to July 1, 2007 and not subject to any rate revision effective on or after July 1, 2007 shall be deemed to be reasonable in relation to premiums if the lifetime anticipated loss ratio is not less than 50%.

(c) Benefits provided by supplemental policies of individual health insurance that provide coverage for vision care expenses only, dental care expenses only, or short-term limited duration health insurance with coverage durations of 6 months or less shall be deemed to be reasonable in relation to premiums if the lifetime anticipated loss ratio is not less than 50%.

(d) Benefits provided by a hospital, medical or surgical policy designed to supplement Medicare, as defined in subdivision (1) of Insurance Code section 10192.4, must meet the loss ratio standards established in Subdivision (a)(1)(A) of Section 10192.14 of the Insurance Code.

NOTE: Authority cited: Insurance Code section 10293.
Reference: Insurance Code section 10293(a).

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ⁱ Insurance Code section 10293(a)

ⁱⁱ Insurance Code section 10293(a)

ⁱⁱⁱ California Department of Insurance Ruling 127, file number RH-89, November 30, 1962, "In the Matter of the Proposed Adoption of Rules and Regulations of the Insurance Commissioner relating to Standards by which the Insurance Commissioner shall withdraw Approval of any Individual Medical, Hospital, or Surgical Policy the Benefits of which are Unreasonable in Relation to the Premium Charge."

^{iv} see, "Health Insurance in California: Where Do Your Premium Dollars Go?" PowerPoint presentation by Department of Insurance staff at June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236).

^v As of 2004, the growth rate in national health expenditures was 7.9%, compared with an annual growth rate in the Consumer Price Index of 2.7 percent. Per-capita national health care expenditure in 2004 was 17.6 times the level in 1970, while consumer prices, as measured by the CPI were 4.9 times 1970 levels. *Snapshot: Health Care Costs 101, 2006 edition*, pp.1, 15, 16, California Health Care Foundation, www.chcf.org.

^{vi} *Snapshot: Health Care Costs 101, 2006 edition*, p.4, California Health Care Foundation, www.chcf.org.

^{vii} *Snapshot: Health Care Costs 101, 2006 edition*, p.6, California Health Care Foundation, www.chcf.org.

^{viii} *Snapshot: Health Care Costs 101, 2006 edition*, p.14, California Health Care Foundation, www.chcf.org.

^{ix} Buntin, *supra* at W3-456.

^x *California Health Care Almanac: California Health Plans and Insurers*, October 2010, California HealthCare Foundation, www.chcf.org

^{xi} *Snapshot: Health Care Costs 101, 2006 edition*, p.1, California Health Care Foundation, www.chcf.org.

^{xii} Marquis, et al., *Consumer Decision Making in the Individual Health Insurance Market*, Health Affairs, W226, 227, May 2, 2006, www.healthaffairs.org.

^{xiii} Testimony of Mr. Roupen Berberian, Health Net Life Ins. Co., December 1, 2005 California Department of Insurance Investigatory Hearing Regarding Profitability of Health Insurance Companies, (file number IH05049314) RT 64:16-18.

^{xiv} Marquis, et al., *Consumer Decision Making in the Individual Health Insurance Market*, Health Affairs, W226, 228, May 2, 2006, www.healthaffairs.org.

^{xv} Marquis, et al., *Consumer Decision Making in the Individual Health Insurance Market*, Health Affairs, W226, May 2, 2006, www.healthaffairs.org.

^{xvi} Buntin, et. al., *Trends and Variability in Individual Insurance Products in California*, Health Affairs, W3-449, Sept. 23, 2003, www.healthaffairs.org.

^{xvii} Buntin, *supra* at W3-457

^{xviii} Lavarreda, S.H., Brown, E.R., Cabezas, L., & Roby, D., *Number of Uninsured Jumped To More than Eight Million from 2007 to 2009*, UCLA Health Policy Research Brief, UCLA Center for Health Policy Research, March, 2010, p. 4.

^{xix} Chernew, M., Cutler, D.M., Keenan, P.S., *Increasing Health Insurance Costs and the Decline in Insurance Coverage*, Health Services Research, August, 2005, p. 1031

^{xx} Wilper, A.P, Woolhandler, S., Lasser, K., McCormick, D., Bohr, D., & Himmelstein, D., , *Health Insurance and Mortality in US Adults*, American Journal of Public Health, v. 99, no. 12, December 2009, p. 2289, 2292.