

Health Insurance

Should California Regulate Health Insurance Premiums?

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Introduction

After nearly a decade of modest increases in health insurance costs, California is again experiencing double-digit premium inflation. According to a survey of California employers,¹ premiums for employer-sponsored health insurance increased 13 percent in 2002, six times California's inflation rate. In response, a state senate bill (SB 26) was proposed to curtail premium growth (see sidebar). Although SB 26 did not pass out of committee in 2003, proponents of premium regulation are likely to continue to pursue the idea, perhaps through new legislation or a future ballot initiative.

In order to better understand the potential impact of SB 26 and similar proposals, the California HealthCare Foundation funded a research team from RAND Health to analyze the likely effects of premium regulation on the California health insurance market. This brief summarizes that analysis. It evaluates why health insurance premiums are rising and examines the potential long-term consequences of regulating premium costs, using examples from other insurance products such as automobile coverage and workers' compensation. It also reviews California's experience with Proposition 103, which was the impetus for SB 26.² The discussion highlights the differences between health insurance and auto

insurance markets and describes how these differences might affect conclusions regarding the likely long-term consequences of health insurance premium regulation.

Based on the evidence summarized here, the research team has determined that SB 26 would have limited premium growth in the short run. However—without modification—it would have done little to cure the root causes of health care cost inflation, thus making California vulnerable to undesirable long term consequences, including greater numbers of uninsured, reduced quality or rationing of medical care, and more limited access to health insurance.

About SB 26

SB 26, introduced in the 2003 legislative term, would have required that premium increases be approved by the Department of Insurance or by the Department of Managed Health Care before being implemented. Health plans would have been required to refund policyholders for premium increases (with interest) imposed between April 1, 2000 and January 1, 2004, if those rates were found to be excessive under the standards of the bill.

ISSUE BRIEF

Findings

Why Are Health Insurance Premiums Rising in California?

The goal of premium regulation is to lower prices and curtail excessive industry profits. If markets are non-competitive—that is, if suppliers of services have a sufficient monopoly in the market that they can set rates without regard to the underlying costs of providing services—regulation can lower premiums to competitive levels. However, if premiums are already at competitive levels, stringent rate regulation will reduce the availability and quality of insurance products in the long run.

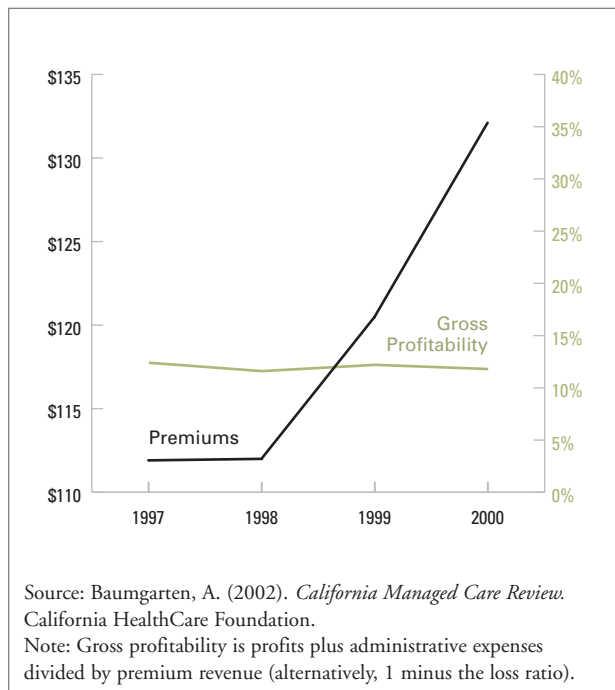
The research team analyzed profits and premiums of California health maintenance organizations (HMOs) from 1997 to 2000.³ As Figure 1 shows, HMO premiums increased about 18 percent during that period. However, profits remained basically flat, suggesting that most of the increase in premiums

resulted from greater payouts for claims. This is not surprising since health expenditures per capita in California increased by more than 25 percent over the last decade.⁴ Major causes of rising medical care costs include higher pharmaceutical expenses, technological changes in medical procedures and products, tight labor markets for nurses and physicians, hospital consolidation and market power, expansion of insurance coverage and mandated benefits, and changes in the population's age structure.

It is also possible that health insurers have been increasing premiums to maintain already high profit margins (rather than to increase them). However, this does not appear to be the case. Table 1 shows that in 2001 and 2002, the top four HMOs in California had profit margins of less than 5 percent.

Conclusion. Increases in health insurance premiums are not the result of higher profits for insurers.

Figure 1. Average Premium Per Person vs. Profitability for California HMOs, 1997–2000



Lessons from Other States

Prior-approval rate regulation of the sort proposed in California is new to health insurance markets. However, health insurance is not completely free from state regulation. In the 1990s, several states (including California) implemented legislation for the individual and small group insurance markets that restricted the factors insurers could use in setting rates, and guaranteed the issue and renewal of health insurance to certain policyholders.⁵

These premium restrictions can take several forms, including “community rating” (in which everyone in a geographic area faces the same premium), a ban on certain rating factors (such as gender, industry, or other predictors of medical expenditures), or specifying

Table 1. Profits and Losses for California’s Four Largest HMOs

PLAN	Revenue (in billions)		Net Income/Loss (in millions)		Margin*		Total Administrative Expenses (in billions)	
	2001	2002	2001	2002	2001	2002	2001	2002
Kaiser Foundation Health Plan, Inc.	\$14.9	\$17.0	\$120.3	(\$117.6)	0.81%	(0.70%)	\$0.48	\$0.41
Blue Cross of California	7.3	9.1	314.8	434.6	4.30%	4.80%	1.00	1.20
PacifiCare of California	6.5	6.1	41.4	87.0	0.64%	1.40%	0.56	0.59
Health Net of California, Inc.	4.8	5.2	111.4	135.7	2.34%	2.60%	0.44	0.52

Source: California Department of Managed Health Care (2002). Financial Reports of Health Plans are available at <http://wps0.dmhc.ca.gov/fe/search.asp>.
*Margin is calculated as net income (loss) divided by revenues.

rating bands for defined markets (i.e., minimum and maximum premiums for certain health factors). The goal of these regulations is to increase insurance coverage by creating cross subsidies from low-risk to high-risk firms and individuals. In other words, because people who are using few health services pay the same premium as those who are using many services, part of the premium paid by the former is, in effect, helping to pay for services used by the latter. Prior-approval rate regulation also has the potential to increase cross subsidies from low-risk to high-risk individuals. Under rate regulation, firms may have an incentive to alter the composition of their risk pools (by attracting more low-risk individuals) in order to subsidize the large losses incurred by high risks, thereby curtailing premium growth.

A growing body of literature has examined how these individual and small group insurance reforms affect insurance coverage. The studies found that these reforms had little or no effect on health insurance coverage.⁶

In addition, economic theory predicts that cross subsidies resulting from rating restrictions might also increase adverse selection in health insurance markets. That is, high-risk consumers within a given premium band will increase insurance coverage while low-risk

consumers will drop coverage. As a consequence, health insurance markets might become unstable—over time, low-risk consumers will drop coverage, premiums will rise, and a predominately high-risk population of consumers will buy insurance.

The majority of the empirical evidence is consistent with this economic theory. Studies have found that the risk composition of the insured population has changed as a result of regulation: Older people and people with health problems were more likely to buy coverage, while younger and healthier people dropped coverage.⁷

Conclusion. To date, there is little evidence that premium regulation in health insurance markets affects either premiums or coverage, and some evidence that regulation might shift the makeup of the insured population towards high-risk consumers.

Lessons from Other Insurance Products

There are no studies that examine how prior-approval rate regulation of the sort proposed in California affects health insurance markets. However, prior experiences with rate regulation of other insurance products such as auto insurance and workers’

compensation may provide important lessons for California. Because auto insurance and health insurance differ in fundamental ways—auto insurance is mandatory and purchased individually while health insurance is optional and usually provided by the employer—some of the lessons learned from auto insurance may not be applicable to the health insurance market. Therefore, this discussion will describe the long-term consequences of rate regulation and focus on how some of the key differences between auto insurance and health insurance markets might influence its potential effects.

What Could Go Wrong

More than half of all states set rates or require prior approval of rates in the homeowners, auto insurance, and workers' compensation markets.⁸ Most evaluations of rate regulation in property liability markets have found that the majority of states requiring prior approval of premium increases had lower prices than those with no prior-approval requirement.⁹

However, lower premiums don't automatically benefit consumers. Suppressing premium growth could force insurers to sell coverage at a price below its true cost. In the long run, this practice is unsustainable. In response, insurers may offer lower quality products, refuse to insure high-risk consumers, or exit the industry.

Rapid claims growth in the 1970s and 1980s prompted a number of states to regulate auto insurance premiums. Their experience illustrates some of the undesirable consequences of regulation. These include:

- *Denying insurance to high-risk individuals.*

Because auto insurance is usually mandatory, most states have a "residual market" where high-risk

individuals are guaranteed coverage and all insurers share responsibility for the losses incurred.

Compared with non-regulated states, insurers in states with regulated premiums are more likely to reject individuals who are expected to accumulate large losses, pushing them into the residual market.

That is what happened in Massachusetts after the state began to regulate auto insurance rates in 1977. For most of the 1980s, 40 to 50 percent of the state's drivers were insured in the residual market. In unregulated states, the residual markets constitute less than 10 percent of the total market. By 1989, the number of Massachusetts drivers insured in the residual market increased to 72 percent.¹⁰ If similar effects appeared in the health insurance market, it could lead to more uninsured high-risk individuals such as older persons or those with chronic disease. There is currently no residual market in health insurance where these individuals could be assured coverage.

- *Exiting the market.* Insurers also appear to abandon heavily regulated insurance markets.¹¹ For example, in regulated South Carolina, approximately 59 insurers now offer auto insurance policies, compared with about 197 in neighboring states without regulation.¹² In New Jersey, a state with strict rate regulation, the number of firms providing private passenger automobile coverage dropped from 104 in 1980 to 64 in 1998, a decrease of nearly 40 percent. The number of firms writing such policies nationwide did not drop significantly over the same period.¹³
- *Distorting incentives.* In a regulated market, high-risk individuals have little incentive to control costs or increase safety, so their behavior may

lead to increasing costs. Regulation of workers compensation premiums provides an example:

In the 1980s, rapidly rising workers' compensation claims stimulated widespread regulation of workers' compensation premiums. However, regulation distorts the incentives of both employers and insurers. When premiums are not regulated, firms with higher claims in the previous year face higher premiums in the subsequent year. By suppressing rates for high-risk firms, rate regulation lowers incentives for safety and claims control. As a result, regulating workers' compensation premiums has *increased* the frequency and severity of employee injury claims and hence increased employers' losses.¹⁴

Since 1990, states have responded to the negative effects of regulation by deregulating their property-liability insurance lines. Between 1998 and 2002, more than one-third of the states that previously had property-liability rate regulations in place deregulated rates for large commercial insurers.

Conclusion. Rate regulation in other insurance markets has resulted in less access to coverage for high-risk individuals, fewer insurers participating in the market, and less incentive for individuals to control costs. These undesirable effects are likely to occur in the health insurance market if health care costs continue to rise while premiums are controlled.

Lessons from the Proposition 103 Experience

California's Proposition 103, passed on November 8, 1988, has been cited as a successful application of premium regulation.¹⁵ Proposition 103 was motivated by a 40 percent increase in auto insurance premium rates in the three years prior to the referendum. The

proposition required:¹⁶

- Prior approval of increases in auto insurance premiums;
- A "good-driver" premium discount of 20 percent; and
- A 20 percent rollback in premiums for companies earning more than a 10 percent rate of return.

At first glance, Proposition 103 appears to have been a success. Premiums fell. Before enactment, the average auto insurance premium per insured car grew at 12 percent annually in California compared to the U.S. average of 9 percent. Afterwards, premiums in California actually declined at an annual rate of 0.1 percent, while premiums in the rest of the United States grew at an annual rate of about 3 percent.¹⁷ Contrary to expectations, Proposition 103 did not cause insurers to cede large numbers of drivers to the residual market, and firms did not exit the market at abnormal levels.¹⁸

However, a closer look suggests that the decrease in premiums in California had other, more important causes. Between 1990 and 1998, California auto insurers experienced a 37 percent decline in liability losses. Table 2 provides an explanation. Collisions per insured car in California declined by 35 percent between 1990 and 1998 compared to a 14 percent decline during the same period in the rest of the United States. Moreover, declines were highest among collisions with fatalities (51 percent) and collisions with injuries (41 percent)—the two categories that typically generate the most liability claims.¹⁹

Table 2. Vehicle Collision Rates, 1990 and 1998

TYPE OF COLLISION	Rate Per 1,000		Change 1990–1998
	1990	1998	
Fatalities			
California	0.35	0.17	–51%
U.S.	0.29	0.25	–15%
Injuries			
California	17.90	10.60	–41%
U.S.	15.61	13.24	–15%
Only Property Damage			
California	23.52	16.30	–31%
U.S.	33.09	28.63	–14%
TOTAL COLLISIONS			
California	41.76	27.07	–35%
U.S.	48.99	42.12	–14%

Source: National Highway Traffic Safety Administration (1998); California Highway Patrol, Annual Report of Vehicle Traffic Collisions, 1998.

What caused this dramatic improvement in traffic safety and decline in insurance losses? Contributing factors include Proposition 103’s mandated “good-driver” discount;²⁰ safer roadways, tough seat-belt laws, and strict enforcement of DUI laws;²¹ and a ruling that denied third parties the right to sue insurance companies that act in “bad faith” (e.g. misrepresent coverage limitations upon issuing policies).²²

Did Proposition 103 reduce insurers’ profits? It actually increased them because insurers’ losses dropped faster than the premiums did.²³ These windfall profits explain why insurers did not exit the market as had been predicted.

The reduction in the size of the residual market in California can also be explained by factors other than Proposition 103. The most significant reason is probably the 85 percent increase in premiums in the residual market in 1991. Prior to this change, premiums were actually lower in the residual market than in the primary market for a large number of

drivers, attracting some who would otherwise have qualified for standard policies. Thus, it is not surprising that the size of the residual market declined when premiums there suddenly became higher than those in the primary market.²⁴

Conclusion. Experience from the implementation of Proposition 103’s rate regulation provisions does not provide insights into the likely effects of SB 26: Most of the Proposition’s benefits stemmed from fewer accidents and lower claims overall.

Special Features of the Health Insurance Market

Auto insurance and health insurance differ in important ways. The following discussion highlights these differences and suggests how they affect the potential consequences of rate regulation.

■ *Health insurers have greater control over quantity and quality of services.* Unlike automobile insurers, health insurers have much greater control of what health services are used. This is the premise behind managed care. In fact, in some cases the insurer is essentially the provider of care (for example, Kaiser Foundation Health Plan through its exclusive relationship with The Permanente Medical Group). This control allows an insurer/provider system to expand its waiting list (thereby reducing the quantity of services); hire less-experienced staff or not maintain existing facilities (reducing overall quality); or—more subtly— not invest in new technology. Even among HMOs that have a looser relationship with providers, rate regulation may still affect quality of care by inducing insurers to lower their reimbursements to providers (thereby making it necessary for doctors and hospitals to limit services

and stint on quality) or remove costly, high-quality providers from preferred lists. By contrast, automobile insurers such as State Farm neither own repair shops nor are in a strong market position to set payment rates to them, so insurers have less control over services provided. Therefore health insurers might be more likely than auto insurers to respond to premium regulation by cutting the quantity and quality of services in the short run.

- *Health insurance is provided primarily by employers.* Most people get health insurance from their employer, while auto insurance is purchased individually. Therefore in an unregulated automobile insurance market, there is a direct link between a person's driving record and auto insurance premiums—those who drive more carefully pay less for their policies. When premiums are regulated, drivers have less incentive to keep their records clean. But health insurance is mainly provided through employers, so all employees share the risk or benefit of one employee's health-related behavior. Because there is no strong link between premium prices and behavior, regulating premiums is less likely to have a positive influence on health habits.
- *Health-related behaviors are less likely to affect short-term health costs.* Safer driving immediately affects auto insurance costs by reducing the likelihood of traffic accidents. Proposition 103's "good-driver" discount provided incentives for safe driving, thus potentially playing an important role in reducing traffic accidents and auto insurance claims in California. In contrast, mandating "good health behavior" discounts (for example, for individuals who maintain a healthy weight or don't

smoke) might both be controversial and infeasible because such behaviors are so difficult to monitor. In addition, health-related behaviors have little effect on short-term health costs. Therefore, even if such discounts are mandated, it is unlikely that they will have an immediate impact on health care costs. The long-term savings, however, might be significant.

- *Health insurance is not mandatory.* Unlike auto insurance, health insurance is a voluntary purchase. Therefore, there are no residual markets, and people who cannot afford health coverage are either insured through public programs or join the ranks of the uninsured. Since rate regulation discourages unhealthy consumers from enrolling in plans, over time it is likely to increase the number of uninsured. In addition, mandated auto insurance is often cited as one of the reasons for regulating auto insurance. Implementation of SB 2, which will require California employers with more than 50 employees to provide insurance, might increase pressure to regulate health insurance premiums.²⁵

Conclusion. Proponents of SB 26 hope to extend the apparent success of auto insurance regulation to the health insurance market. However, the challenges of regulating auto insurance and regulating health insurance are different, and analogies between them must be viewed cautiously.

What About Rollbacks?

SB 26 did not specify how the state would determine whether past rate increases were excessive. But if California were to adopt the same rollback guidelines of Proposition 103 (which allowed no more than a

20 percent increase in premiums for the year prior to implementation), the health insurance industry would owe \$636 million in rebates for the premium increases incurred between 2000 and 2001 (Table 3). Moreover, each firm with a premium increase of more than 20 percent would have to refund an average of \$58 million to policyholders. This refund exceeds the net worth of all but seven of California’s 45 HMOs. Less stringent criteria would, of course, require smaller refunds, but even allowing a 25 percent increase in premiums would require refunds totaling \$495 million.

Conclusion. Rollbacks such as those proposed by SB 26 could have a significant impact on the solvency of health insurers in California.

Table 3. Estimated Refunds to Members of California HMOs for Premium Increases between 2000 and 2001

	ASSUMING MAXIMUM ALLOWED PREMIUM INCREASE OF:			
	10%	15%	20%	25%
Number of Firms Exceeding Maximum (total firms n=45)	21	12	11	6
Average Refund Per Firm* (in millions)	\$66.67	\$76.08	\$57.82	\$82.5
Total Industry Refunds (in millions)	\$1,400	\$913	\$636	\$495

Source: Simulation uses data from California Department of Managed Health Care. Financial reports of health plans (2000, 2001) are available at <http://wps0.dmhc.ca.gov/fe/search.asp>.

*Average for those firms required to refund only.

Potential Effects of Premium Regulation

Health care premiums are rising in California, but HMO profits have remained flat. Profitability is only one component of costs. Other components include new technology, more use of expensive services, more prescription drugs, expansion of insurance coverage and mandated benefits, and demographic changes. SB 26

would have only restricted growth in premiums. It would not have addressed the underlying reasons for that growth.

If costs continue to rise while premiums are frozen, stringent rate regulation could lead to undesired consequences.

- *In the short term, insurers could balance their losses by reducing the quality or quantity of care — or both.* For example, insurers might implement stricter utilization management (thereby reducing quantity of services); or contract with less-experienced staff (potentially reducing quality).
- *Insurers could discourage unhealthy consumers from enrolling in plans, thus increasing the number of uninsured over time.* This type of cream-skimming may occur in various ways. An insurer might exit the individual or small-group market, for example — or it could increase wait times or restrict its provider network, thereby discouraging high-risk consumers for enrolling in health plans.
- *If costs continue to rise and premiums are fixed, insurers may exit the market entirely.* If insurers cannot find ways to limit costs — and do not see any future where they can make profits — they will refuse to operate in the marketplace. The large costs resulting from the premium rollback may also threaten solvency.
- *Over the longer term, regulation could reduce cost growth by discouraging expensive technologies from coming to market while motivating the introduction of cost-saving technologies.* Some of these effects are highly desirable; the search for cost-saving technologies that either maintain or improve

outcomes should be encouraged, and there may be reason to think that insurers, providers, and consumers lack appropriate incentives to seek out these technologies at present. But as noted above, insurers trying to control costs may also reduce the quantity and quality of services. Often this means restricting access to newer, expensive procedures and treatments. Medical manufacturers and drug companies recognize these limits and become hesitant to bring new products to market. Thus, it could be that only the treatments that actually reduce health care costs would be introduced, while those that increase costs — even if associated with enormous health benefits — would be overlooked.

Recommendations

The research team found no compelling need to regulate health insurance premiums in California, and some cause for concern that such regulation could have unintended, adverse consequences. However, if regulation is implemented, steps should be taken to monitor its effects. In particular, the state should:

- Monitor both insurance coverage and the quality of health care that people receive;
- Use objective indicators such as insurers' profits over a two- to three-year period to judge whether premium increases are appropriate;
- Monitor market participation among insurers;
- Design rollbacks to take insurer solvency into account; and
- Monitor technology adoption in California vs. unregulated locations.

Conclusion. Before implementing health insurance premium regulation, policymakers should review their goals and assess whether the regulatory approach is likely, over the long term, to accomplish those goals.

If regulation is implemented, the design features listed above can lessen the likelihood of unintended, detrimental consequences.

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ENDNOTES

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The California HealthCare Foundation's program area on Health Insurance works to serve the public by increasing access to insurance for those who don't have coverage and helping the market work better for those who do. For more information on the work of the Health Insurance program area, contact us at insurance@chcf.org.

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