# Testimony of Director Michael T. McRaith Before the United States Senate Committee on Health, Education, Labor and Pensions

*Please visit the US Senate's site for the full Committee Hearing, including video and testimonies with exhibits.*

**WASHINGTON**—April 20, 2010.

## Introduction

Chairman Harkin, Ranking Member Enzi, and distinguished Members of the Committee, thank you for the invitation to talk with you about the need for regulatory approval of health insurance premium changes. My name is Michael McRaith. I am the Director of the Illinois Department of Insurance, and I speak today in that capacity.

As regulators of the insurance sector, state insurance officials have a demonstrable record of successful consumer protection and industry oversight. Consumer protection has been, is and will remain priority one for state insurance officials. Each day our responsibilities focus on ensuring the insurance safety net remains available when individuals, families and businesses are in need. We advocate for insurance consumers and objectively regulate the U.S. insurance market, relying upon the strength of local, accountable oversight and national collaboration.

With continually modernized financial solvency regulation, state insurance regulators supervise the world's most competitive insurance markets. Twenty-eight (28) of the world's fifty (50) largest insurance markets are individual states within our nation. By gross premium volume, Illinois is the 16th largest jurisdiction in the world. As a whole, the U.S. insurance market surpasses the combined size of the second, third and fourth next largest markets. The insurance markets in California, New York and Florida are each larger than the markets in India, Ireland or South Africa.

Insurance regulators monitor, examine and verify the financial status of insurance companies. For example, insurance regulators not only restrict the types of assets in which an insurer can invest but, also, restrict how much an insurer can invest in any one type of asset. With respect to capital sufficiency, regulators measure insurers based on the nationally uniform standard of "risk-based capital" (or RBC).[1]

RBC measures an insurer's financial strength by testing actual capital levels and includes an analysis of the line of insurance, size of insurer, the insurer's appetite for risk, and other factors. For health insurers, regulatory intervention occurs, as a matter of law, if the risk-based capital level is 200% or less. Since regulators do not limit or control how much capital a health insurer can accumulate, standard notions of health insurer "profitability" are unreliable.

To the extent that the Department currently has authority to regulate health insurance rates, that authority is limited to assuring the solvency of the insurer or, rather, to assuring that rates charged by the health insurer are not too low.

## The "Illinois Model" of Rate Regulation

Illinois proudly, and appropriately, embraces the "Illinois model" for rate regulation in the life and property and casualty lines of insurance. Where many states require prior approval by the insurance regulator before an insurer's use of a proposed rate, Illinois allows competition and a dynamic marketplace to generate prices for commonly required insurance like auto and homeowner.

The "Illinois model," as often cited by proponents for deregulation of insurance markets, does not repose rate approval authority in the Department, or any other state agency, for any line of insurance other than Medicare Supplement, long-term care, the auto and home residual markets, and the worker compensation assigned risk pool. Until recently, Illinois law required prior approval on medical malpractice liability insurance rates if a proposed increase exceeded six percent (6%).[2]

For property and casualty insurance, Illinois has an exceptionally competitive market. More companies offer auto, homeowner and worker compensation insurance in Illinois than in any other state. Despite exceptional demographic and geographic diversity, Illinois has rates average among all states, and insurer profitability for personal lines is typically in the middle third of all states. Participation in the auto and homeowner insurance residual markets is nominal.[3]

For property and casualty insurance, the "Illinois model," while not entirely beyond reproach, performs well for Illinois families, businesses and insurers. In contrast, the absence of prior approval rate regulation for health insurance exacerbates the dysfunction in a health insurance marketplace that fails to perform efficiently or effectively for Illinois' businesses and families.

In Illinois, individuals and families can be denied insurance for any reason other than "race, color, religion or national origin." 215 ILCS 5/424. In at least one instance, one applicant was denied insurance for herself and her three healthy children because she attended grief counseling after her young husband died.

A recent survey by the National Association of Insurance Commissioners (NAIC) revealed that Illinois has more rescissions by volume than any state in the entire country—almost fifty percent (50%) more than California. See Exhibit A. In at least one instance, an insurer attempted to rescind a teenager's coverage on her family policy because her parents failed to disclose her congenital deformity—she wore braces.

Illinois law does not limit the rate variance between genders, the price impact of health status, the price impact of age, or the impact of any one rating factor on renewal. If a woman and man are of the same age, live in the same house, have the same health status, and see doctors in the same hospital, the woman can be charged as much as 57% more than the man—independent of maternity benefits.

Unlike the property and casualty insurance market—in which every willing buyer receives an offer—Illinois families are denied offers of coverage, or denied coverage at an affordable price. Illinois' dysfunctional health insurance market serves too few families because willing buyers do not even receive an offer.

Small employers offering health insurance to employees nearly always experience explosive rate volatility because, even though rates are subject to "bands," or variance limits, at the time of issuance, the Illinois small group rate bands are among the nation's broadest. For this reason, small employers in Illinois, even with only one injured or ailing employee, can experience rate increases in excess of fifty percent (50%) on renewal.

Exclusive of Medicare and long-term care, health insurers in Illinois collect more than $15b in premiums. Illinois is one of three states (with Utah and Louisiana) that fund the payment of high risk pool health care claims with direct general revenue fund, or taxpayer support.[4] For the right to reject people who are or might become sick, the Illinois health insurance industry pays only an assessment to fund the HIPAA-compliant high risk pool which, in 2009, totaled $43,371,000.

# Illinois — Current Oversight of Health Insurance Premiums

Illinois law does not require that either individual or group plan rate increases must be actuarially justified.

# Individual Major Medical

As provided in Illinois law, individual market premiums are effective when the insurer submits a "classification of risks and the premium rates pertaining thereto have been filed with the Director." 215 ILCS 5/355. Consequently, the Department receives an individual major medical rate increase filing, notifies the insurer that the filing has been received, and the insurer may then rely upon and use that rate change.

# Health Maintenance Organizations

Health Maintenance Organizations (HMO) comprise a small and shrinking percentage of Illinois' commercially insured, with some estimates as low as fifteen percent (15%) of all covered lives. HMO's must file with the Department "schedules of base rates to be used," 50 Ill. Admin.Code 5421.60, and submit to the "Director, prior to use, a notice of any change in rate methodology[.]" 215 ILCS 125/4-12. As with individual major medical insurance, even though HMOs submit rate-related information, the Department does not have authority to approve or deny any HMO rate change.

# Small Employer Groups (2-50)

For non-HMO small group plans—by far the largest share of the Illinois small group market—insurers are not required to file with the Department the amount of a base rate or the percentage change of a base rate from year-

to-year. In fact, insurers are only required to file annually "an actuarial certification certifying that the carrier is in compliance" with the Illinois Small Employer Health Insurance Rating Act, or "SEHIRA." 215 ILCS 93/30.

The broad rate bands in SEHIRA provide health insurers with expansive latitude to price a small employer. While small employers enrolled in the first year pay premiums dependent upon health status of employees, the renewal years bring profound rate volatility due not only to employee health status (up to 15%) but also a lack of limitation on the base rate increases. 215 ILCS 93/25(3)(A) and (B). In Illinois, a small group "base rate" is the lowest rate charged to a small employer. Small employer premiums can also increase, without limitation, due to "case characteristics," otherwise known as age, gender and geography. 215 ILCS 93/25(C).

## Large Employer Groups (50+)

Illinois law is silent on rate oversight for employers with more than fifty (50) employees. In fact, unlike employer groups of fifty (50) or fewer, health insurers can—and do—deny applications from employers with more than fifty (50) employees.

## "Base Rates" — Only One Indicator

Base rate information can be illustrative but is far from conclusive. For example, Illinois policyholders can be charged more than the base rate due to health status, geography, gender and age. For individual major medical policies, the Department does not receive information regarding the percentage of covered lives who pay more than the base rate versus those who pay less than the base rate, or how much those covered lives pay.

## Renewal Penalty

In addition, some health insurers in Illinois offering individual health coverage impose a renewal penalty of three to five percent (3 – 5%). Since individual policies are "guaranteed renewable," only those who have filed claims in the preceding year will renew because, of course, failure to renew will result in outright denial of that person's coverage, or an exclusion rider. The renewal penalty, therefore, incentivizes the healthy insured to move to a less expensive block of the insurer's business, promoting risk segregation that leads to the proverbial "death spiral." Illinois law does not limit rate increases for any individual major medical health insurance block of business.

## Illinois Individual Major Medical Health Policy Rate Filing Report

With the public discussion leading to the March 21, 2010, US House of Representatives vote on the Patient Protection and Affordable Care Act (the "PPACA"), the Department posted on its web site (Insurance.Illinois.gov) a report of individual market health insurance premium increases, the "Individual Major Medical Health Policy Rate Filing Report" (the "Report"). Since the initial Report, the Department has expanded the retrospective to include all individual market filings since January, 2005. See Exhibit B.

The Report illustrates that Illinois families and individuals covered or seeking coverage in the major medical marketplace have experienced dramatic base rate increases into 2010 and beginning at least in 2005. Base rate increases have frequently exceeded 30% since at least January, 2005.

# Health Insurance Rate Regulation — A Necessary Step Forward

Rate approval authority, vested with the Department, would improve the performance, transparency and accountability of the health insurance market for employers and families. With an entirely for-profit health insurance industry, Illinois is uniquely well positioned to benefit from an additional regulatory tool such as rate regulation for health insurers and HMOs.

Rate regulation need not be a punitive or contentious exercise. Consistent with the priorities of Illinois Governor Pat Quinn, the Department pursues the regulatory mission in a professional, direct and collaborative manner, an approach that will continue through all phases of PPACA implementation.

Consistent with the Department's core mission to protect the solvency of the insurance industry, rate regulation complements the insurance reforms of PPACA. For example, effective September 23, 2010, insurers will be required to report medical loss ratios, and minimum medical loss ratios are required for plan years beginning January 1, 2011. See PPACA Section 1001.

Even now, the US Department of Health and Human Services and the states are working to establish a process for the annual review of unreasonable premium increases. See PPACA Section 1003. In that same section, insurers are required to post on company web sites "a justification for an unreasonable premium increase prior to implementation of the increase."

With other reforms effective September 23, 2010, including the removal of lifetime limits and coverage for children with preexisting conditions, the Department has heightened concerns about health insurer solvency. With heightened concern, the Department also needs sharper tools and more opportunities to learn about the rate-making strategies of health insurers.

In addition, less responsible insurers may opt to increase premiums dramatically, and unnecessarily, in anticipation of the comprehensive reforms effective January 1, 2014. Health insurer rate regulation, therefore, is essential to prevent both inadequate and excessive premiums.

Even without the improvements from PPACA, health insurance consumers in Illinois would benefit from health insurance rate regulation. Most Illinois families scrape and save to pay premiums with hard-earned dollars. Small businesses, trying to retain skilled employees to facilitate growth, spend income earned through dreams, sweat and dedication just to offer meaningful health insurance to those employees. Illinois families and businesses, trying to obtain financial security with the purchase of health insurance, are entitled to know that those premiums are reasonable, fair, and not an insurer's exploitation of an overly passive or archaic regulatory ideology.

# Feinstein - Schakowsky (S. 3078/H.R. 4757)

To be clear, the Department, reflecting the priorities of Governor Quinn, supports statebased insurance regulation. Insurance regulation at a state level affords consumers access to direct, prompt, meaningful interaction with regulators who understand the communities in which we live, the markets in which we buy, the insurers from whom we buy, and the producers who aid in our purchase of insurance. This reality is apparent in every line of insurance, but especially visible with health insurance.

State regulators approve health insurance policies sold in each state, the provider networks offered by insurers, the provider communities in areas as diverse as Chicago and downstate Marion, and the relative impact of one change versus an "unintended consequence." For that reason, the Feinstein-Schakowsky bill, which would establish the "Health Insurance Rate Authority," warrants the support of the Department.

Congress, in passing Feinstein-Schakowsky, would provide a federal "tools" approach to health insurance rate oversight. In effect, a federal "tools" law imposes on the states an obligation to act. Failure to act would result in federal preemption. This approach has been previously used for insurance purposes, including for Medicare Supplement guidelines, the Health Insurance Portability and Accountability Act, and Gramm-Leach- Bliley. In addition to differing regulations for rate approval, states have different health insurance markets: some are predominantly non-profit, some almost evenly split between for- and non-profit, some more for-profit, some have medical loss ratio standards and some do not.

For those states that have rate oversight authority—twenty-seven (27) currently have some form of health-related rate approval authority—Feinstein-Schakowsky would be supplementary and not a new or lower level of authority. For those states that do not have health insurance rate regulation—of which Illinois is one—Feinstein-Schakowsky would provide an impetus.

In short, Feinstein-Schakowsky vests the states with discretion about whether and how to regulate rates. For those states that do not opt to supervise proposed rates, the families and businesses of those states will have the opportunity for federal oversight.

The funding available to states to support the enhanced rate regulatory authority, or some portion of $250 million, would bolster the Department's efforts to afford Illinois families and businesses better health insurance performance and accountability. At a minimum, rate regulation will assure Illinois' families and businesses that hard-earned premium dollars are used primarily for health care.

# Conclusion

Not every state seeks health insurance rate approval authority. For Illinois, with our dysfunctional health insurance market and with the enactment of PPACA, rate approval authority will enhance the performance, transparency and accountability of the health insurance our families and businesses strive to purchase. While regulation for the sake of regulation does not comprise an end worth pursuing, increased efficiency of health

insurance products will improve the quality of life for Illinois' families and the prospects for growth of Illinois' small businesses.

We welcome the interest of Congress and this Committee in this important question of consumer protection. As the entire country moves forward with implementation of health insurance reform, we pledge to share our experience and expertise with Congress and to work with the members and staff of this Committee.

Regulation of all financial sectors must allow for evolution to facilitate but monitor innovation and efficiency. Here, as we work toward affordable and accessible health insurance coverage for all families and businesses, the Department seeks additional rate approval tools with which to limit, if not eliminate, the potential abuses of inadequate or excessive rate changes.

After all, health insurance differs from other personal lines of insurance: we can choose the car we drive and we can choose our home. We do not choose breast or prostate cancer. We do not choose a heart attack. We do not choose autism.

Thank you for the opportunity to testify. I look forward to your questions.

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**Footnotes**

[1] Risk-based capital levels are confidential and not available to the public. To calculate an RBC, regulators compare an insurer's Total Adjusted Capital (the actual amount of capital and surplus) to its Authorized Control Level Risk-Based Capital (the minimum levels of capital for an insurer with the subject insurer's characteristics).

[2] See Abigaile Lebron, a minor, et al., v. Gottlieb Memorial Hospital, et al., Nos. 105741,105745 (Ill. Feb 4, 2010).

[3] As a percentage of the total insurance premiums, the residual market for auto was 1.10% and for home .26%.

[4] In 2009, the Utah general revenue fund contributed $9.3m and the Louisiana general revenue fund contributed $2m. In Illinois, taxpayers contributed $28.9m to support the high risk pool.