Testimony of Michael T. McRaith
Director of the Department of Insurance
State of Illinois

Before the United States Senate
Committee on Health, Education, Labor and Pensions

Regarding:
Protection from Unjustified Premiums

April 20, 2010

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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

[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).

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

[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%.

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.

[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.

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 state-based 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.

EXHIBIT A

National Association of Insurance Commissioners

RESCISSION DATA CALL

of the NAIC Regulatory Framework (B) Task Force

December 17, 2009

National Association of Insurance Commissioners

Executive Summary

In October 2009, the Regulatory Framework (B) Task Force issued a data call to 52 companies that wrote individual major medical policies or individually underwritten certificates.

The data call was divided into four parts. The first part of the data call was designed to determine the actual numbers of policies/certificates that were written and in force and how many were rescinded in each state per year. In the second part of the data call, the Task Force requested information on the underlying conditions that were the basis of the rescissions. In the third part, the companies were asked to provide information on their underwriting and rescission-making process. Finally, each company was asked to provide details on their rescission appeal process, if one was in place.

The data call revealed that there were roughly 27,246 rescissions against a sampling size of about 6.7 million issued policies. This translates into a rescission rate of 3.7 rescissions for every 1,000 policies/certificates that were written over the five-year period covered by the survey (2004 to 2008). The rate of rescissions peaked in 2005 and was at its lowest in 2008. Psychiatric conditions were cited most frequently as the basis for a rescission. The rescissions and rescission rates were also summarized by state and by company. While it is not the intent of this report to isolate specific companies, three companies do have significantly higher rescission rates and account for the higher rescission rates in some of the states.

As would be expected, the companies reported having a robust information-gathering process for underwriting policies and when considering a rescission. Almost all of the companies also have detailed rescission appeal processes in place that include two or three tiers of appeal, including the use of third parties as well as medical and legal experts.

Because the majority of individual major medical policies are medically underwritten, it is important for companies to have the right to rescind a policy if the information provided by an applicant is both fraudulently misrepresented, and material to the condition for which coverage is being sought. This serves not only to protect the company, but also to protect their customer base, whose premiums are based on the collective experience of the book of business. To balance the company's right to rescind a policy with the consumer's right to collect on coverage that was fairly contracted and paid for, companies must implement policies to guard against incorrect decisions to rescind. The companies included in this data call have attempted to implement appeal processes that include reviewers that are not associated with the original decisions to underwrite or rescind a policy and, in many cases, are not associated with the company.

After some background information, the remainder of this report will present the details of the findings in the order in which they were asked in the data call: (1) the number of policies/certificate issued and in force, as well as the number of rescissions; (2) the cited conditions that were that basis of the rescissions; (3) the information sources used for underwriting and rescinding a policy; and (4) the appeals processes of the companies.

National Association of Insurance Commissioners

Background

In a July 24, 2009, letter to Chairman Bart Stupak (D-MI) of the U.S. House of Representatives' Energy and Commerce Subcommittee on Oversight and Investigation, NAIC President Roger A. Sevigny (NH), Commissioner Sandy Praeger (KS), Commissioner Joel Ario (PA) and NAIC CEO Therese M. Vaughan, Ph.D., advised the House Committee that:

> …the NAIC Regulatory Framework (B) Task Force has been given the responsibility of determining to what extent rescissions are used and of recommending laws and regulations to prevent abuse of the [rescission] process. To this end, at its most recent meeting in June, the Task Force approved a data call that will be sent to insurers selling coverage in the non-group market. This data call is intended to uncover the number of policies that have been rescinded in each state over the past five years, the health conditions that are most frequently cited as the basis of rescissions, and determine the formal procedures the insurers have in place to review rescission decisions.

The referenced data call was sent to 52 companies that reported writing individual major medical polices. The policies issued by these 52 companies encompassed 80% of the lives covered by individual major medical policies. Three companies were eventually exempted from the data call because they either wrote only group and non-major medical insurance, or they wrote only governmental plans that were not vulnerable to rescissions at the insurer's discretion. In addition, the data call was sent to each company by the insurance department of the domiciliary state. One state decided not to participate, because its three companies had already responded to the previous, similar survey issued by U.S. Rep. Henry Waxman (D-CA) of the House Oversight Committee in October 2008. In total, responses were received from 46 companies (four additional responses were received from companies that were not originally part of the sample, but wrote individual major medical policies and were affiliated with other companies that were part of the original sampling) representing a sample of 70% of the covered lives and 69% of the premium earned in 2008.

To meet its charge, the Regulatory Framework (B) Task Force designed the data call (Appendix A) to address the five-year time span of 2004 through 2008. It asked each company for the total number of individual major medical policies issued and in-force by state for each year, as well as the total number of rescissions by state per year. In addition, the data call asked how many of the total rescissions were based on conditions that were undiagnosed prior to the application. Each company was also requested to provide the top four conditions upon which the rescissions were based and, if any rescissions were based on conditions undiagnosed prior to the application, the top four conditions for those rescissions.

The data call defined an individual major medical policy as "…a type of health insurance policy designed to cover an individual, or an individual and specified dependents, for hospital, medical and surgical expenses." It specifically did not include "…among other things: standalone dental or vision plans, specified/named disease policies, short-term health insurance policies (of less than 12 months in total duration), hospital indemnity insurance policies, long-term care insurance policies, supplemental insurance policies, or disability income policies." The companies that received a data call were asked to not include any governmental plan information with their data if the policies were not vulnerable to rescission at the company's discretion.

Along with the actual numbers of policies and rescissions, the data call asked the companies what information was used in underwriting a policy and what information was used in making a decision to rescind a policy.

Finally, the data call asked the companies to explain what procedures were in place to allow a consumer to appeal a determination to rescind a policy.

In order to fulfill the responsibility of the Task Force, this report aggregates the data received, totals the rescissions nationally and by state, and summarizes the responses received regarding underwriting, rescission and appeal procedures.

The Sample Size of Individual Major Medical Policies and Certificates

In the five-year period, 2004 to 2008, the 46 companies issued more than 6.7 million individual major medical policies. The number of policies issued in each year rose consistently. Over the five-year period, there was a 50% increase in the number of such policies issued (Figure 1). The number of in-force policies also increased about 50% during the same period, totaling almost 4 million policies in-force by the end of 2008 (Figure 2).

Figure 1

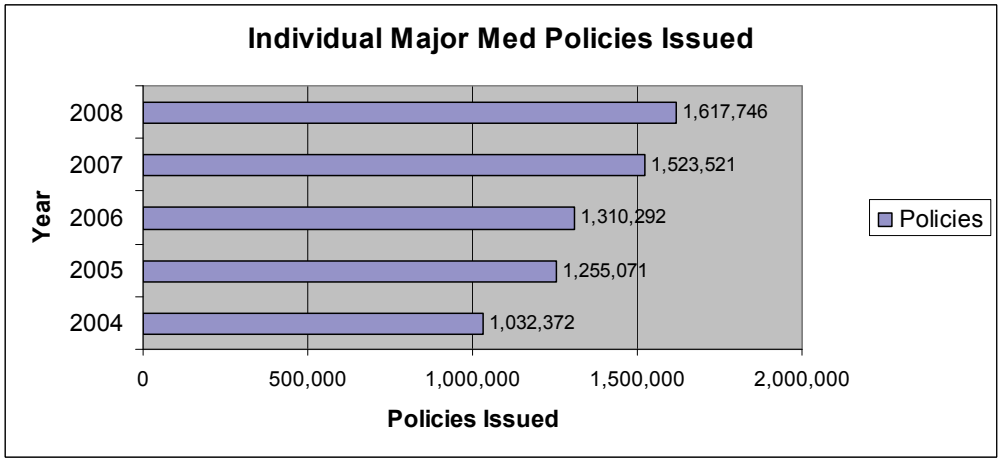
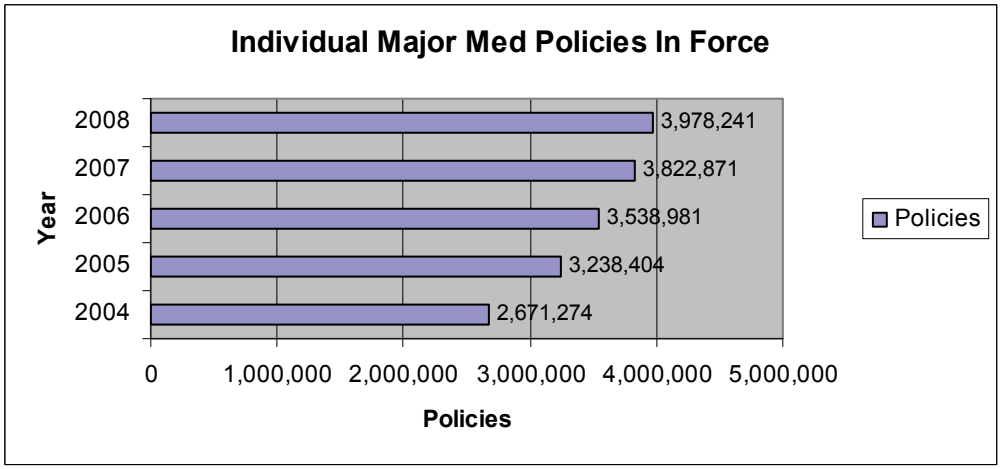


Figure 2



Per the counts reported by the insurers in the data call, about 8% of the individually underwritten major medical coverage is written on a certificate basis. The number of such certificates written per year is illustrated in Figure 3. The in-force number of certificates is provided in Figure 4. Interestingly, in 2006, the sampled insurers reported having individually underwritten an additional 7,200 certificates, yet reported that the in-force number of certificates dropped at year-end 2006 by 3,700 certificates.

Figure 3

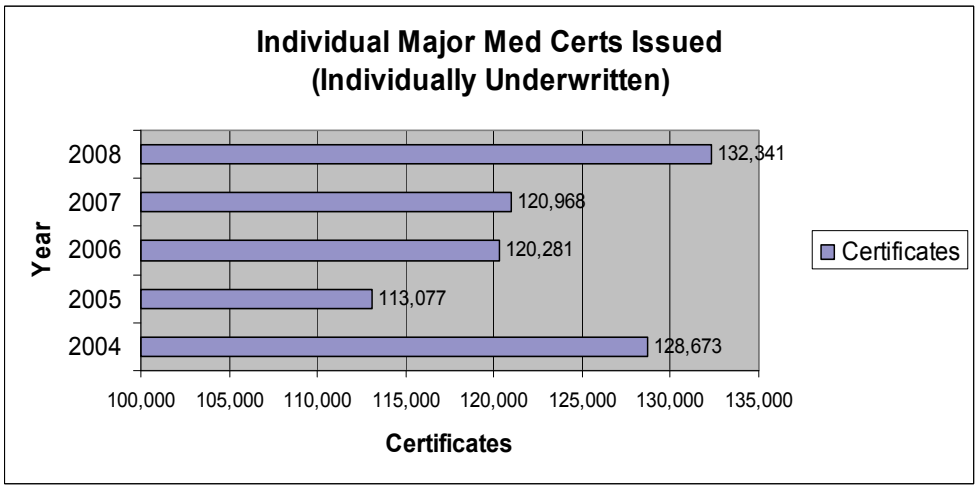
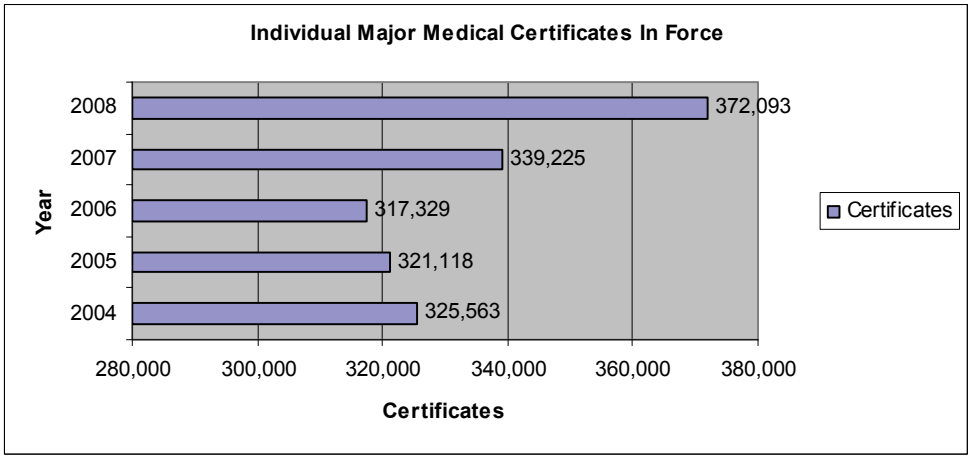


Figure 4



Adding together all of the policies and certificates written per year for the companies responding to the data call, there were 7.35 million individually underwritten polices and certificates issued in the five-year period sampled. At the end of 2008, there were a total of 4.35 million policies and certificates in-force.

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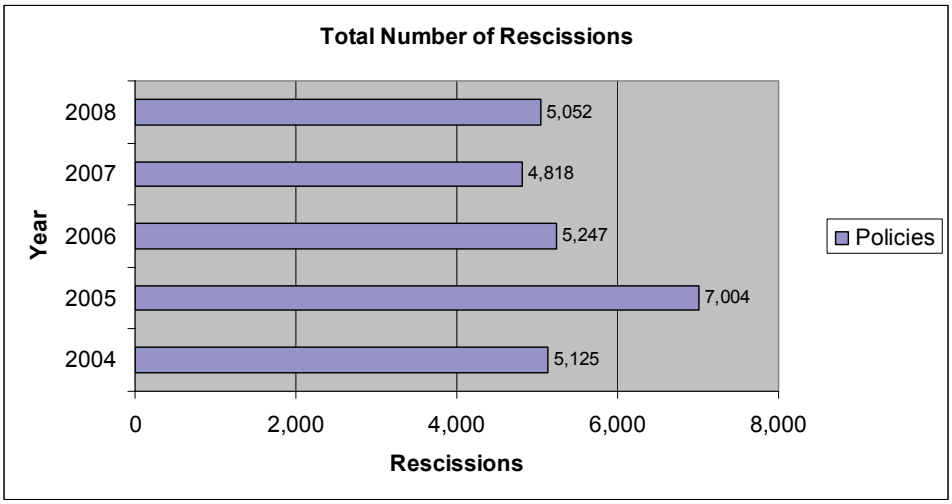
Rescissions

In the data call, the Task Force asked for the total number of policies and certificates rescinded in each year for each state. Although the number of certificates was counted, there was no distinction made whether a rescinded insured was a policyholder or a certificateholder. Please note that some companies rescinded coverage for individuals and not the entire policy. A rescission, therefore, does not necessarily indicate the rescission of an entire policy or certificate.

Figure 5 shows the total number of rescissions nationally by year and for the entire five-year period of the data call. The figure shows that there was a 27% increase in the raw number of rescissions from 2004 to 2005. After 2005, the number of rescissions begins to decline to a low of 4,818 in 2007. There was a 5% increase in the number of rescissions in 2008.

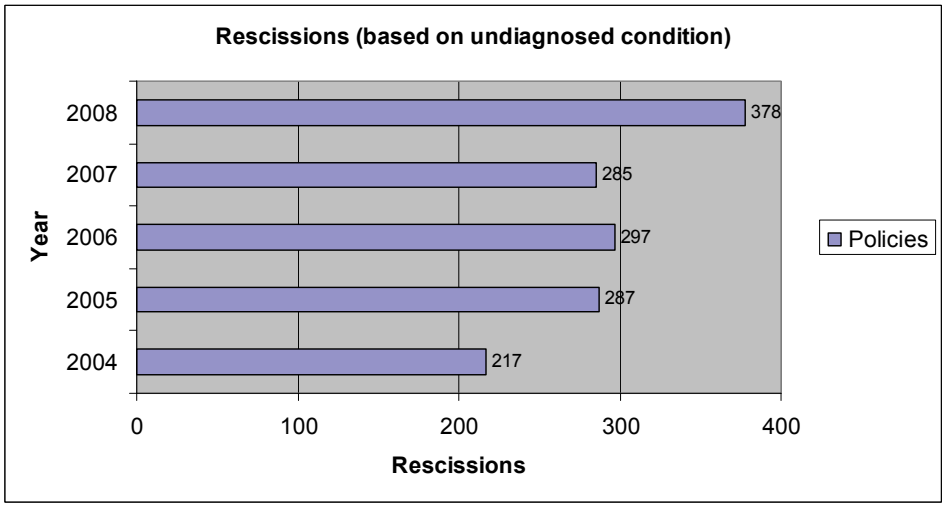
Figure 5



The data call asked each company for "the total number of policies and certificates rescinded in the calendar year" (the source of the data for Figure 5). It also asked for "the number of policies and certificates rescinded in the calendar year, based on a condition(s) not diagnosed prior to application". The second data element was included to encompass those situations in which an applicant has received indications of a medical condition, but has postponed any testing to confirm a diagnosis until after an application has been completed and a policy or certificate has been issued.

The number of rescissions based on condition(s) undiagnosed prior to the application was about 5% of the total number of rescissions. The actual number of these rescissions is illustrated in Figure 6. Unlike the total number of rescissions, these rescissions peaked in 2008 (instead of 2006), contributing to 7% of the total rescissions for that year. Except for a decrease from 2006 to 2007, the number of rescissions based on conditions undiagnosed prior to the application has increased each year.

Figure 6



Using the above data, rescission ratios could be calculated per the number of polices/certificates issued and per the number of policies/certificates in-force for each year (Figure 7).

Figure 7

The ratios were derived per every 1,000 policies and certificates. These ratios used the total number of rescissions and we did not calculate a separate ratio for rescissions based on conditions that were undiagnosed prior to the application because they were such a small percentage of the total.

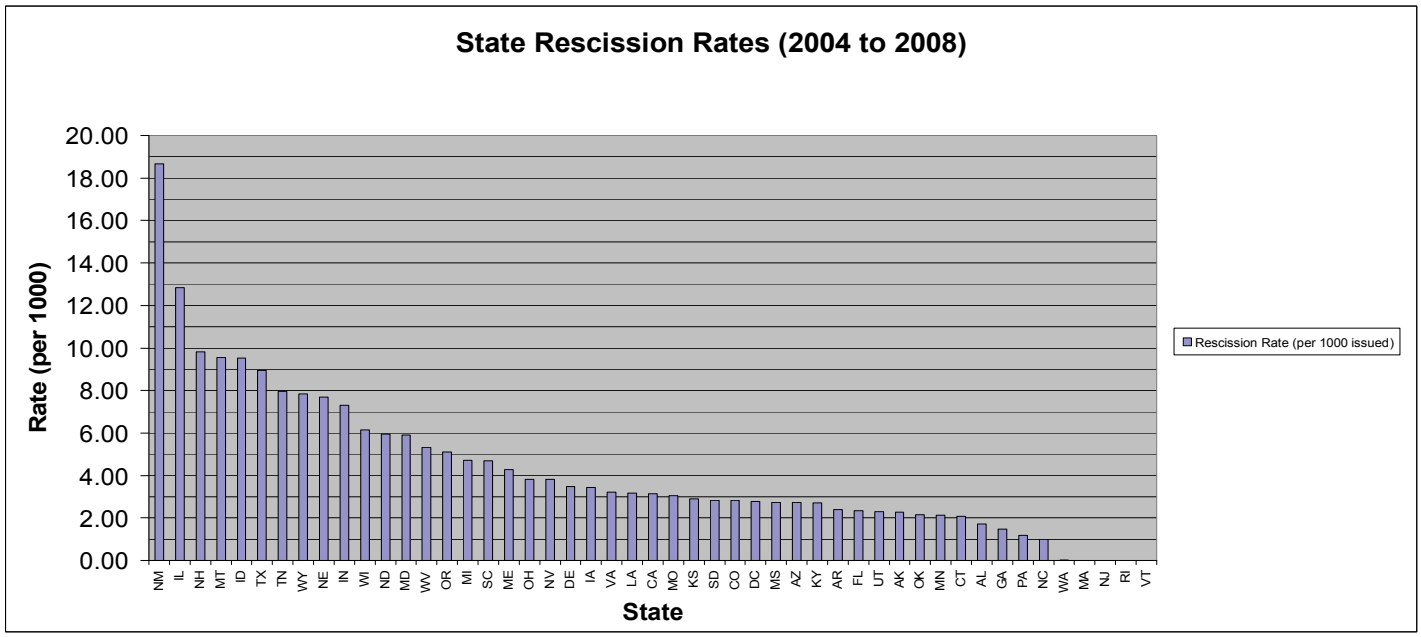
The peak rescission rate occurred in 2005, with approximately five of every 1,000 issued policies being rescinded. Because rescissions might also occur on policies that were issued in prior years, it is helpful to also look at the number of rescissions compared to the number of policies in-force at the end of each year. Again, the rescission ratio peaked in 2005, with approximately 2 of every 1,000 in-force policies being rescinded. After 2005, there was a steep decline in the rescission rate, decreasing just more than 40% to 2.9 rescissions for every 1,000 policies issued and 1.2 rescissions for every 1,000 policies in-force.

For the five-year period of the data call, the rescission ratio is 3.7 rescissions per 1,000 policies issued. Excluding the first two years of 2004 and 2005, the rescission ratio is about 3.1 rescissions per 1,000 policies issued.

In 2005, the California Department of Managed Health Care began its investigation into the rescission practices of some of the health insurers in its state. Fines were announced in 2007 and a settlement was reached in 2009. The reduction in the numbers of rescissions and the rescission rates appear to have begun in 2006 and reached their minimum in 2007 and 2008. Though there is not enough data from enough insurers to draw any firm conclusions, there does seem to be some connection with the actions of the State of California regarding rescissions.

One of the responsibilities of the Regulatory Framework (B) Task Force was to determine the number of rescissions per state. The rescission ratios per state are provided in Figure 8.

Figure 8



National Association of Insurance Commissioners

Because so few companies write in any individual state, the sample size for each state is a fraction of the national sampling. This explains the wide swing in rescission ratios from 18.5 per 1000 policies issued to as little as none or 1 per 1000 issued. Two states, Hawaii and New York, did not have any companies reporting individual major medical business. New Jersey and Rhode Island each had a small amount of business reported and no rescissions. In Maine[1], Massachusetts, New Jersey, New York, Washington and Vermont health insurers are required to provide health coverage on a guaranteed-issue basis with no medical underwriting.

To provide some perspective to the ratios in Figure 8, the raw numbers reported by the sampled companies for each state are provided in Table 1. All columns are five-year totals reported in each state.

Table 1

State	Total Issued	Total In Force	Total Rescissions	Rescissions - condition(s) not diagnosed	State	Total Issued	Total In Force	Total Rescissions	Rescissions - condition(s) not diagnosed
AK	2,205	3,853	5	0	MT	10,580	39,440	101	0
AL	91,083	275,113	157	1	NC	339,933	1,079,351	337	3
AR	76,942	287,255	184	1	ND	4,536	15,309	27	0
AZ	224,683	636,688	613	11	NE	26,556	65,061	204	10
CA	1,192,463	2,462,211	3,736	213	NH	3,770	10,147	37	0
CO	183,220	433,032	519	22	NJ	0	38	0	0
CT	89,305	194,470	186	9	NM	35,065	119,101	655	52
DC	16,143	37,883	45	1	NV	56,898	136,196	217	4
DE	3,728	6,336	13	1	OH	205,484	523,344	785	42
FL	630,997	1,447,418	1,480	76	OK	78,922	81,259	169	3
GA	346,202	912,789	514	23	OR	91,136	277,997	465	0
IA	95,276	397,767	328	1	PA	295,238	745,854	350	88
ID	5,564	14,393	53	0	RI	246	247	0	0
IL	410,877	1,122,140	5,279	353	SC	92,838	260,394	436	7
IN	35,324	70,459	258	6	SD	27,848	120,321	79	1
KS	94,151	326,317	274	5	TN	43,174	79,434	343	7
KY	141,590	480,591	383	25	TX	378,705	960,040	3,389	212
LA	148,950	508,120	471	55	UT	58,086	155,197	134	6
MA	273,649	238,237	0	0	VA	293,498	779,038	942	95
MD	163,392	443,407	966	5	VT	0	12	0	0
ME	466	457	2(1)	0	WA	250,102	630,826	9	0
MI	323,040	628,299	1,520	81	WI	42,913	101,948	264	4
MN	139,246	911,380	295	0	WV	4,504	9,249	24	0
MO	250,933	585,289	762	39	WY	6,120	13,423	48	0
MS	68,761	297,969	188	2					

[1] Any policy written with a term of exactly 12 months was considered reportable to this data call. The data call excluded "short-term policies," which it defined as any policies with a term of *less than* 12 months. Maine law exempts short-term policies from guaranteed issue and guaranteed renewal requirements, and allows insurers to issue short-term coverage for a term of *up to* 12 months. The two rescissions reported in Maine were rescissions of two separate 12-month short-term policies.

Rescissions within the Contestability Period

All of the companies were asked to identify how many rescissions were made within the contestability period established by the state where the policy or certificate was issued. From 2004 through 2008, there were 1,464 policies/certificates that were rescinded based on a condition that was undiagnosed prior to the application. For all such reported rescissions (except for three times), the same number of rescissions were reported as having been made within the contestability period; i.e., 1,461.

Health Conditions Most Frequently Cited as a Cause for Rescission

In addition to the actual numbers of rescissions within each state, the data call asked the companies to identify the top four conditions that were most frequently cited as the reason for a rescission in the five-year period. The top four conditions were to be provided for the total rescissions, as well as rescissions that were based on conditions that were undiagnosed at the time of the application.

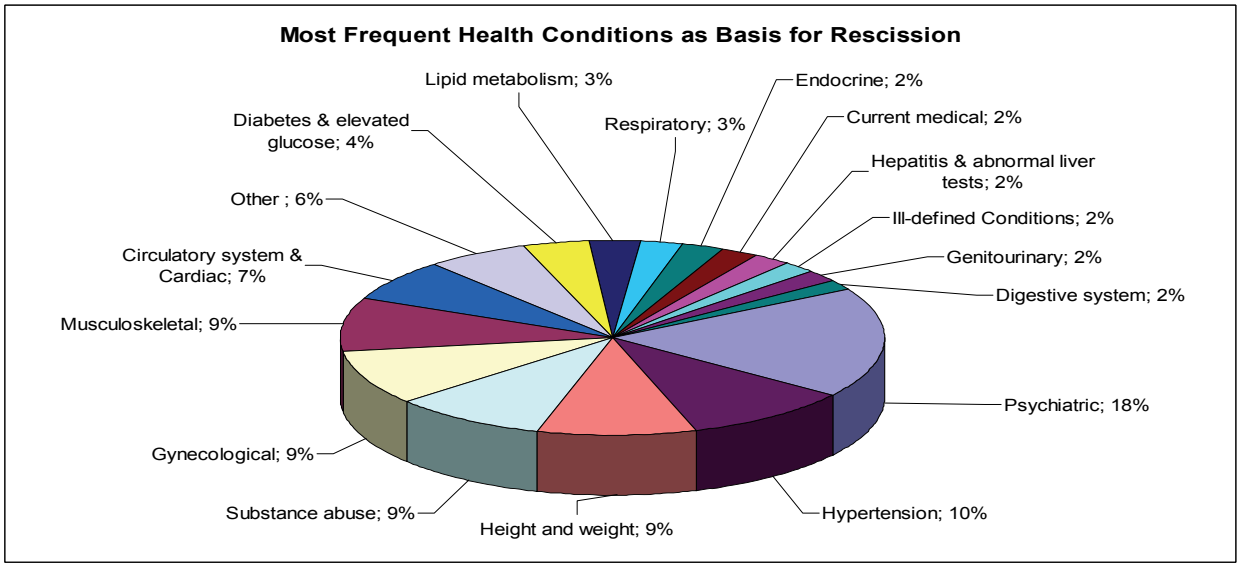
Many companies responded correctly by providing one list of conditions that covered the five-year span of years. Quite of few others, however, provided the information on a yearly basis, and cited the top four conditions in each year and in each state. To compensate for this mix in method of reporting, we tracked the most frequent conditions per year. If a company reported only one list for the entire five-year period, each condition was counted once in each year. Once all the responses were tallied per year, they were totaled for the entire five-year period. Although the individual yearly totals might be misrepresented by the companies that reported just one list of conditions, the cumulative total for the five years should be reflective of the sample as a whole.

Different companies reported the same conditions using different terminology. We aggregated the responses in the most comprehensive categories. For example, drug abuse, substance abuse, alcohol abuse and smoking were often either mentioned separately or together. We put them into one category labeled “substance abuse.” Anxiety, depression and mental disorders were all combined in the “psychiatric” category. There might be some disagreement as to which category a condition belongs. For example, it was not clear whether arthritic conditions belong in the “musculoskeletal” category. We attempted to keep the most frequently cited categories as the main categories. Any condition that was cited fewer than three times in any one year was categorized under “other.” A full list, which breaks out the “other” category for each year, is provided in Appendix B.

Figure 9 is a pie chart of the most frequently cited conditions for all rescissions reported by the companies. Of all the rescissions, 48% of them fell into one of the four broad categories of psychiatric (18%); hypertension (10%); height and weight, including obesity (9%); and substance abuse (9%).

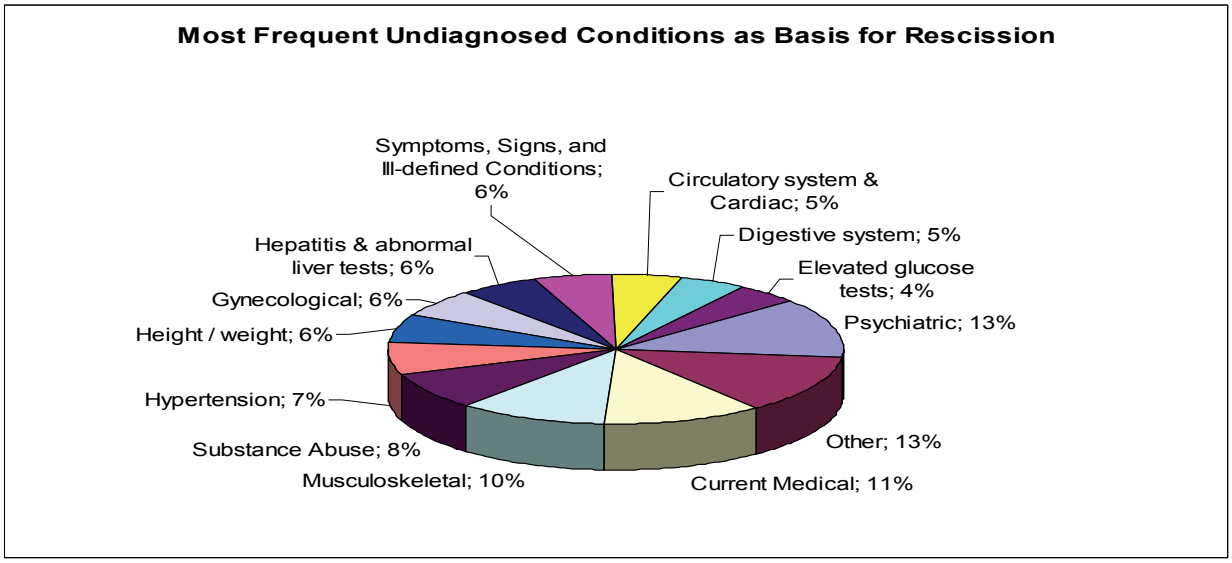
National Association of Insurance Commissioners

Figure 9



For rescissions based on conditions that were undiagnosed prior to an application being completed, Figure 10 illustrates the most frequently cited conditions that were the basis of such rescissions. This survey data element combined rescissions and company decisions to apply a pre-existing condition exclusion. The top four categories accounted for 47% of the rescissions. Again, psychiatric conditions (13%) were the most frequently cited basis. Many specific conditions were the basis of another 13% of these rescissions and are classified as "other." No one condition in this category was cited often enough to fall into its own named category. A more comprehensive list of what fell into the "other" category is provided in Appendix B; it includes such conditions as sleep apnea, hypercholesterolemia and headaches. Current medical testing due to be completed, follow-up appointments that have not yet been completed, and current prescriptions are all included in "current medical," which accounts for 11% of the rescissions. Musculoskeletal conditions are the basis for another 10% of the rescissions or the application of a pre-existing condition exclusion.

Figure 10



Types of Information Used in Underwriting a Policy

The companies were asked to provide, in an attachment, the types of information used in underwriting a policy. Every company, except the two Massachusetts health carriers, cited an enrollment application as the primary source of underwriting information. As noted above, Massachusetts health carriers must guarantee issuance and cannot medically underwrite.

Most of the applications included medical release forms that the applicant is required to sign. In addition to the application, medical records and prescription drug history, most companies relied on additional written and verbal communication with the applicant, as well as any prior claim history or prior applications that the company had for an applicant. Table 2 lists all the responses for this data call question.

Table 2

Sources of Underwriting Information	Responses
Application	44
Medical Records	34
Additional verbal or written information	19
Prior claims	16
Prescription drug history	15
Prior applications	11
Paramedical exams, including lab tests	7
State motor vehicle records	1
Visa (for non-US citizens)	1
Replacement form (if applicable)	1

Types of Information Used in a Rescission Determination

The companies utilized more sources of information when determining whether to rescind a policy. The leading source was, of course, the medical records of the insured that was compared to the information gathered at the time of underwriting. As in underwriting a policy, the prior claims and application history can also be reviewed. Often, the insured is asked to provide verbal or written comments regarding the information gathered by the insurer or provided by the insured at the time of the application. Table 3 lists all of the sources of information cited by the companies.

Table 3

Sources of Information Considered for a Rescission	Responses
Medical records	33
Additional verbal or written information	19
Comparison with data gathered at underwriting	17
Claims history	17
Prescription drug history	15
Prior applications	10
Customer communication	3
Height and weight	3
Psychiatric records	2
Agent input	2
Underwriting policies and procedures	2
Effective date of coverage	1
Milliman Health Cost Guidelines	1
Referral diagnosis	1
Other pertinent documents	1
Underwriting and legal opinions	1

Rescission Appeal Process

All but three of the companies reported having an appeal process in place for policyholders to appeal a decision to rescind a policy. Seven companies did not respond to this question because they either did not or could not rescind a policy or certificate of coverage. All of these appeal processes included an initial internal review of the rescission. An internal review was most often conducted by officers or management that were not involved in the original decision. Frequently, the companies brought in legal and medical experts to assist in the review process. A second and third level of appeal was included in the appeal process of 17 of the companies. Usually, the second level of appeal was to an independent third party, and, in one instance, to an external utilization review agency. Many of the companies forwarded detailed appeal process policies and procedures. Table 4 summarizes the responses.

Table 4

Rescission Appeal Process	Responses
Internal committee, then third-party review	13
Internal committee	11
RN/MD/Legal – two levels of review	3
Rescission committee	2
Appeal rights consistent with state law	1
RN review	1
Special services (internal)	1
State Department of Insurance	1
Internal committee and/or third-party review	1
Internal / external utilization review agency / third-party review	1

EXHIBIT B

Illinois Department of Insurance

PAT QUINN
Governor

MICHAEL T. McRAITH
Director

Guide to the Illinois Department of Insurance
Individual Major Medical Health Policy Rate Filing Report

The Department provides this Report to inform Illinois health insurance consumers seeking to learn more about rate increases to individual major medical health policies. The Department does not receive small or large group health insurance rates or rate changes. The Department continues to improve the clarity and completeness of the information presented in this Report and encourages you to check back frequently for updates.

Illinois law allows for underwriting and rating of individual major medical health insurance policies based on health status as well as several other factors. Illinois law does not limit the amount an insurance company can charge based on health status.

The following columns of information are presented in the Department's Report:

- **Percent Rate Change.** This column reflects the change in the plan's base rate from that plan's most recently filed base rate. The base rate for a plan may be increased by an insurance company based on several reasons, including the claims submitted by every individual enrolled in your plan. A base rate is a starting point for a premium that applies before other factors are taken into account. Some factors, such as your health status, may only affect your premium at the time your policy is issued. Other factors, such as geographic location, may affect your premium both when your policy is issued and when it is renewed. Some of the factors that may affect the actual premium you will pay include:
  - **Health status**. Health status is perhaps the most important factor in determining the amount of premium you pay. Illinois law allows insurance companies to increase your premium based on your past or present medical conditions.
  - **Geographical location**. Your premium will vary depending on where you live in Illinois. For example, consumers living in urban areas like Chicago are typically charged more than consumers living in rural areas.
  - **Policy duration**. Your premium may be increased based on the amount of time you are enrolled in a plan. This factor is typically used by a company to account for the assumption that a policyholder is more likely to file a claim the longer he or she has had the policy.
  - **Gender**. Your premium will be affected by your gender, with women paying significantly more than men for the same policy, even without maternity benefits.
  - **Age**. Your premium will also be affected by your age, with premiums typically rising as you age.

- **Open/Closed.** This column indicates whether the plan listed is accepting (open) or not accepting (closed) new enrollees. Insurance companies routinely create new insurance plans and close new enrollment in existing plans. Pursuant to Illinois law, individuals can be denied major medical health insurance for any reason other than "race, color, religion or national origin." In addition, Illinois law requires that individual policies are guaranteed renewable. As a result, individuals with health care needs who are enrolled in a plan that is closed to new enrollees will remain in

that plan, sometimes for many years. The insurance company will continue to adjust the plan's base and other rates as long as individuals are enrolled in the plan.

NOTE: HMOs do not regularly report whether a plan is open or closed. The Department is in the process of determining whether the listed HMO plans are open or closed and will update the Report accordingly.

- **Company Name**. The names reflected in the Report are the registered business names of the insurance companies offering a plan. HMO plans are distinguished from insurance plans by an "**HMO**" following the insurance company's name. The insurance company name in the Report may not necessarily be the name you see on your policy form or health insurance card. For example, Health Care Service Corporation does business in Illinois as Blue Cross Blue Shield of Illinois. If you do not see the name of your insurance company in the Report you should contact your insurance company or the Department to determine the appropriate registered business name. In the process of compiling this public information, the Department observed that several insurers offering major medical insurance do not appear to have filed rates or rate changes. The Department is investigating.

- **Filing Date.** This column lists the date on which the insurance company rate filing was received by or placed on file with the Department.

- **Policy Name/Number.** This column lists the policy name or number assigned to a plan by the insurance company. This number can be used to track rate changes to your particular plan. The policy name/number should be on your policy but may not be the name by which you know your plan. Please contact your insurance company or the Department for more information on how to find your policy name/number.

More Information

The Department's mission is to protect consumers by providing assistance and information, by efficiently regulating the insurance industry's market behavior and financial solvency, and by fostering a competitive insurance marketplace. The Department assists consumers with all insurance complaints, including health, auto, life, and homeowner. Consumers in need of information or assistance should visit the Department's Web site at insurance.illinois.gov or call our toll-free hotline at (866) 445-5364.

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
CONTINENTAL GENERAL INSURANCE	1/10/2005	+12%	PPQ	Closed
AMERICAN NATIONAL LIFE	1/20/2005	+30%	ANL-KMMT, AML-KMM92, ANL-KM95	Closed
THRIVENT FINANCIAL FOR LUTHERANS	1/21/2005	+70%	BMM, DMM, EMM	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	1/25/2005	+16%	PMED	Closed
THRIVENT FINANCIAL FOR LUTHERANS	1/25/2005	+80%	AMA	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	2/28/2005	+21% for Option A; +11% for Option B	A-3310, A-3326	Open
TRUSTMARK INSURANCE COMPANY	3/25/2005	+17%	TELE-MED IV	Closed
WORLD INSURANCE	3/25/2005	+23%	A3601,A3602,A3603,A3604,A3605, A3606	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	3/29/2005	+20%	HAS	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	4/20/2005	+40%	H-28	Open
AMERICAN NATIONAL INSURANCE	4/20/2005	+30%	POOLED	Closed
GUARANTEE TRUST LIFE	4/20/2005	+49%	6005MM, 6035MM	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/25/2005	+18%	640,650,680	Closed
THRIVENT FINANCIAL FOR LUTHERANS	4/25/2005	+35%	H-1	Closed
KNIGHTS OF COLUMBUS	5/2/2005	+25%	KMD,KMM1	Closed
NEW YORK LIFE INSURANCE	5/2/2005	+40%	51-160,5502-1,6170-1,6670-1,6970-1,8280-1,8281-1,8570-1,8580-1,8581-1	Closed
THE TRAVELERS INSURANCE	5/2/2005	+20%	GR1-GR6B , MGR1-MGR7	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/5/2005	+15%	800 94, 880	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/5/2005	+50%	840, 860	Closed
PRUDENTIAL INSURANCE	5/5/2005	+27%	CHIP34500C-B	Closed
ILLINOIS MUTUAL LIFE INSURANCE	5/12/2005	+25%	743,744,745,746,760,775,776,843,885,886	Closed
TRUSTMARK INSURANCE COMPANY	5/16/2005	+35%	OLD FORMS	Closed
GUARANTEE TRUST LIFE	5/26/2005	+20%	841500, 90100	Closed
INVESTORS LIFE INSURANCE COMPANY	5/26/2005	+30%	621,622,623,624,671,672,673,674	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-22,DB-23,DB-26,DB-40,DB-41	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-19, DB-20	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB11, DB-12	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-13,DB-15,DB-18,DB-19,DB-24,DB-25	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-10	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	CB-5,CB-6,CB-7,CC-24,CC-26, CC-01.1,CC-0.01	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-42, DB-43, DB-44, DB-45	Closed
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-42, DB-43, DB-44, DB-45	Open
HEALTH CARE SERVICE CORPORATION	6/3/2005	+2.7%	DB-46, DB-47	Open
HEALTH CARE SERVICE CORPORATION	6/3/2005	+2.7%	DB-48, DB-49	Open
HEALTH CARE SERVICE CORPORATION	6/3/2005	+9%	DB-18	Closed
HUMANA INSURANCE	6/3/2005	+8%	GN-70129 / IL-70129	Open
CONTINENTAL GENERAL INSURANCE	6/9/2005	+25%	01A,01C,116,12A,12M,19A,544	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	6/15/2005	+31.8%	H-95	Closed
CONTINENTAL GENERAL INSURANCE	6/22/2005	+20%	PPQ	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	7/1/2005	+20%	A-2434,A-2481,A-2484,A-2485, A-2523, A-2718, A-2744, A-2745, A-2927, A-3062, A-3064, A-3065, A-3066, A-3067, A-3166, A-3167,	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	7/6/2005	+21%	H14	Closed
CENTRAL UNITED LIFE INSURANCE	7/11/2005	+15%	MMGR/OR	Closed
GOLDEN RULE INSURANCE COMPANY	7/27/2005	+25%	AS-208, GR-108	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	8/9/2005	+6%	H425	Closed
KANSAS CITY LIFE INSURANCE COMPANY	8/30/2005	+25%	L5333GR,L5337,L5360,L5700	Closed

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
THE PYRAMID LIFE INSURANCE	9/22/2005	+30%	G-91	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	10/5/2005	+25%	CBM	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	10/5/2005	+25%	ACM, CMM	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	10/5/2005	+20%	LMM	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/5/2005	+10%	RURL	Closed
TRUSTMARK INSURANCE COMPANY	10/5/2005	+20%	TELE-MED V	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	10/18/2005	+17.5% for Option A; +10% for Option B	A-3310, A-3326	Open
HUMANA INSURANCE	10/18/2005	+8% for $500 deductible; +1% for $1,000 deductible; -1% for $1,000 deductible; -5.1% for $5,000 deductible	GN-70129 / IL-70129	Open
PHYSICIANS MUTUAL INSURANCE	10/18/2005	+45%	P295, P297	Closed
CONTINENTAL GENERAL INSURANCE	12/8/2005	+20%	01A,01C,116,12A,12M,19A,544	Closed
THRIVENT FINANCIAL FOR LUTHERANS	1/17/2006	+60%	AMA	Closed
THRIVENT FINANCIAL FOR LUTHERANS	1/17/2006	+35%	BMM, DMM, EMM	Closed
PRUDENTIAL INSURANCE	1/24/2006	+15%	PRUD-MED 83	Closed
GOLDEN RULE INSURANCE COMPANY	1/30/2006	+14%	GR1-H1, GR1-H8	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	2/10/2006	+25%	A-3310, A-3326	Open
AMERICAN NATIONAL LIFE	2/22/2006	+17%	ANL-KMMT, AML-KMM92, ANL-KM95	Closed
WORLD INSURANCE	3/9/2006	+9%	A3601,A3602,A3603,A3604,A3605, A3606	Closed
CONTINENTAL GENERAL INSURANCE	4/5/2006	+8%	PPQ	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/7/2006	+10%	PMED	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-22,DB-23,DB-26,DB-40,DB-41	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-19, DB-20	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+6.4%	DB-50, DB-51	Open
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB11, DB-12	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-13,DB-15,DB-18,DB-19,DB-24,DB-25	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-10	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	CB-5,CB-6,CB-7,CC-24,CC-26, CC-01.1,CC-0.01	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+6.4%	DB-42, DB-43, DB-44, DB-45	Closed
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-42, DB-43, DB-44, DB-45	Open
HEALTH CARE SERVICE CORPORATION	4/18/2006	+6.4%	DB-46, DB-47	Open
HEALTH CARE SERVICE CORPORATION	4/18/2006	+6.4%	DB-48, DB-49	Open
HEALTH CARE SERVICE CORPORATION	4/18/2006	+9.3%	DB-18	Closed
WORLD INSURANCE	5/1/2006	+25%	A3570,A3680,A3685,A3690,A3695,A3800,A3810,A3820,A3830	Closed
PRUDENTIAL INSURANCE	5/12/2006	+60%	CHIP34500C-B	Closed
AMERICAN NATIONAL INSURANCE	6/12/2006	+17%	POOLED	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	7/6/2006	+15%	640	Closed
ILLINOIS MUTUAL LIFE INSURANCE	7/25/2006	+25%	743,744,745,746,760,775,776,843,885,886	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	8/2/2006	+30%	H-28	Open
GUARANTEE TRUST LIFE	10/11/2006	+25%	6005MM, 6035MM	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	10/12/2006	+17% for H-400; +32% for H-425	H-400, H-425	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	10/12/2006	+39.3%	H-95	Closed
CONTINENTAL GENERAL INSURANCE	10/12/2006	+10%	01A,01C,116,12A,12M,19A,544	Closed

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	10/17/2006	+20%	LMM	Closed
THRIVENT FINANCIAL FOR LUTHERANS	10/18/2006	+33%	H-1	Closed
PEKIN LIFE INSURANCE COMPANY	11/16/2006	+20%	H39	Open
PHYSICIANS MUTUAL	11/22/2006	+45%	P295, P297	Closed
TRUSTMARK INSURANCE COMPANY	11/28/2006	+35%	OLD FORMS	Closed
GUARANTEE TRUST LIFE	12/8/2006	+20%	841500, 90100	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	12/19/2006	+30%	A-2434,A-2481,A-2484A-2523, A-2718, A-2744, A-2745, A-2927, A-3062, A-3064, A-3065, A-3066, A-3067, A-3166, A-3167,	Open
AMERICAN REPUBLIC INSURANCE COMPANY	12/21/2006	+30%	A-3310, A-3326	Open
WORLD INSURANCE	12/28/2006	+15%	A3601,A3602,A3603,A3604,A3605, A3606	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	12/29/2006	+7%	ACM, CMM	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	1/4/2007	+30%	A-3393, A-3394	Open
PYRAMID LIFE INSURANCE	1/4/2007	+40%	G-81	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	1/11/2007	+30%	ACM, CMM	Closed
CONTINENTAL GENERAL INSURANCE	1/11/2007	+10%	PPQ	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/22/2007	+5%	H-600	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/23/2007	+39.3%	H14	Closed
PEKIN LIFE INSURANCE COMPANY	1/23/2007	+20%	H8	Closed
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+10%	H39	Open
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+10%	H38	Open
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+20%	H30	Open
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+20%	H29	Open
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+20%	H1	Closed
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+20%	H21	Closed
PEKIN LIFE INSURANCE COMPANY	2/10/2007	+20%	H17	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	3/5/2007	+50%	840, 860	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	3/7/2007	+12.68%	HSA	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	3/7/2007	+20%	800, 880	Closed
AMERICAN INSURANCE COMPANY OF TEXAS	3/14/2007	+30.5%	K4954,K5115,K5388,MM86	Closed
TRUSTMARK INSURANCE COMPANY	4/12/2007	+17%	TELE-MED IV	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/1/2007	-18%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/1/2007	-18%	ICDHP-HSA	Open
THRIVENT FINANCIAL FOR LUTHERANS	5/1/2007	+40%	BMM, DMM, EMM	Closed
THRIVENT FINANCIAL FOR LUTHERANS	5/1/2007	+60%	AMA	Closed
PRUDENTIAL INSURANCE	5/2/2007	+48%	PRUD-MED 83	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/9/2007	+12%	980	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/9/2007	+50%	890	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/9/2007	+12%	880	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	5/23/2007	+22%	A-2434,A-2481,A-2484A-2523, A-2718, A-2744, A-2745, A-3064, A-3065, A-3066, A-3067, A-3167, A-3393, A-3394	Open
AMERICAN REPUBLIC INSURANCE COMPANY	5/23/2007	+20%	A-3310, A-3326	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/29/2007	-18% for new business	PMED	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	5/29/2007	+20%	PMED	Open
KANSAS CITY LIFE INSURANCE	6/4/2007	+25%	L5333, L5337, L5360, L5700	Closed
KNIGHTS OF COLUMBUS	6/4/2007	+15%	KMD, KMM1, KMP1	Closed
GOLDEN RULE INSURANCE COMPANY	6/8/2007	+12%	AS-208,GR-108	Closed
HEALTH CARE SERVICE CORPORATION	6/26/2007	+10%	CB-5,CB-6,CB-7,CC-0.01,CC-5,CC-6,CC-26,DB-10,DB-11,DB-12,DB-13,DB-15,DB-18,DB-19,DB-24	Closed

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
HEALTH CARE SERVICE CORPORATION	6/26/2007	+8.5%	DB-42, DB-43, DB-44, DB-45	Open
HEALTH CARE SERVICE CORPORATION	6/26/2007	+10.2%	DB-22,DB-23,DB-26,DB-40,DB-41	Closed
HEALTH CARE SERVICE CORPORATION	6/26/2007	+8.5%	DB-50, DB-51	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	6/29/2007	+35%	H-28	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	8/7/2007	+25%	BMM	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	8/8/2007	+40%	H-235	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	8/17/2007	+18% for in-force business; -18% for new business	HSA	Open
GUARANTEE TRUST LIFE	8/17/2007	+25%	6005MM, 6035MM	Closed
THRIVENT FINANCIAL FOR LUTHERANS	8/17/2007	+40%	H-1	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	8/24/2007	+20%	800, 880	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	8/24/2007	+20%	640, 680	Closed
ILLINOIS MUTUAL LIFE INSURANCE	8/24/2007	+25%	743,744,745,746,760,775,776,843,885,886	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	8/27/2007	+25%	840, 860	Closed
CENTRAL UNITED LIFE INSURANCE COMPANY	9/11/2007	+25%	123, 96077,A6308, CGR-61, H220, HMM60,HN200, 0056,TCBS1	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	10/10/2007	+10%	A-3310, A-3326	Open
AXA EQUITABLE LIFE INSURANCE COMPANY	10/29/2007	+30%	ACM, CMM	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	11/5/2007	+30%	A-2523, A-2718, A-2744, A-2745, A-3064, A-3065, A-3066, A-3067, A-3167, A-3393, A-3394	Open
GOLDEN RULE INSURANCE COMPANY	12/19/2007	+12%	GR1-H1, GR1-H8	Closed
GUARANTEE TRUST LIFE	12/27/2007	+10%	841500, 90100	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/28/2007	+10%	RUR	Closed
AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS	1/3/2008	+17%	ANL-KMMT	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/15/2008	+33%	H14	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/15/2008	+33%	H-95	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	1/25/2008	+25%	CBM	Closed
THE PYRAMID LIFE INSURANCE COMPANY	2/5/2008	+30%	H-71, G-30, G-31, G-50, G-51, G-90, G-91, G-94	Closed
PERSONALCARE INSURANCE COMPANY	2/8/2008	+2.9%	INDPPO	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	3/4/2008	+19.5%	H-400, H-425	Open
THRIVENT FINANCIAL FOR LUTHERANS	3/11/2008	+40%	BMM, DMM, EMM	Closed
THRIVENT FINANCIAL FOR LUTHERANS	3/12/2008	+50%	AMA	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/9/2008	+18 for in-force business; -5% for new business	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/9/2008	+18%	ICDHP-HSA	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/10/2008	+10%	RUR	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	4/25/2008	+33%	AH-50	Closed
CONTINENTIAL GENERAL INSURANCE	5/6/2008	+50%	FORM01A, FORM01C, FORM116, FORM12A, FORM12M, FORMPPQ	Open
HEALTH ALLIANCE MEDICAL PLANS	5/14/2008	+15% for policies issued more than 3 years prior; +4.9% for policies issued in 3 years prior; -15% for new business	Individual	Open
TRUSTMARK INSURANCE COMPANY	5/14/2008	+17%	TELE-MED IV	Closed
TRUSTMARK INSURANCE COMPANY	5/14/2008	+17%	TELE-MED V	Closed

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
PEKIN LIFE INSURANCE COMPANY	5/27/2008	+15%	H41	Open
PEKIN LIFE INSURANCE COMPANY	5/27/2008	+15%	H39	Open
PEKIN LIFE INSURANCE COMPANY	5/27/2008	+15%	H38	Open
PEKIN LIFE INSURANCE COMPANY	5/27/2008	+15%	H30	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	5/30/2008	+18.2%	H-600	Open
GOLDEN RULE INSURANCE COMPANY	5/30/2008	+15%	GR1-H1, GR1-H8	Closed
HUMANA INSURANCE COMPANY	5/30/2008	+1.1%	GN-70129, IL-70129	Open
AMERICAN NATIONAL INSURANCE COMPANY	6/4/2008	+17%	OLD FORMS	Closed
WORLD INSURANCE COMPANY	6/6/2008	+22%	OLD FORMS	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	6/20/2008	+15%	A-2523, A-2718, A-2744, A-2745, A-3064, A-3065, A-3066, A-3067, A-3167, A-3393, A-3394	Open
AMERICAN REPUBLIC INSURANCE COMPANY	6/20/2008	+20%	A-3310, A-3326	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	6/25/2008	+30%	H-28	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	6/27/2008	+38%	A-1589, A-2288	Closed
WORLD INSURANCE COMPANY	7/14/2008	+30%	A-3601, A-3602, A-3603, A-3604, A-3605, A-3606	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	7/25/2008	+4.7%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	7/25/2008	+4.1%	PMEDII	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	7/25/2008	+4.8%	ICDHP-HSA	Open
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	7/30/2008	+20%	CHIP 34500C-B	Closed
THRIVENT FINANCIAL FOR LUTHERANS	8/21/2008	+35%	H-1	Closed
HEALTH CARE SERVICE CORPORATION	8/26/2008	+18%	CB-5,CB-6,CB-7,CC-0.01,CC-5,CC-6,CC-26,DB-10,DB-11,DB-12,DB-13,DB-15,DB-18,DB-19,DB-24	Closed
HEALTH CARE SERVICE CORPORATION	8/26/2008	+18%	DB-42, DB-43, DB-44, DB-45	Closed
HEALTH CARE SERVICE CORPORATION	8/26/2008	+18%	DB-22,DB-23,DB-26,DB-40,DB-41	Closed
HEALTH CARE SERVICE CORPORATION	8/26/2008	+9%	DB-46,DB-47,DB-48,DB-49	Open
HEALTH CARE SERVICE CORPORATION	8/26/2008	+9%	DB-50, DB-51	Open
HEALTH CARE SERVICE CORPORATION	8/26/2008	+12.6%	DB-42, DB-43, DB-44, DB-45	Open
PERSONALCARE INSURANCE COMPANY	9/3/2008	+2.95%	INDPPO	Open
TRUSTMARK INSURANCE COMPANY	9/17/2008	+25%	GMD-IL, GCA-167, GHC-180	Open
UNITED TEACHER ASSOCIATES INSURANCE COMPANY	10/3/2008	+25%	708, 75.791, 69MG, 1-A1-563, 1708, 63GR01, 67.790, L160, P1-51833	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/23/2008	+20%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/23/2008	+15%	ICDHP-HSA	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/23/2008	+20%	840, 860	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/23/2008	+20%	800, 880	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/23/2008	+18%	HSA	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	10/24/2008	+20% for issues after 1/1/2006; +30% for issues prior to 1/1/2006	PMED	Closed
CENTRAL UNITED LIFE INSURACE COMPANY	12/24/2008	+35%	123, 96077,A6308, CGR-61, H220, HMM60,HN200, 0056,TCBS1	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	12/29/2008	+25%	ACM, CMM	Closed
PERSONALCARE INSURANCE COMPANY	12/29/2008	+3.2%	INDPPO	Open
UNION HEALTH SERVICE INC. (HMO)	1/5/2009	+2.4%	Clinic	-
UNION HEALTH SERVICE INC. (HMO)	1/6/2009	+7.1%	Non-Clinic	-
UNION HEALTH SERVICE INC. (HMO)	1/7/2009	+5.3%	HMO	-
HUMANA HEALTH PLAN, INC. (HMO)	1/9/2009	+3%	Staff Model Network	-

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
PERSONALCARE INSURANCE COMPANY	1/16/2009	+2.9%	INDPPO	Open
TRUSTMARK INSURANCE COMPANY	1/19/2009	+32%	OLD FORMS	Closed
KNIGHTS OF COLUMBUS	1/27/2009	+15%	KMD,KMMI,KMP1	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	1/28/2009	+20%	640, 650, 680	Closed
AMERICAN FAMILY INSURANCE COMPANY	2/25/2009	+40%	H-235	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	2/25/2009	+14%	A-2718,A-2744,A-2745,A-3064,A-3065,A-3066,A-3067,A-2523,A-3167	Open
WORLD INSURANCE COMPANY	2/25/2009	+19.5%	A3601,A3602,A3603,A3604,A3605,A3606	Closed
GUARANTEE TRUST LIFE INSURANCE COMPANY	4/13/2009	+25%	6005-MM, 6035-MM	Closed
AMERICAN NATIONAL LIFE INSURANCE CO OF TEXAS	4/21/2009	+30%	ANL-KMMT	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/22/2009	+16%	PMEDII	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/22/2009	+16%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	4/22/2009	+14%	ICDHP-HSA	Open
HUMANA HEALTH PLAN, INC. (HMO)	5/4/2009	+12%	Michael Reese Personal Plan	Closed
HUMANA HEALTH PLAN, INC. (HMO)	5/4/2009	+14%	Conversion Personal Plan	Closed
HUMANA HEALTH PLAN, INC. (HMO)	5/4/2009	+14%	HHP Direct Payment Plans	Closed
HUMANA INSURANCE COMPANY	5/5/2009	-0.3%	GN-70129, IL-70129	Open
HUMANA INSURANCE COMPANY	5/12/2009	+14.2%	GN-70129, IL-70129	Open
PEKIN LIFE INSURANCE COMPANY	5/14/2009	+15%	H29	Open
HEALTH CARE SERVICE CORPORATION	6/5/2009	+8.4%	DB-43,DB-44,DB-45	Open
HEALTH CARE SERVICE CORPORATION	6/5/2009	+8.4%	DB-46,DB-47,DB-48,DB-49	Open
HEALTH CARE SERVICE CORPORATION	6/5/2009	+8.4%	DB-22,DB-23,DB-26,DB-40,DB-41	Closed
HEALTH CARE SERVICE CORPORATION	6/5/2009	+8.4%	CB-5,CB-6,CB-7,CC-0.01,CC-5,CC-6,CC-26,DB-10,DB-11,DB-12,DB-13,DB-15,DB-18,DB-19,DB-24	Closed
HEALTH CARE SERVICE CORPORATION	6/5/2009	+8.4%	DB-42, DB-43, DB-44, DB-45	Closed
HEALTH CARE SERVICE CORPORATION	6/5/2009	+6.3%	DB-50, DB-51	Open
PERSONALCARE INSURANCE COMPANY	6/10/2009	+3.2%	INDPPO	Open
HEALTH CARE SERVICE CORPORATION (HMO)	7/7/2009	+19.8	Series DB-1 HCSC	-
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	7/13/2009	+40%	890	Closed
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H41	Open
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H39	Open
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H38	Open
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H30	Open
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H29	Open
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H21	Closed
PEKIN LIFE INSURANCE COMPANY	7/24/2009	+20%	H17	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	8/4/2009	+6%	ICDHP-HSA	Open
AMERICAN NATIONAL INSURANCE COMPANY	8/4/2009	+30%	OLD FORMS	Closed
GOLDEN RULE INSURANCE COMPANY	8/4/2009	+13%	GR1-H1, GR1-H8	Closed
HUMANA INSURANCE COMPANY	8/4/2009	+4.3%	GN-70129, IL-70129	Open
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	8/4/2009	+30%	PRUD-MED 83	Closed
TRUSTMARK INSURANCE COMPANY	8/4/2009	+24%	TELEMED IV	Closed
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/9/2009	+3.7%	GSA High Base Plan	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/10/2009	+5.1	GSA Med Base Plan	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/11/2009	+6.4%	GSA Low Base Plan	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/12/2009	+3.7	94 GSA $5 Plan	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/13/2009	+5.4	94 GSA $10 Plan	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/14/2009	+.5%	94 GSA $10 CoPay Hosp Coins	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/15/2009	+1.7%	94 GSA $15 CoPay Hosp Coins	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/16/2009	+5%	94 GSA $10 CoPay $250	-

COMPANY NAME	Filing Date	% Rate Change	Policy Name/Number	Open/Closed
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/17/2009	+6.1%	94 GSA $15 CoPay $500	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/18/2009	+3.8%	96 GSA low 5/50	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/19/2009	+3.7%	96 GSA low 5/100	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/20/2009	+5.4%	96 GSA low 10/100	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/21/2009	+6.6%	96 GSA low 15/150	-
CIGNA HEALTHCARE OF ST. LOUIS (HMO)	9/22/2009	+7.9%	96 GSA low 20/150	-
GUARANTEE TRUST LIFE INSURANCE COMPANY	9/24/2009	+10%	90100	Closed
PERSONALCARE INSURANCE COMPANY	10/2/2009	+3.2%	INDPPO	Open
THRIVENT FINANCIAL FOR LUTHERANS	10/6/2009	+25%	EMM	Closed
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	11/19/2009	+60%	CHIP34500C-B	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+10%	HSA	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+45%	PMED	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+25%	840, 860	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+10%	800, 880	Closed
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+20%	PMEDII	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+35%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+10%	ICDHP-TIER	Open
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	12/3/2009	+10%	ICDHP-HSA	Open
AMERICAN REPUBLIC INSURANCE COMPANY	12/3/2009	+21.6%	A-3562,A-3565,A-A-3566,A-3567,A-3569	Open
PERSONALCARE INSURANCE COMPANY	12/3/2009	+3%	INDPPO - NEW	Open
TRUSTMARK INSURANCE COMPANY	12/3/2009	+24%	TELEMED V	Closed
AMERICAN REPUBLIC INSURANCE COMPANY	12/4/2009	+14%	A-2718,A-2744,A-2745,A-3064,A-3065,A-3066,A-3067,A-2523,A-3167	Open
GUARANTEE TRUST LIFE INSURANCE COMPANY	12/4/2009	+12%	90100	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	12/17/2009	+32.6%	H-600,H-610,H-616	Open
HUMANA INSURANCE COMPANY	12/18/2009	+5.3%	GN-70129, IL-70129	Open
AXA EQUITABLE LIFE INSURANCE COMPANY	12/21/2009	+10%	CBM	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	12/22/2009	+15%	LMM	Closed
PERSONALCARE INSURANCE COMPANY	12/30/2009	+3.2%	INDPPO - 2006 BLOCK	Closed
UNITEDHEALTHCARE OF IL, INC (HMO)	12/30/2009	+13%	GC HMO Choice	-
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	12/31/2009	+30%	H-28	Closed
AXA EQUITABLE LIFE INSURANCE COMPANY	12/31/2009	+25%	BMM	Closed
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/5/2010	+24.5%	H-400,H-425	Open
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	1/5/2010	+20%	AH-50,H-14,H-95	Closed
UNION HEALTH SERVICE INC. (HMO)	1/7/2010	+1.5%	Clinic	-
UNION HEALTH SERVICE INC. (HMO)	1/8/2010	+31.1%	Non-Clinic	-
UNION HEALTH SERVICE INC. (HMO)	1/9/2010	+20.1%	HMO	-
WORLD INSURANCE COMPANY	1/20/2010	+25%	OLD FORMS	Closed
HUMANA HEALTH PLAN, INC. (HMO)	2/16/2010	+3%	Staff Model Network	-
KNIGHT OF COLUMBUS	2/23/2010	+15%	KMD, KMM1, KMP1	Closed