

Statement of Scott E. Harrington  
Alan B. Miller Professor  
The Wharton School, University of Pennsylvania

On “PPACA's Effects on Maintaining Health Coverage and Jobs: A Review of the  
Health Care Law's Regulatory Burden”

Before the  
Subcommittee on Health  
Committee on Energy and Commerce  
United States House of Representatives

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Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee:

I am pleased to have this opportunity to provide testimony on the health insurance rate review and minimum medical loss ratio (MLR) provisions of the Patient Protection and Affordable Care Act (PPACA). My main points are as follows:<sup>1</sup>

1. The PPACA’s rate review and MLR provisions represent costly, bureaucratic interference with insurers’ legitimate business decisions and state regulatory prerogatives that will do little to enhance competition in health insurance markets and the availability and affordability of health insurance.
2. The rate review provisions and their implementation will not enhance consumer choice or lower premiums, but instead will increase insurers’ costs and risk, reduce their willingness to offer coverage, undermine their financial strength, and possibly increase pressure for even tighter regulation and/or enactment of a public option.
3. The MLR provisions will distort insurers’ incentives for legitimate business decisions, destabilize some states’ markets, and could reduce incentives for certain beneficial innovations in coverage and payment.
4. The PPACA’s rate review and MLR regulations should be replaced with pro-competitive reforms that would encourage states to adopt policies that promote informed competition and consumer choice.

## **Introduction**

Although the PPACA does not authorize the U.S. Department of Health and Human Services (HHS) to approve or deny proposed rate changes, it requires health insurers to justify “unreasonable” rate increases to state regulators in states with HHS approved rate review procedures, or to the HHS if a state’s procedures are not approved. Insurers with “unreasonable” rate increases can be excluded from participation in the health insurance exchanges scheduled to commence operation in 2014. The law authorizes grants to states to “enhance” their rate review, and the HHS proposes supplemental financial awards to states that adopt prior approval regulatory of rate changes.

In addition to its rate review provisions, the PPACA requires that health insurers’ spending on medical care and “activities that improve health care quality” must equal or exceed 85 percent of premiums (net of certain taxes and fees) for large group coverage and 80 percent of premiums for individual and small-group coverage. If necessary, insurers must rebate premiums to achieve these minimum “medical loss ratios” (MLRs).

## **Health Insurer Competition, Expenses, and Profits**

The PPACA’s rate review and MLR provisions reflect views that health insurance competition and previous state regulation did not adequately discipline insurers’ expenses and profits and that federal regulation and oversight of health insurers is the preferred response. However, aggregate data do not support the notion that health insurers’ expenses and profits are major drivers of high and rapidly growing health insurance premiums. According to National Health Expenditure (NHE) data, the projected “net cost” of private health insurance (premiums less benefits, including for self-funded plans) for 2010 was \$96.4 billion, representing 11.6 percent of \$829.3 billion in projected expenditures for private health insurance and 3.8 percent of \$2,569.6 billion in projected total health care expenditures.<sup>2</sup> The estimated MLR for all private health insurance (ratio of medical benefits to total premiums, including premium equivalents for self-funded plans) has averaged 87.8 percent since 1965, with little or no trend (see figure 1).<sup>3</sup>

Health insurers’ profit margins typically average about 3-5 percent of revenues (less for not-for-profit insurers). MLRs for insured plans average roughly 85 percent

(higher for not-for-profit than for-profit insurers); administrative expense ratios average about 11 to 12 percent.<sup>4</sup> Expense and profit data reported to state insurance regulators during 2006-2009 indicate that aggregate MLRs ranged from 85 to 88 percent for all insured coverage (including Medicare supplement and Medicare Advantage plans) and from 83 to 87 percent for comprehensive major medical coverage.<sup>5</sup>

While often high at the state and metropolitan levels, health insurance market concentration varies widely across regions, and high concentration does not necessarily imply adverse effects on consumers.<sup>6</sup> Market concentration is highly correlated with Blue Cross Blue Shield plan market shares. Many large Blues are not-for-profit and operate with high MLRs and very low profit ratios, making it difficult for other insurers to gain market share.

The extent and scope of economies of scale or other entry barriers in health insurance are uncertain. Consolidation in many health insurance markets has coincided with consolidation among hospitals and hospital-provider networks, in some cases increasing insurers' ability to negotiate favorable rates with providers, and in other cases the opposite, depending on relative bargaining leverage.<sup>7</sup> Third-party administrators and employer self-funding and administration in general represent significant sources of competition for insurance companies in the employer-sponsored market, except for small-group coverage.

The limited antitrust exemption for the "business of insurance" has little effect on health insurers; there is no evidence that it has raised prices, profits, or market concentration. Insurers' relationships with medical care providers, such as the inclusion of "most favored customer" clauses in contracts with hospitals, are not protected. In contrast to property/casualty insurance, health insurance has no history of joint ratemaking activity that is protected by the exemption. Health insurer mergers have been subject to federal antitrust jurisdiction since at least the early 1970s, and mergers and acquisitions of health insurers are subject to approval by state regulators.

## **Rate Review**

State oversight of health insurance rate changes is highly diverse across and within states for individual and small-group coverage, and, in some states, health maintenance organizations. Similar to personal automobile and homeowners' insurance, in 2009 about half the states required prior regulatory approval of rate changes for individual health insurance.<sup>8</sup> Approximately twenty states required regulatory approval of rate changes for one or more types of group health insurance (for example, coverage for small groups). About a quarter of the states required individual market rates to be filed with regulators before use without a prior approval requirement, but often providing regulators with the ability to challenge filings or disapprove rates after they take effect. The remaining states generally required that rates be filed, at least for the individual market. Many states required actuarial certification that small-group rates comply with relevant law.

Section 2794 of the PPACA, "Ensuring that Consumers Get Value for Their Dollars," stipulates that the Secretary, in conjunction with the states, establish a process for annual review of "unreasonable" rate increases. Insurers must provide the Secretary and the relevant states with justification of unreasonable increases prior to implementation, and "prominently post such information on their Internet websites," with public disclosure otherwise ensured by the Secretary. As a condition for receiving federal grants for rate review and stimulating creation of research data, states must provide the Secretary with information about trends in premium increases and make recommendations "about whether particular insurers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases." Section 2794 does not require prior approval of rate changes by states or explicitly permit HHS to deny increases.<sup>9</sup>

The HHS rate review regulations for the individual and small group markets are scheduled to become effective for rates filed or effective on September 1, 2011 or later. The regulations specify a 10 percent annual increase for a given "product" in a state as the threshold for potentially unreasonable rates, with state-specific thresholds likely to begin in 2012. Insurers that propose greater increases must file a preliminary justification

with HHS and the state, to be published on the HHS website. If HHS deems a state as not having an effective rate review process, HHS will conduct the review. If a state's review process is deemed effective, it will determine whether the proposed increase is unreasonable, with the consequences governed by state law. If not, the HHS will evaluate whether the increase is unreasonable ("excessive," "not justified," or "unfairly discriminatory"). If the HHS deems an increase unreasonable and the insurer nonetheless implements the increase, the insurer must submit a final justification to HHS and post it on the insurer's website.

Even without formal prior approval regulation, federal requirements for justification of unreasonable rate increases – at the federal level if state regulation does not receive approval from HHS – and the threat of exclusion from the exchanges establishes significant federal authority over rate increases and state rate review processes. As I noted above, the rate review grants program will provide supplemental financial awards to states that have or adopt prior approval requirements.

The rate review provisions will further politicize health insurance pricing. They will not enhance consumer choice, increase quality, or lower costs. They will instead increase insurers' costs and risk, reduce choice and availability of coverage, undermine insurers' financial strength, and possibly increase pressure for even tighter regulation and/or enactment of a public option.

The adverse consequences of prior approval rate regulation and politicization of insurance ratemaking have been demonstrated by decades of experience with state rate regulation for automobile insurance, workers' compensation insurance, and, more recently, homeowners' insurance in catastrophe-prone regions. The evidence indicates that rate regulation cannot be used to lower average rates without reducing coverage availability and/or causing exit by insurers.<sup>10</sup> In the 1980s and early 1990s, for example, rate regulation led significant numbers of insurers to exit the automobile insurance market in Massachusetts, New Jersey, and South Carolina, and some workers' compensation insurers withdrew from states with unfavorable regulatory climates during the late 1980s and early 1990s.

Despite its self-defeating consequences, regulatory rate suppression in environments of rapid cost growth can be politically popular before its adverse effects become apparent. The direct costs of administering and complying with rate regulation or review are ultimately born by consumers. Prior approval rate regulation produces delays in adjusting rates to loss trends. It increases variation over time in insurers' profitability and willingness to offer coverage and expand to meet growing demand. It has sometimes caused slower expansion or exit of efficient firms.

The rate approval process in some states and periods has been costly, lengthy, and periodically biased toward unjustified rate suppression. Uncertainty about permissible rate levels increases insurers' risk and the capital and premiums needed to maintain solvency. At the same time, the threat of regulatory rate suppression reduces insurers' incentives to commit capital to enhance solvency and support the sale of coverage. The likely results include both higher prices (to the extent achievable) and increased insolvency risk.

While empirical research to date has not provided detailed evidence of the effects of state regulation of health insurance rate changes, many studies have compared loss ratios for other types of insurance, most often for automobile insurance, in states with and without prior approval rate regulation to examine whether regulation affects average rate levels in relation to claim costs.<sup>11</sup> The analyses indicate that short-run regulatory suppression of rates in some states and periods of rapid cost growth resulted in higher automobile insurance loss ratios in states with prior-approval rate regulation (for example, during the mid- to late-1970s and early-1980s).

On the other hand, and consistent with an inherent inability of regulation to lower rates persistently, studies have found no consistent difference over time between loss ratios in states with and without prior approval laws. In a 2002 study, for example, I analyzed automobile insurance loss ratios, coverage availability ("residual market" shares), and volatility in premium growth by type of rate regulation with state-level annual data during 1972–98.<sup>12</sup> The estimated average difference in loss ratios between states with and without prior-approval regulation was positive but negligible in magnitude, primarily attributable to the 1970s, and at most weakly significant in a

statistical sense (see figure 2 for mean loss ratios by type of regulation by year).

Consistent with other studies, I found that prior approval regulation was persistently and reliably associated with less availability of coverage and greater volatility in loss ratios and premium growth. There is no reason to believe that requiring prior regulatory approval or tight review of health insurance rate changes would be any different.

### **The Minimum MLR Requirements**

About half the states had pre-PPACA requirements that premium rates achieve a minimum MLR (ratio of medical expenses to premiums) standard for individual health insurance.<sup>13</sup> The minimums generally ranged from 60 to 75 percent. About twenty states had MLR requirements for the small-group or large-group markets, also generally ranging from sixty to seventy-five percent. Most states' minimum MLR rules were designed to deter aberrant players from selling coverage to unsophisticated buyers with a large proportion of premiums (30 to 40 percent) going towards administrative expenses and profits rather than medical expenses.

Section 2718 of the PCACA requires health insurers to pay premium rebates to the extent that the sum of reimbursements “for clinical services” and expenditures “for activities that improve health care quality” to the “total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees)” is less than 85 percent for the large group market or less than 80 percent in the individual or small group market. It permits the HHS Secretary to adjust the 80 percent standard if its application would destabilize the individual market. The PPACA's requirements differ from existing state MLR requirements given the inclusion of expenditures to improve quality in the numerator and exclusion of certain taxes in the denominator. The requirements are nonetheless materially higher than many states' minimums.

Section 2718 reflects the premise that a higher MLR (lower margin for non-medical expenses and profits) necessarily implies better value for consumers. While that might be true holding equal premiums, quality and access to care, claims and other service, and availability of coverage, those factors vary widely across insurers and plans.<sup>14</sup> A given consumer, for example, could prefer coverage with more cost sharing, tighter utilization review, and a lower expected MLR to more generous coverage with a

higher expected MLR and much higher premium, or to not being able to find any coverage. Moreover, minimum MLR requirements will inherently exert upward pressure on premiums of some insurers that expect to achieve the minimums. As long as there is some chance that an insurer will have to pay rebates as a result of unexpectedly low medical costs, its expected MLR net of rebates will be higher than its pre-regulation target MLR. It will need to charge somewhat higher premiums to expect to achieve that target.

**HHS/NAIC Regulations.** Section 2718 and the HHS MLR regulations, which largely adopted proposed regulations developed by the National Association of Insurance Commissioners (NAIC),<sup>15</sup> are remarkable for their emphasis on allowing expenses that increase health care costs and premiums to be included in the MLR calculation, while largely excluding expenses that help reduce health care costs and premiums. As recommended by the NAIC and adopted by HHS, expenses that improve healthcare quality encompass those:

. . . for all plan activities that are designed to improve health care quality  
. . . in ways that are capable of being objectively measured and of  
producing verifiable results and achievements. . . . They should not be  
designed primarily to control or contain cost, although they may have cost  
reducing or cost neutral benefits as long as the primary focus is to improve  
quality.

Eligible quality improvement activities are defined further as those primarily designed to improve outcomes and reduce disparities; prevent hospital readmissions; improve safety, reduce errors, and lower infection and mortality rates; increase wellness and promote health activities; and enhance the use of data to improve quality, transparency, and outcomes. Specific exclusions include expenses for retrospective and concurrent utilization review; fraud prevention, with the exception of “detection/recovery expense up to the amount recovered that reduces incurred claims”; developing and administering provider contracts, networks, and credentialing; marketing; accrediting providers; and calculating and administering individual enrollee or employee incentives.

MLRs and rebates must be calculated at the licensed entity and state level, without aggregation across affiliates, increasing the likelihood and amount of rebates compared with allowing aggregation, and providing incentives for firms to consolidate

affiliates. The regulations specify “credibility adjustments” that decrease the MLR minimums for smaller plans for which average medical costs are subject to greater statistical variation. But the regulations do not consider that plans with higher average deductibles and other forms of cost-sharing tend to have lower MLRs because non-medical expenses grow at a slower rate than expected medical reimbursement. Some entities that specialize in high-deductible or other high-cost-sharing plans could find it difficult or impossible to meet the minimums.

Expenses on quality-improving activities notwithstanding, variation in insurers’ MLRs arises from numerous sources that need bear no relationship to market power or efficiency.<sup>16</sup> In addition to statistical variation and the effects of differential cost sharing, differences in the mix of fixed and variable administrative costs will cause MLRs to vary in relation to differences in the average number of enrollees in an insured’s group plans and differences in average medical-care costs across regions or customer groups within a region. Other factors causing variation in MLRs include differences among insurers in expenditures on fraud detection/prevention and utilization review and management; the use of managed care and provider contracting; marketing costs, including agent compensation; customer turnover and duration; possible cyclical variation over time in average premium rates; and the extent to which health plans with different expense structures and expected MLRs are offered by separate corporate subsidiaries rather than a single entity.

**Market Destabilization and Waivers.** Section 2718’s implementation could destabilize markets in numerous states, especially for individual coverage. The NAIC leadership expressed concern to Secretary Sebelius of possible destabilization, including potential effects on premiums, insurer solvency, the number of insurers marketing products, consumers’ ability to find coverage should their carrier leave the state, benefits and cost sharing of existing products, and consumers’ access to agents and brokers. It urged the Secretary to consider a transition period for implementation and for deference to waiver requests.<sup>17</sup> HHS has thus far granted waivers to three states.

**Incentives and Innovation.** Potentially binding minimum MLRs will produce some distortions in insurers’ legitimate business decisions. A minimum MLR requirement caps the percentage of premiums available for nonmedical expenses and

profits: the lower the cap, the lower the potential for profit, and the less incentive for innovation. By reducing potential returns from investment, the minimum MLR rules will likely deter some innovation to develop new coverage arrangements, more cost-efficient provider networks, and information to guide consumer choice, including evidence on medically and cost-effective care.

As noted, the MLR requirements will also likely discourage some coverage designs that could lower premiums but involve relatively high nonmedical costs in relation to insured benefits, such as certain high-deductible plans. They could discourage potential innovations in coverage design and managed care that might require a lower MLR in conjunction with lower premiums and better value for buyers. They could cause some plans to contract with narrower provider networks and/or enter into arrangements shifting more administration to providers.

**Mandatory Public Reporting.** Section 2718 requires regulators to develop systems for publicly reporting insurers' MLRs, ostensibly to assist consumers in identifying high-value coverage. Given the complexities described above, providing reliable and meaningful information on insurers' MLRs is problematic.

Public provision of information should focus on key attributes that affect consumer value, including covered benefits, premiums, cost sharing, access to providers, quality of claims administration, and insurer financial strength. Given information on those attributes, an insurer's MLR for individual, small group, or large group coverage in a state will not provide reliable information to enhance decision-making, including consumer evaluation of tradeoffs between attributes (for example, higher premiums and lower cost sharing versus lower premiums and higher cost sharing). Promulgating MLR metrics will instead provide consumers with noisy, confusing, and potentially misleading information.

### **Pro-Competitive Reform**

The PPACA's rate review and minimum MLR provisions are unnecessary and counterproductive. Appropriate policy would instead promote informed competition and consumer choice with pro-competitive regulation and disclosure at the state level (and thus without a significant federal bureaucracy) through targeted minimum standards for

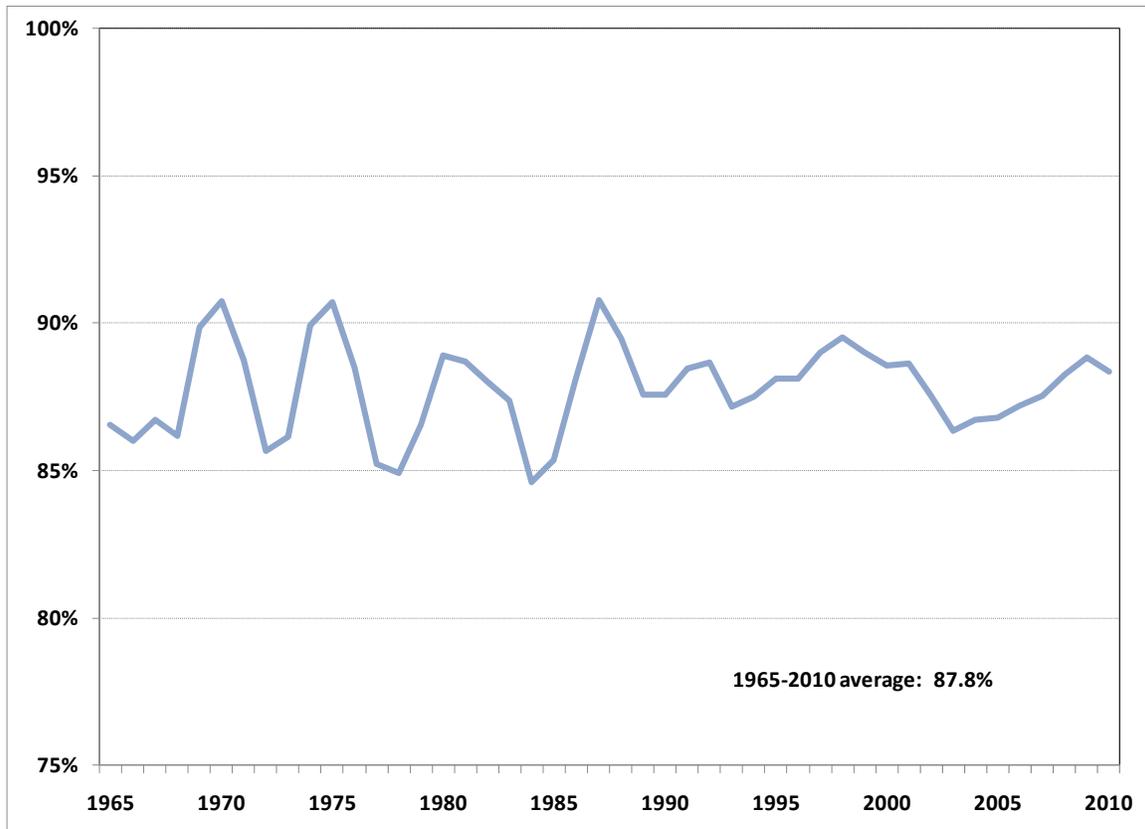
state regulation, providing the states with flexibility to meet regulatory objectives given differences in consumer needs, preferences, and economic conditions, and given that local regulators can better respond to such differences. Relying primarily on state-level action would also help identify approaches that are most effective, promote regulatory competition, and localize regulatory mistakes.

To stimulate further competition, the Congress could authorize a health insurer that is licensed in any state to be automatically licensed to write coverage in additional states by appropriate notification of the states' regulators. A minimum level for such licensing would require an insurer to comply with all state regulation in each state where it writes business, including rate regulation and benefit mandates. A broader approach would allow consumers in a state to choose from a different mix of regulations that lowers their premiums by permitting an insurer to designate a home state for regulation of rates and coverage but requiring it to comply with solvency and market-conduct regulation in each state where it writes business.

Enacting such an agenda would promote consumer choice and informed competition to make coverage more affordable and available. Compared with the PPACA's regulatory scheme, there would be much less interference in insurers' legitimate business decisions and practices, far less bureaucracy, lower administrative and compliance costs, and more available and affordable coverage.

Figure 1

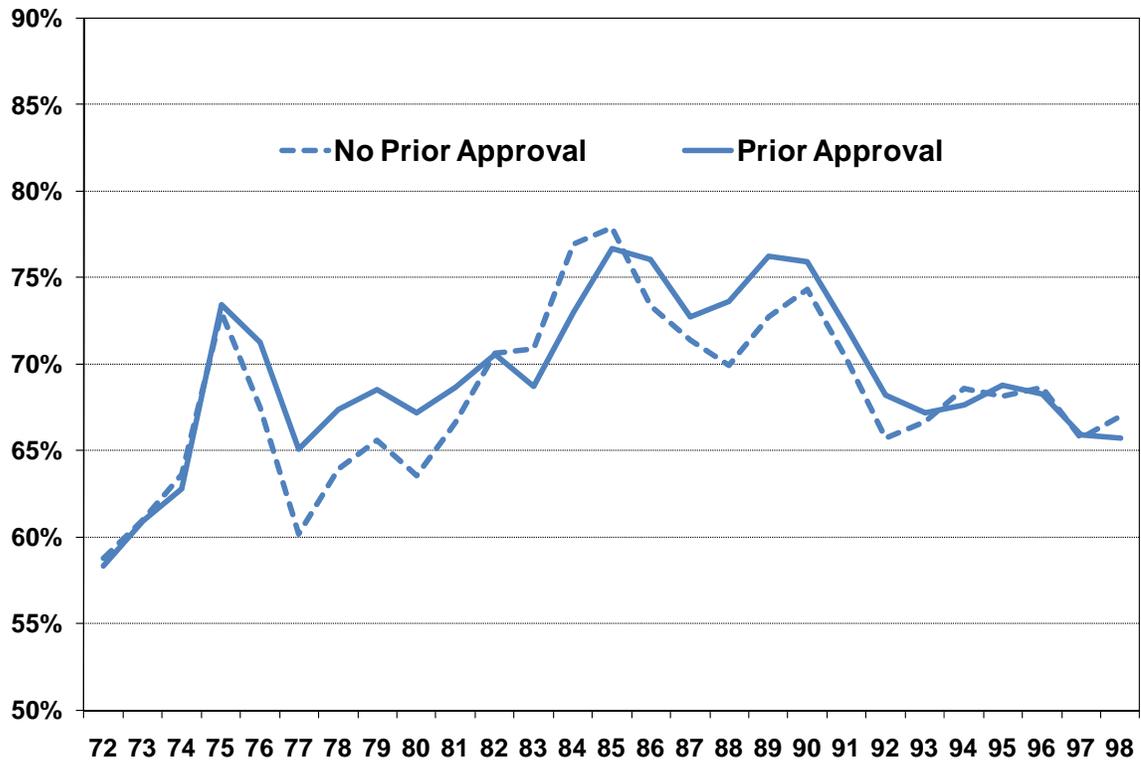
Estimated Private Health Plan Benefits as Percent of Premiums: 1965–2010  
(includes self-funded plan premium equivalents)



Note: Author's calculations with national health expenditure data. Projections for 2009-2010.

Figure 2

Mean Automobile Insurance Loss Ratios by Type of State Regulation: 1972-1998



Source: Harrington (2002).

## Notes

<sup>1</sup> My study, *Regime Change for Health Insurance Regulation: Rethinking Rate Review, Medical Loss Ratios, and Informed Competition*, American Enterprise Institute, December 2010 (available at [www.aei.org/docLib/Regime-Change-for-Health-Insurance-Regulation.pdf](http://www.aei.org/docLib/Regime-Change-for-Health-Insurance-Regulation.pdf)) provides additional detail and also considers the PPACA's provisions dealing with health insurance policy rescissions and claims practices.

<sup>2</sup> The data (<http://www.cms.gov/>) are from NHE tabulations by type of expenditure and source of funds, calendar years 1965-2019, with projections for 2009-2019. The projections are based on the 2008 version of the national health expenditure accounts released in January 2010.

<sup>3</sup> The NHE data report estimated premium expenditures and the estimated difference between premiums and benefits (denoted the "net cost" of private health insurance in the expenditure accounts). The ratios in Figure 1 equal one minus the ratio of net cost to premiums.

<sup>4</sup> My article, "The Health Insurance Reform Debate," *Journal of Risk and Insurance* 77, no. 1 (2010): 5-38 summarizes other evidence from a variety of sources.

<sup>5</sup> Debra A. Donahue, "Health Plans See Revenue Shift Away from Commercial," *Healthcare Business Strategy*, Mark Farrah Associates, May 10, 2010, available at <http://www.markfarrah.com/healthcarebs.asp?article=80> (accessed November 9, 2010).

<sup>6</sup> Christopher Conover and Thomas Miller, "Why a Public Plan is Unnecessary to Stimulate Competition," (AEI Working Paper No. 162, Washington, DC, January 2010), available at <http://www.aei.org/docLib/MillerConoverworkingpaper.pdf> (accessed November 9, 2010), provides a detailed review of health insurance market concentration and its implications for competition.

<sup>7</sup> Research has provided mixed evidence of the effects of increased concentration on healthcare markets (see Christopher J. Conover and Thomas P. Miller, "Why a Public Plan is Unnecessary to Stimulate Competition"). Asako S. Moriya, William B. Vogt, and Martin S. Gaynor, "Hospital Prices and Market Structure in the Hospital and Insurance Industries," *Health Economics, Policy, and Law* 5, no. 4 (2010): 459-479, for example, present evidence that increased concentration in health insurance reduces hospital prices. Using a proprietary panel dataset of health plans offered by a large sample of U.S. firms, Leemore Dafny, "Are Health Insurance Markets Competitive?" (NBER Working Paper w14572, National Bureau of Economic Research, Washington, DC, December 2008), available at <http://www.nber.org/papers/w14572.pdf> (accessed November 9, 2010), provides evidence that health insurers on average charged higher premiums to employers with relatively high profitability in more highly concentrated markets than in less concentrated markets. The implication that higher concentration raises premiums is thus based on the interaction between concentration and employers' profitability. Using the same dataset, Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium: Consolidation in the U.S. Health Insurance Industry," (NBER Working Paper w15434, National Bureau of Economic Research, Washington, DC, October 2009), available at <http://www.nber.org/papers/w15434> (accessed November 9, 2010) provide evidence that health insurance rates increased with increases in market concentration associated with the merger of health insurers Aetna and Prudential. The possible implications of the relatively poor profitability of Prudential's health insurance business prior to the merger are not addressed.

<sup>8</sup> National Association of Insurance Commissioners (NAIC), "Filing Requirements Health Insurance Forms and Rates," in *NAIC's Compendium of State Laws on Insurance Topics* (Washington, DC: NAIC, February 2009), II-HA-10; *Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable*, Kaiser Family Foundation, December 2010 (available at <http://www.kff.org/healthreform/upload/8122.pdf>).

<sup>9</sup> A variety of consumer groups and advocates recommended that the PPACA's rate review provisions be implemented with elaborate, public-utility-style regulation with regulatory authority to approve rates. See Elizabeth Abbott, Amy Bach, and Deeya Beck et. al., *PPACA Implementation: Consumer Recommendations for Regulators and Lawmakers*.

<sup>10</sup> See, for example, J. David Cummins, ed., *Deregulating Property-Liability Insurance* (Washington, D.C.: AEI-Brookings Joint Center for Regulatory Studies, 2002), Patricia Danzon and Scott E. Harrington, *Rate Regulation of Workers' Compensation Insurance: How Price Controls Increase Costs* (Washington, D.C.:

American Enterprise Institute, 1998), and Scott E. Harrington, *Insurance Deregulation and the Public Interest* (Washington, DC: AEI-Brookings Joint Center for Regulatory Studies, 2000).

<sup>11</sup> See my study, “Effects of Prior Approval Regulation in Automobile Insurance,” in J. David Cummins, ed., *Deregulating Property-Liability Insurance* (Washington, DC: AEI-Brookings Joint Center for Regulatory Studies, 2002) for detailed discussion and references. Also see Cummins (J. David Cummins, “Property-Liability Insurance Price Deregulation: The Last Bastion,” in J. David Cummins, ed., *Deregulating Property-Liability Insurance* (Washington, D.C.: AEI-Brookings Joint Center for Regulatory Studies, 2002)).

<sup>12</sup> Scott Harrington, “Effects of Prior Approval Regulation in Automobile Insurance.”

<sup>13</sup> National Association of Insurance Commissioners (NAIC), *NAIC Response to Request for Information Regarding Section 2718 of the Public Health Service Act* (Washington, DC, May 12, 2010), available at [www.naic.org/documents/committees\\_e\\_hrsi\\_hhs\\_response\\_rr\\_adopted.pdf](http://www.naic.org/documents/committees_e_hrsi_hhs_response_rr_adopted.pdf) (accessed November 9, 2010); America’s Health Insurance Plans (AHIP), *Individual Health Insurance 2009 – A Comprehensive Survey of Premiums, Availability, and Benefits* (Washington, DC: AHIP Center for Policy Research, October 2009), available at <http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf> (accessed November 9, 2010).

<sup>14</sup> James C. Robinson, “Use and abuse of the medical loss ratio to track health plan performance,” *Health Affairs* 16 (1997): 176-187 provides detailed discussion of many of these factors.

<sup>15</sup> In order to prevent disruptions in the market for plans with annual limits of \$250,000 or less and for specialized plans covering U.S. citizens residing abroad, HHS modified the NAIC recommendation to permit multiplying those plans’ loss ratios by two in determining whether they meet the minimums.

<sup>16</sup> James C. Robinson, “Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance.”

<sup>17</sup> National Association of Insurance Commissioners, letter to HHS Secretary Kathleen Sebelius, October 13, 2010, available at [http://www.naic.org/documents/committees\\_ex\\_grlc\\_ml\\_r\\_sebelius\\_letter\\_101013.pdf](http://www.naic.org/documents/committees_ex_grlc_ml_r_sebelius_letter_101013.pdf) (accessed November 10, 2010); National Association of Insurance Commissioners, letter to HHS Secretary Kathleen Sebelius, October 27, 2010, available at [http://www.naic.org/documents/committees\\_ex\\_ml\\_r\\_reg\\_asadopted.pdf](http://www.naic.org/documents/committees_ex_ml_r_reg_asadopted.pdf).