



Ensuring Accountability:

Common Sense Policies for a Consumer-Oriented Health Insurance Market in Illinois

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Illinois PIRG
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 To Powerful Interests

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Illinois PIRG Education Fund

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1. Executive Summary

As our economy weakens nationwide, Illinoisans are having a harder time accessing and affording health insurance. Illinois needs to change the way it regulates the health insurance industry to make sure residents have access to predictable and affordable coverage. An analysis conducted by the Illinois Public Interest Research Group indicates that increasing cost-containment and accountability measures for health insurance companies does not mean that the premium costs paid by consumers will increase.

Health insurance in the United States is regulated by federal and state laws. The federal government sets standards for employee benefit plans and protects consumers who experience lapses in coverage due to losing or changing jobs.^{i ii} States have the authority to regulate the business of the private individual health insurance market, as well as some components of employer-provided insurance.¹

With regulation of the individual health insurance market left to the states, it is important that states provide consumers with the protections they need to access quality, affordable health care by holding insurance companies accountable. Without proper regulation, consumers often fall victim to unfair insurance industry practices that leave them in debt and without medical care.

There are fewer regulations placed on the health insurance industry in Illinois than in most other states, leaving insurance companies less accountable to the consumers they serve. Regulation in other states can provide a model to increase consumer accountability and protections and strengthen the marketplace.

The goal of any regulation policy change in Illinois should be to increase access, predictability, and affordability for consumers while preventing unethical, discriminatory or unfair price manipulation practices that consumer choice alone cannot prevent.

For this reason, it is important to consider the potential for cost increases in health insurance premiums generated by additional consumer protections. This has been a common argument made by opponents of insurance industry reform to justify avoiding instituting regulations to protect consumers.

A statistical analysis comparing the levels of regulation from state to state with average premiums, however, has found little evidence of a correlation between the number of regulations placed on industry and higher premium prices. According to the analysis conducted by the

“Every year our premium soars higher. I have to wonder who is receiving the profits.

Something must be done to help families like ours. We work hard to earn and save our money, but the health insurance game is one we cannot win.”

- Andrea, Aurora, Illinois

¹ States cannot regulate health benefits that employers “self-fund”- that is, arrangements in which employers pay medical claims for employees rather than paying premiums to an insurance company - but when employers and employees pay premiums for employer-sponsored health insurance, states can regulate the health insurance plans.)

Illinois Public Interest Research Group (PIRG) Education Fund, opposing increased regulation by arguing that it will lead to higher premium prices is not tenable.

As job losses in Illinois continue to rise and family budgets tighten, it is important that consumers have health insurance coverage that is predictable and accessible when they need it. There are many oversight and accountability measures that can be added to Illinois regulations that make the individual and small group markets accessible and affordable for consumers. Based on the experience of other states, Illinois PIRG Education Fund recommends that the following basic reforms be a part of any reform policy:

- Require insurance companies to spend 85% of premiums on health care, not profit and administrative costs.
- Establish prior approval measures that prevent insurance companies from arbitrarily raising rates.
- Eliminate unfair coverage revocation by preventing the industry from unfairly canceling coverage after a policy has already been issued.
- Reduce barriers to access by creating an objective standard for “preexisting conditions”

This report provides further details of these recommended policies, compares Illinois’ current oversight of the private health insurance market to other states, and provides statistical evidence that new regulations do not correlate with higher premium costs for the consumer.

2. Background: The Current State of Affairs

Background

Congress enacted the McCarren-Ferguson Act in 1945, giving states the power to regulate their own private insurance markets.ⁱⁱⁱ Since then, state governments have been left with the responsibility of regulating their own private, individual insurance market. Although federal laws such as ERISA (the Employee Retirement Income Security Act of 1974) and HIPAA (Health Insurance Portability and Accountability Act) regulate elements of the insurance market on a national level, these regulations focus largely on employer-sponsored insurance plans.^{iv v} In areas where ERISA, HIPAA, and other regulations are silent, states must regulate their own markets. With each state in control of its own market regulations, individuals and small businesses rely on the state to require basic consumer protections within the health insurance market to make sure they can purchase adequate and affordable coverage to meet their medical needs.

There are three ways in which Americans have access to health insurance. Fifty-four percent of Americans have employer-sponsored insurance.^{vi} Twenty-six percent of Americans are enrolled in Medicare, Medicaid or some other public insurance program.^{vii} Sixteen percent remain uninsured, citing cost and barriers regarding pre-existing conditions as the top two reasons they

go without insurance.^{viii} The remaining 4 percent of health insurance consumers in this country purchase insurance in the private, individual market.^{ix}

In the individual insurance market, consumers can choose between different health care plans offered by insurance providers. The individual plans offered across the country vary widely. There is no standard benefits package or application process on either the state or federal level.

In Illinois, insurance companies can vary the premium and benefits packages they offer consumers based on age, location, gender, and health status, among other factors. Insurance companies can use the health status of an applicant to determine premium prices, or to deny the applicant coverage all together. Some policies offer low premium prices but have extremely high deductibles that must be met before coverage begins. Others exclude conditions or even body parts from coverage for a limited amount of time, or permanently through “exclusion riders” attached to policies that bar coverage for the duration of the policy.

Consumer Voices

Illinois residents go without access to predictable affordable health coverage in Illinois. The following quotes from Illinoisans highlight the struggles they go through as they look for affordable accessible coverage.

Consider the situation Christine in Glen Ellyn finds herself in:

“I’ve had a hard time getting any health insurance because of a pre-existing condition which I’ve had under control for many years. I exercise, try to eat right and do the right things for my health...

Health insurance takes a bigger bite out of my income every year, and I’ve been afraid of switching jobs for fear of having trouble getting insurance.”

Or consider the concerns of Maryanne from Blue Island:

“It’s like people are just giving all their money away to the CEO's of the insurance companies. They sure are not getting the medical treatment they need.

My pre-existing condition itself makes me ineligible for any of the medical insurance companies in Illinois or anywhere.

Regardless, I can't afford it. No matter how cheap the insurance they claim it to be it's still way too expensive for me and they don't accept anyone with pre-existing conditions.”

Michelle from Champaign has a story all too common for consumers:

“I can't get health insurance from work, so I tried to get Blue Cross Blue Shield on my own. At the time I was working at a daycare center with a lot of very noisy toddlers, so I was getting headaches a few times a week. On the application, I told them about the headaches. A nurse called to ask how often I had the headaches, and they ended up denying me coverage because of it.

By the time my rejection letter came, I had changed jobs to one without noisy toddlers, and was getting headaches only a few times a month, so I sent a letter asking them to reconsider. They still turned me down based on the headaches.

Apparently, no one who has ever had a headache can get insurance from Blue Cross Blue Shield of Illinois!”

Andrea from Aurora sums up the concerns of Illinois consumers when she says:

“Every year our premium soars higher. I have to wonder who is receiving the profits.

Something must be done to help families like ours. **We work hard to earn and save our money, but the health insurance game is one we cannot win.”**

Illinois Lacks Basic Regulations

Housed within the Department of Financial and Professional Regulation, the Division of Insurance (DOI) serves as the insurance industry watchdog in Illinois. The responsibility of the DOI is protecting consumers by “efficiently regulating the insurance industry’s market behavior and financial solvency.”^x Unfortunately, the legislature has yet to give the DOI the tools it needs to fully protect consumers.

A recent study by Families USA of all 50 states and the District of Columbia showed that Illinois provides only 1 out of 11 key consumer protections (*see Appendix*). For example, Illinois does not: require insurance companies to spend a certain percentage of each premium dollar on health

care; ensure that premiums are reasonable and fair before insurers begin charging them; prevent insurance companies from unfairly canceling coverage after a policy has been issued; or reduce the impact pre-existing condition exclusions have on the ability of consumers to purchase meaningful health coverage (*see Table 1*).^{xi}

Table 1
Illinois vs. Other States

Consumer Protection	Number of States Requiring Some Level of Regulation *	Required by Illinois?
<i>Prior Approval for Premium Increases</i>	30	No
<i>Minimum Medical Loss Ratio</i>	5	No
<i>Eliminate Post-claims Underwriting</i>	21	No
<i>Objective Standard for Pre-Existing Condition</i>	18	No

**see Appendix for regulation level detail*

3. Policy Recommendations

Sound public policy demands increasing regulation of the health insurance industry in the individual insurance market. Regulations can create consistent predictable insurance products that benefit all consumers regardless of age, race and gender, a problem inherent in unregulated markets. Industry regulations also provide transparency, giving consumers and government watchdogs the power to monitor and stop unfair business practices.

All Illinoisans should have access to quality, affordable health care and the individual health care insurance market should have the transparency and regulation necessary to prevent unethical, discriminatory or price manipulation practices that consumer choice alone cannot prevent. Such reforms will make the market more predictable and easy for consumers to navigate.

The recent state-by-state survey of eleven common insurance regulations conducted by Families USA^{xii} provides the best sense of what policies would help achieve this goal. Illinois PIRG has chosen a combination of four basic reforms that should be included in any reform policy developed for Illinois (*see Section 4 for more details*). We propose adopting the following consumer protections:

- *Minimum medical loss ratio requirement of 85 percent.*
- *Advanced review of proposed premium rates;*
- *Medical underwriting to be completed at the time of application.*
- *Objective standards to define pre-existing conditions; and*

Minimum Medical Loss Ratios

Medical Loss Ratio (MLR) is a term used to describe how much a health insurance company spends on actual health care versus administration and profit.

In Illinois there is no guarantee that the money consumers pay in the individual market for health insurance will be used for their health care. Without limits on how they may spend consumer dollars, insurance companies in the individual market in Illinois may spend as much as 40 cents of each premium dollar on profit and administrative costs.

Required levels of MLRs combat the practice of paying unfairly low proportions of premium dollars on health care. A minimum MLR requires insurance companies to spend a specific amount of each premium dollar on health care, instead of profit and administrative costs. Doing so helps to combat the practice of paying unfairly low proportions of premium dollars on health care in an effort to maximize profit.

Minimum MLRs ensure that insurers use consumers' premium dollars efficiently. The requirement also increases transparency for insurance regulators. Without a minimum MLR, insurance regulators and policyholders can never be sure if their rising premium costs are the result of higher care costs or simply the result of a desire for more profit on the part of the insurance company. Medical loss ratios hold insurance companies to account, which is especially important for small businesses and individuals who cannot use their size to negotiate with insurance companies.

In most states where insurance companies are required to operate at a specific ratio, insurance companies that fail to meet the minimum loss ratio must refund excess premiums to consumers at the end of the year. This makes insurance companies directly accountable to consumers when they take an unfair cut of premiums for profit and administrative costs.

New York and New Jersey have the highest requirements in the individual insurance market, both at 80 percent.^{xiii}

Illinois does not have a minimum medical loss ratio standard nor are insurance companies required to report to state regulators their medical loss ratio.

Prior Approval

Prior approval regulations go hand-in-hand with MLRs in protecting consumers from arbitrary premium increases. To combat the practice of arbitrarily increasing premiums, states can require that insurance companies justify their need to raise rates before they are allowed to do so.

Thirty states require some level of prior approval as a protection for individual consumers against arbitrary premium increases.^{xiv}

In these states, insurance companies must justify their rate increase requests to state insurance regulators and prove the proposed rates are not excessive. Although regulation procedures vary state to state, the justification for prior approval for rate increases must be rooted in fair business practices. The insurance company must prove that the premium increase requested is not excessive or discriminatory but necessary based on medical costs and administration. Rate increases designed simply to increase the bottom line will not be approved.

Insurance regulators in states that have prior approval policies have helped point to countless examples of excessive premium increase requests by insurance companies.^{xv} Prior approval gives states the power to prevent those increases from occurring before unfair rate hikes harm consumers.

Illinois does not have prior approval regulations. Insurance companies in the state can increase their rates without state oversight.

Post-claims Underwriting

When a consumer applies for a policy in the individual insurance market, the insurance company screens the applicant by a process known as medical underwriting. Through this process, applicants supply medical history information, and insurers determine whether they wish to extend a policy. Based on the information provided by the applicant, insurers also determine premium costs and decide whether they will exclude from coverage any of the pre-existing conditions the applicant lists.

If a policy is revoked or cancelled after it has been issued, the insurance company has engaged in post-claims underwriting. This is the process of reviewing medical history after a policy has already been issued, then rescinding coverage or eliminating benefits after a claim is made. . In cases seen around the country, insurance companies typically perform post-claims underwriting when policyholders have sought expensive medical care (following a catastrophic accident, for example) or when they have been diagnosed with a serious disease or condition (such as cancer).

Federal law and regulations protect consumers from unfair cancellations. The law, the Health Insurance Portability and Accountability Act (HIPAA) prohibits insurance companies from

canceling coverage based on health status after a policy has been issued except in specific circumstances: if a person (a) stops paying premiums, (b) moves out of the health plan's service area, (c) commits fraud, (d) ends membership in an association that made the coverage available, or (e) if the plan stops selling the coverage in the individual market.

The rule states that a person can be dropped for fraud only if "The individual has performed an act or practice that constitutes fraud or made an *intentional* [italics added] misrepresentation of material fact under the terms of the coverage" (45 Code of Federal Regulations, Section 148.122). This law may protect policyholders whose coverage is revoked based on an insurer's post-claims underwriting. However, there is some debate about whether the rules apply if an insurance company asserts that it never should have issued a policy in the first place. Individuals who face such coverage revocations may wish to seek an attorney's advice.

Illinois could play a helpful role in asking the federal government to clarify that HIPAA does apply to revocations. Illinois should also amend its own law and regulations to clearly protect consumers from post-claims coverage limitations and revocations.

Abusive post-claims underwriting occurs when a policyholder submits a claim that the insurance company does not want to pay. The company reviews the application and independently researches the medical history of the policyholder looking for discrepancies. For example, the company may allege that they had inadequate information from the applicant regarding a particular pre-existing condition, and had they known, they would have excluded coverage of the specific condition, or they would not have issued the policy at all. If the company determines the policyholder has not been accurate in their medical history description, the company may revoke coverage even though the policy has already been issued.

Insurance companies can abuse this loophole to cancel coverage for policyholders that submit claims for payment of medical costs. Consumer applications are scoured intentionally to find innocent omissions on and use this as reason to cancel policies after they were issued.

To protect consumers from unexpected health care costs and abusive use of post-claims underwriting, the practice should be banned. Instead, insurance companies should be required to complete all medical underwriting at the time of application. With such regulation (barring acts of willful misrepresentation on the application by the consumer) insurance companies cannot revoke coverage based on an examination of the policyholder's medical history after they are approved for coverage. This policy prevents insurance companies from choosing to revoke coverage after they receive a claim from the policyholder they do not wish to pay.

Across the country, 16 states already report requiring insurance companies to complete all medical underwriting at the time of application.^{xvi} Eliminating post-claims underwriting ensures that the failure of the insurance company to investigate facts at the time of application will not become a reason to revoke a policy once it has been issued. Doing so creates certainty and security for consumers in the otherwise difficult-to-navigate market of individual insurance. It also ends the all-too-common situation where consumers fall deep into debt after an insurance company decides to revoke coverage following costly medical procedures.

Currently in Illinois, insurance companies must only prove that the consumer made a false statement.^{xvii} Innocent omissions can be dubbed as “false statements” as a justification to revoke coverage after it has been issued.^{xviii} There is no requirement in the Illinois insurance code that, in order to revoke coverage or eliminate benefits for health services, consumers must have willfully attempted to deceive the insurance company.

Unless the false statement can be proven to be *willful*, insurance companies should not be permitted to revoke coverage or eliminate benefits from the scope of coverage. If false statements are required to be willful, merely identifying a discrepancy in the insured’s medical history compared to their application will no longer be sufficient to prove that the consumer did not fully disclose her medical history. In order to revoke coverage after the policy has been issued, the industry would have to prove to the DOI that the consumer was willfully fraudulent in reporting her medical history and that if the medical history had been accurately reported they would not have issued coverage.

Illinois does require that the false statement made on the application materially affected a company’s decision to insure the person, but that protection is not sufficient if the false statement itself is the result of an innocent mistake on the part of the consumer.^{xix} Insurance applications are worded vaguely, and it is not always clear what information is being requested. If no requirement exists that the false statement be made willfully, Illinois consumers can, at the fault of poorly-worded questions posed by the insurance company, omit or falsely report medical conditions.

Objective Standard for Pre-Existing Conditions

When consumers apply for individual health insurance policies, they can be denied access to coverage because they have pre-existing conditions. Pre-existing conditions are health issues that are present in a person’s medical history at the time of application. Five states require all insurance companies to issue policies to all applicants, regardless of their medical history.^{xx} If an individual with a pre-existing condition is able to obtain a policy, the premium may be extremely expensive as a result of an individual’s pre-existing condition, the policy may exclude the condition from coverage for up to two years, or the policy may have an “exclusion rider” that prevents coverage of the pre-existing condition for the duration of coverage.

Unfortunately for consumers, the term “pre-existing condition” is not objectively defined in Illinois. When determining whether an applicant has a pre-existing condition, insurance companies use the “prudent person” standard. This means that a person is deemed to have a pre-existing condition if any prudent person would have sought medical advice for the condition.

However, what is prudent is a subjective analysis insurance companies are permitted to make on their own. Therefore, regardless of whether a person actually did seek medical advice or was given medical advice, the insurance company is free to determine that a prudent person would have done so and can thus deny the applicant coverage. Applicants are given no guidelines as to what the insurance company will use to determine whether a prudent person would have sought

treatment, leading to a lack of predictability and accountability in the market. The prudent person standard leaves consumers vulnerable to abuse by insurance companies.

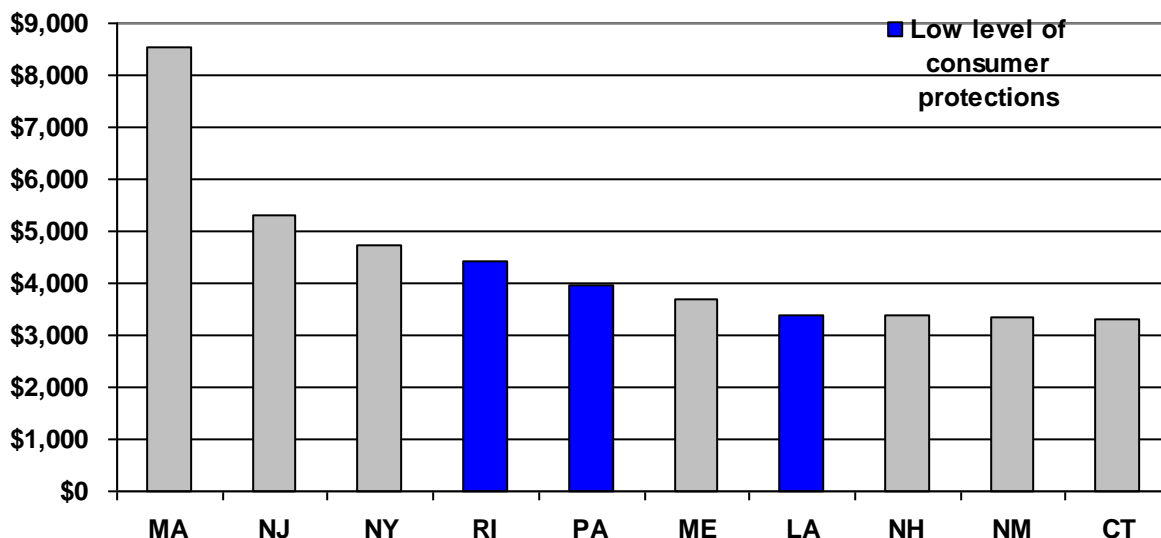
Currently, 18 states require an objective standard for defining pre-existing conditions.^{xxi} The objective standard defines a pre-existing condition as a health condition for which a health care professional provided or recommended treatment, as opposed to a condition that an individual unknowingly had and that had not been diagnosed by a health care provider.

Illinois currently has no objective standard for pre-existing conditions. Instead, insurance companies are provided wide latitude leaving consumer less predictability and choice in health care coverage.

4. Analysis: Do Regulations Mean Higher Premiums for Consumers?

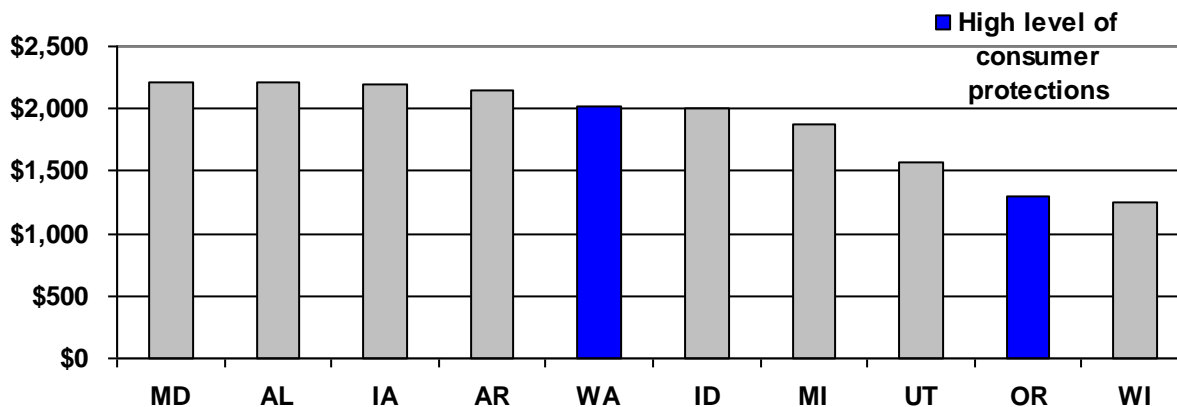
When new health insurance regulations are considered, it is often argued that increasing regulations creates greater costs that are passed on to consumers in the form of higher premiums. This argument may seem convincing on the surface, as only four of the ten most expensive individual market premiums have few consumer protections in the individual market (*see Chart 1*).

Chart 1
Ten Most Expensive Average Individual Premiums^{xxii}



On the other hand, Washington and Oregon, states with relatively high levels of consumer protection, rank 6th and 2nd respectively as the *least* expensive premiums in the country (see Chart 2).

Chart 2
Ten Least Expensive Average Individual Premiums^{xxiii}



Consideration of only the top and bottom ten states, however, fails to address the thirty states occupying the middle ground. Therefore, in order to determine if higher numbers of regulations do in fact mean higher premiums, Illinois PIRG performed a statistical analysis comparing premium prices and regulations across the country. The following sections describe the statistical modeling conducted and the conclusions that can be made based on the statistical analysis.

Data Sources

A report by America's Health Insurance Plans (AHIP) supplied average annual individual insurance market premium data. AHIP gathered the information through a comprehensive survey of their member companies in 2006 and 2007.^{xxiv} The data includes more than 2.9 million policies, which cover 4.2 million people.^{xxv}

Families USA provided the data on consumer protections gathered from all state insurance departments (including the District of Columbia) in 2008.^{xxvi} In this report, Families USA awarded full, partial, or no credit for a variety of consumer protections depending on the level of protection in the state. These consumer protections include whether the state:

- 1) requires insurers to sell coverage to all applicants;
- 2) requires affordable coverage alternatives for uninsurable individuals;
- 3) prohibits higher premiums based on health status;
- 4) requires advanced review of proposed premium rates;
- 5) requires insurers to spend at least 75% of premiums on health care;
- 6) limits how long coverage can exclude pre-existing conditions;
- 7) limits the look-back period;
- 8) requires objective standards to define pre-existing conditions; and
- 9) requires medical underwriting to be completed at the time of application (*see Appendix*).^{xxvii}

The data Illinois PIRG used for our analysis covered 47 states. We did not include Alaska, the District of Columbia, Hawaii, and Vermont. These states lacked significant numbers because average annual single coverage premium data for these states were not available in the AHIP report.

Coding

Illinois PIRG coded consumer protections on a three-point scale. States were assigned a 2 that received full credit from Families USA for a particular protection measure.^{xxviii} We awarded a score of 1 for partial credit on a given measure and a score of 0 for no credit.^{xxix}

Some regulations were coded by Families USA as “N/A.”^{xxx} For example, Maine, Massachusetts, New Jersey, New York, and Vermont all require guaranteed issue and so regulation regarding affordable coverage alternatives does not apply in these states. In the case of affordable coverage alternatives, we coded “N/A” as 0. Families USA awarded each of these same five states an “N/A” for requiring medical underwriting to be completed at the time of application.^{xxxii} However, we coded this regulation as a 2 for each of these five states because they do not allow unfair coverage revocation and therefore deserve full credit for this measure.

It was determined this is an effective coding scheme because it accounts for the relative strength of a given state’s level of regulation. For example, even though New York has scores of N/A for two surveyed regulations, its total regulation score of 14 is the highest out of the 47 states.^{xxxiii} Therefore, by coding “N/A” as full credit, our coding scheme accurately reflects the relative highness or lowness of a given state’s actual level of regulation.

The highest possible score on our policy recommendation package was 8 and the lowest possible was 0. The mean score for our proposed policies between the 47 states was 3. Illinois is well below the national average with a score of 0 (*See Table 2 for a breakdown of states and our proposed regulations*).

Table 2
*Numbers of States with Proposed Regulations **

Amount of Regulation	Prior Approval for Premium Increases		Minimum MLR		Objective Standard for “Pre-existing Condition”		Eliminating Post-claims Underwriting	
	Full	Partial	Full	Partial	Full	Partial	Full	Partial
Number of States	25	5	3	2	18	0	18	3

* see Appendix.

Premium Ranking

Illinois PIRG ranked the 47 states based upon their average single coverage premium, from lowest to highest. With an average premium of \$8537, Massachusetts received the top premium ranking of 47th, and Wisconsin’s average premium of \$1254 gave it the lowest ranking of 1st.^{xxxiii} Illinois ranks 21st out of the 47 states with an average individual premium of \$2499.

Analysis

Illinois PIRG analyzed the statistical association between the average premium ranking for each state and its respective score on our policy recommendations. To measure the association, we calculated the value of gamma between the premium ranking and the proposed regulation score

for each state. Such a measurement assesses whether there is a direct relationship between premium prices and amounts of regulation.

The value of gamma for the association between a state's premium ranking and its policy recommendation score is .237 (*See Table 3*). This value indicates a weak positive relationship.^{xxxiv} Such a relationship lacks the strength needed to make claims that a definitive connection exists between our recommended policies and premium prices. In other words, there is little evidence that there is a strong correlation between our policy recommendations and the average single coverage premium in a given state. This means that it would be difficult to argue that our policy recommendations equal higher premium prices.

Table 3

Association between State Premium Ranking and PIRG Proposed Regulation Score

	Value
Gamma	.237
N of Valid Cases	47

This weak relationship between premium prices and regulations extends beyond just the policies recommended by Illinois PIRG. We see an even weaker relationship between premiums and *all* regulations surveyed by Families USA across the states (*See Table 4*).^{xxxv} This means that no matter what amount of regulations a given state has in effect, there is no strong connection between regulations and premium prices. Again there is little evidence for a strong correlation between regulations and average single coverage premiums. As the number of consumer protections in a given state increases, the average single coverage premium does not necessarily follow suit

Table 4

Association between State Premium Ranking and Total Regulation Score

	Value
Gamma	.196
N of Valid Cases	47

When we look at the data from the 47 states, it appears that the burden of proof lies with those who would argue that more regulations mean higher prices. There is little evidence for a direct relationship between regulations and premium prices. The numbers indicate that anyone wishing to continue claiming that regulation increases mean higher premiums will have to make a stronger case.

5. Conclusion: Common Sense Health Insurance Reform

As the economy in Illinois and nationwide falls deeper into the recession, individuals and families need more predictability, accessibility, and affordability from their health insurance. Yet current Illinois law does not provide for the cost containment and accountability protections that could ensure consumers' ability to navigate their way through the health care system.

When states regulate the market conduct of the industry, insurance companies are made more accountable to consumers. Consumers then have access to a more predictable, fairly priced product. At the moment, Illinois lacks the necessary transparency and regulatory authority to ensure this for consumers. As a result, Illinoisans must contend with a health insurance market that is often inaccessible and unpredictable.

As we have shown, little evidence exists indicating a relationship between regulations and prices. The claim that regulation leads to higher prices for consumers is simply not based in fact.

Illinois PIRG proposes the following policy recommendations for Illinois to better protect consumers in the individual health insurance market:

- **Require a minimum Medical Loss Ratio (MLR) of 85 percent**

The minimum MLR that provides the best balance between the industry and consumers is 85 percent. The Adequate Health Care Task Force Report, a compromise report issued collectively by all major health care stakeholders in the state, recommended that Illinois operate at an 85 percent medical loss ratio to ensure fair premium prices.^{xxxvi} This means for every dollar consumers pay in premiums, 85 cents must go toward medical care. The company can then only use 15 cents for profit and administrative cost.

- **Require prior approval for rate increases**

Illinois should require prior approval in conjunction with a minimum MLR. When an insurance company wishes to increase rates, it should submit proof of its medical loss ratio along with justification for the increase request to the Division of Insurance. If the increase requested is not based on real economic need, or when the insurance company does not meet the minimum MLR, its rates will be adjusted accordingly.

- **Eliminate post-claims underwriting, except in cases of willful misrepresentation**

Illinois should change its standard to require a higher burden of proof for the insurance companies. This protection closes loopholes and ensures that insurance companies cannot use their own poorly-worded applications as an excuse to revoke coverage. This should be made explicit in Illinois law. Specific authority should be written into the insurance code to give the Division of Insurance the power to review rescissions to ensure they are not the result of abusive post-claims underwriting.

- **Create an objective definition of 'pre-existing condition'**

Illinois should require insurers to use the objective standard to define pre-existing conditions. The objective standard defines a pre-existing medical condition as a health condition for which a health care professional provided or recommended treatment, as opposed to a condition that an individual unknowingly had and that had not been diagnosed by a health care provider. An objective standard makes the individual health insurance market predictable and gives consumers confidence that their medical histories are not being skewed in unfair ways just to deny them coverage. When insurance companies end up denying coverage, this regulation makes them accountable for that decision because there is an objective definition by which to judge their decisions.

6. Appendix

Appendix

Average Annual Individual Market Premium Price and Levels of Consumer Protections by State^{xxxvii}

State	Average annual individual market premium price	Guaranteed issue (requires insurers to sell coverage to all applicants)	Affordable coverage alternatives for uninsurables	Prohibit higher premiums based on health status	Prior approval of premium rate increases	75% medical loss ratio	Limit how long coverage can exclude pre-existing conditions	Limit look back period	Use objective standard to define pre-existing conditions	Medical underwriting must be completed during application to eliminate unfair coverage revocation
Alabama	\$2,208	0	0	0	0	0	0	0	2	1
Alaska	N/A	0	0	0	1	0	0	0	0	0
Arizona	\$2,591	0	0	0	0	0	0	0	0	0
Arkansas	\$2,153	0	0	0	2	0	0	0	0	0
California	\$2,565	0	1	0	0	0	1	1	2	2
Colorado	\$2,537	0	1	0	0	0	1	1	2	2
Connecticut	\$3,326	0	2	0	2	0	1	1	2	2
Delaware	\$2,346	0	0	0	0	0	0	0	0	0
District of Columbia	N/A	0	0	0	0	0	0	0	0	0
Florida	\$2,949	0	0	0	2	0	0	0	0	2
Georgia	\$2,419	0	0	0	1	0	0	0	0	0
Hawaii	N/A	0	0	0	1	0	0	0	0	0
Idaho	\$2,006	0	1	0	0	0	1	2	0	0
Illinois	\$2,499	0	0	0	0	0	0	0	0	0
Indiana	\$2,504	0	2	0	2	0	1	1	0	2
Iowa	\$2,202	0	0	0	2	0	0	0	0	0
Kansas	\$2,363	0	0	0	2	0	0	0	0	0
Kentucky	\$2,537	0	0	0	0	0	1	2	2	0
Louisiana	\$3,377	0	0	0	0	0	1	1	0	0
Maine	\$3,686	2	N/A	2	2	0	1	1	0	N/A
Maryland	\$2,208	0	2	0	2	0	0	0	0	2
Massachusetts	\$8,537	2	N/A	2	0	0	2	2	2	N/A
Michigan	\$1,878	0	0	0	2	0	1	1	2	0

State	Average annual individual market premium price	Guaranteed issue (requires insurers to sell coverage to all applicants)	Affordable coverage alternatives for uninsurables	Prohibit higher premiums based on health status	Prior approval of premium rate increases	75% medical loss ratio	Limit how long coverage can exclude pre-existing conditions	Limit look back period	Use objective standard to define pre-existing conditions	Medical underwriting must be completed during application to eliminate unfair coverage revocation
Minnesota	\$2,424	0	2	1	2	0	0	2	2	0
Mississippi	\$2,489	0	0	0	2	0	1	1	0	0
Missouri	\$2,518	0	1	0	0	0	0	0	0	0
Montana	\$2,866	0	2	0	0	0	1	0	2	0
Nebraska	\$2,505	0	0	0	0	0	0	0	0	1
Nevada	\$3,118	0	0	0	2	1	0	0	2	0
New Hampshire	\$3,368	0	1	1	2	0	1	2	2	2
New Jersey	\$5,326	2	N/A	2	0	2	1	2	0	N/A
New Mexico	\$3,362	0	1	0	2	0	2	2	0	2
New York	\$4,734	2	N/A	2	1	2	1	2	2	N/A
North Carolina	\$3,080	0	0	0	2	0	1	0	2	0
North Dakota	\$2,316	0	0	0	2	0	1	2	2	0
Ohio	\$2,498	0	0	0	1	0	1	2	0	2
Oklahoma	\$2,435	0	0	0	0	0	0	0	0	0
Oregon	\$1,297	0	2	2	2	0	0	2	2	1
Pennsylvania	\$3,949	0	0	0	0	0	1	0	2	2
Rhode Island	\$4,412	0	0	0	2	0	1	0	0	2
South Carolina	\$2,981	0	0	0	2	0	0	0	0	0
South Dakota	\$2,914	0	0	0	2	0	1	1	0	0
Tennessee	\$2,221	0	1	0	2	0	0	0	0	0
Texas	\$2,782	0	0	0	0	0	1	0	0	0
Utah	\$1,574	0	1	0	0	0	1	2	2	0
Vermont	N/A	2	N/A	2	2	1	1	2	0	N/A
Virginia	\$2,359	0	0	0	2	0	1	1	0	2
Washington	\$2,015	0	2	2	2	2	1	2	0	2
West Virginia	\$2,540	0	0	0	2	0	1	0	0	0
Wisconsin	\$1,254	0	1	0	0	0	0	0	0	0
Wyoming	\$2,688	0	1	0	0	0	1	2	2	0

ⁱ Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191

ⁱⁱ Employment Retirement Income Security Act (ERISA), 29 USC 18

ⁱⁱⁱ 15 U.S.C. 1011-1015.

^{iv} 29 USC 18

^v See note i.

^{vi} Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of March 2007 CPS.

^{vii} See note i.

^{viii} ABC News/Kaiser Family Foundation/USA Today *Health Care in America Survey* (conducted September 7-12, 2006)

^{ix} See note i.

^x According to mission statement of Illinois Department of Professional Regulation, Division of Insurance, <http://www.idfpr.com/DOI/default2.asp>

^{xi} Families USA, "Failing Grades: State Consumer Protections in the Individual Health Insurance Market." June 2008.

^{xii} Ibid

^{xiii} Families USA, "Medical Loss Ratios: Evidence from the States," Health Policy Memo, June 2008.

^{xiv} Families USA, "The Facts about Prior Approval of Health Insurance Premium Rates," *Health Policy Memo*. June 2006.

^{xv} Ibid.

^{xvi} See note xi.

^{xvii} 215 ILCS 5/359a(3)

^{xviii} Ibid

^{xix} Ibid

^{xx} See note xi.

^{xxi} Ibid.

^{xxii} Comparing individual premium costs found by the America's Health Insurance Plans to insurance industry regulations surveyed by Families USA. See: America's Health Insurance Plans, "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits." December 2007; Families USA, "Failing Grades: State Consumer Protections in the Individual Health Insurance Market." June 2008.

^{xxiii} Ibid.

^{xxiv} America's Health Insurance Plans, "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits." December 2007.

^{xxv} Ibid.

^{xxvi} See note xi.

^{xxvii} See note xi.

^{xxviii} Ibid.

^{xxix} Ibid.

^{xxx} See note xi

^{xxxi} Ibid

^{xxxii} Ibid

^{xxxiii} See note xxiv.

^{xxxiv} Caldwell, S. (2007). *Statistics Unplugged* (2nd Ed.). Belmont, CA: Thomson Wadsworth.; Coolidge, F.L. (2006). *Statistics: A Gentle Introduction*. Thousand Oaks, CA: Sage.; Corty, E.W. (2007). *Using and Interpreting Statistics: A Practical Text for the Health, Behavioral, and Social Sciences*. St. Louis: Mosby Elsevier.; Koenker, R. (1961). *Simplified Statistics*. Bloomington, IL: McKnight & McKnight; Rees, D.G. (1990). *Essential Statistics* (2nd Ed.) London: Chapman and Hall.

^{xxxv} Ibid.

^{xxxvi} See note xxiv.

^{xxxvi} See notes xi and xxiv.
