

Office of Consumer Health Insurance 2003 Annual Report

Table of Contents

- [Preface](#)
 - [Executive Summary](#)
 - [Assisting Consumers with Understanding Their Health Insurance and Appeal Rights](#)
 - [Educating Enrollees About Their Health Plan Rights](#)
 - [Expanding Public Knowledge of OCHI and Available Services / Status Report of OCHI Toll-Free Telephone Line](#)
 - [Uninsured Ombudsman Program](#)
 - [Market Status, Government Actions and Recommendations for Improvements to Health Insurance Regulation](#)
 - [Action Taken on Past Recommendations](#)
 - [Exhibits:](#)
 1. [Zip Code Listing](#)
 2. [Top Ten Subject Categories of Phone Calls](#)
 3. [Top Ten Informational Items Requested](#)
 4. [Number of Phone Calls per Month](#)
 5. [HMO Company Complaint Record -- General Summary 2002](#)
 6. [HMO Company Complaint Record -- Classification Summary 2002](#)
 7. [HMO Independent Review Summary 2002](#)
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PREFACE

Established on January 1, 2000, by the [Managed Care Reform and Patient Rights Act](#) (the Act), the Office of Consumer Health Insurance (OCHI) continued to serve an increasing number of Illinois residents in 2003 by responding to their health related inquiries.

The responsibilities of OCHI, as set forth by the Act, have not changed since its inception. Its two main functions are to assist consumers in relation to their health insurance needs and to report annually on the state of the health insurance marketplace. OCHI provides assistance to Illinois consumers through the toll-free, consumer inquiry telephone line mandated by the Act and through other outreach mechanisms including speaking engagements, radio interviews, and the distribution of informational brochures. Through these media, OCHI has helped consumers understand the terms and meanings of their insurance coverage, advised persons of

their rights under insurance policies, assisted insureds in filing appeals and complaints against insurance companies, and made information available to minority communities.

In assessing the overall state of the health insurance marketplace in Illinois, OCHI reports on state and federal legislation and regulations, monitors significant trends affecting health coverage for Illinois citizens, identifies specific problems faced by health insurance consumers, and sets forth recommendations for possible resolutions to some of the problems it has identified.

In 2002, the Department expanded OCHI to include the administration of the [Uninsured Ombudsman Program](#) established by Public Act 92-0331. The Ombudsman is responsible for providing assistance and education to individuals regarding health insurance benefit options and rights under state and federal laws, and counseling uninsured individuals on finding and shopping for insurance, evaluating insurance products, and comparing options for obtaining health insurance coverage.

EXECUTIVE SUMMARY

The Managed Care Reform and Patient Rights Act (P.A. 91-0617) established the Office of Consumer Health Insurance (OCHI) in January 2000. In 2003, OCHI's fourth year of operation, the office received 18,349 calls and provided consumers with a broad range of health information. Members of the OCHI staff performed a number of outreach activities during the year, assisted health insurance consumers at the State Fair and provided information on various radio talk programs.

[Section 1](#) of this report describes the type of calls received and the methods used for assisting callers.

[Section 2](#) describes the various activities of the OCHI staff, steps taken to educate consumers about their health plans, and lists advisory information available on the Department's Internet site.

[Section 3](#) documents efforts to expand public knowledge of OCHI and its services, and provides details on the number of calls received during the year.

[Section 4](#) describes activities of the Uninsured Ombudsman Program and steps taken to assist uninsured consumers including: assisting in the search for health insurance, helping to access local services at community sponsored health centers, and providing information on the availability of state and federal health related programs.

[Section 5](#) contains information about:

- Trends in the health insurance marketplace.
- Changes to the [Illinois Comprehensive Health Insurance Plan](#).
- Synopsis of the State Planning Grant.
- Insurance companies withdrawing from the health insurance market.
- Insurance market mergers.
- Growth of consumer driven health plans.
- Increase in Multiple Employer Welfare Arrangements (MEWAs).
- Proliferation of discount plans.
- Problems relating to physician networks.
- State and federal legislation.
- Recommendations for improving the health insurance marketplace.

[Section 6](#) provides information on action taken on recommendations contained in last year's report.

1. Assisting consumers with understanding their health insurance and appeal rights

The [Office of Consumer Health Insurance \(OCHI\)](#) answered a wide array of questions from consumers during calendar year 2003. Calls came from a variety of groups including consumers, employers, agents, associations, attorneys, health care providers and advocacy groups.

We were able to provide information on insurance-specific terminologies that the average person could understand. We were also able to explain the differences between benefits available in individual, small group and large group insurance products and the rights associated with each stemming from the Health Insurance Portability and Accountability Act (HIPAA). We were able to provide consumers with specific information applicable to their plans and their rights relating to options regarding continuation of coverage. OCHI also directed consumers to the Department's Internet site (insurance.illinois.gov) enabling them to gain further knowledge of a particular topic through access to "fact sheets" developed by the Department.

OCHI received specific calls relating to: getting a particular medical procedure approved by the plan, understanding and filing appeals with the plan, denials of claims for procedures pre-approved by the plan, how to request an external independent review with HMO plans, and how to file a complaint with the Department of Insurance. OCHI guided HMO enrollees through the external independent review process and explained the information needed by the independent reviewer, the required time periods involved, and the role played by the primary care physician in the process.

The Managed Care Reform and Patient Rights Act requires HMOs to track all complaints received, regardless of the source, and to report the data to the Department of Insurance. [Exhibit 5 \(HMO Company Complaint](#)

[Record - General Summary 2002](#)) shows the general summary of HMO complaints for 2002. [Exhibit 6 \(HMO Company Complaint Record - Classification Summary 2002\)](#) shows the classification breakdown of the HMO complaints. [Exhibit 7 \(HMO External Independent Review Summary 2002\)](#) is derived from Exhibits 5 and 6 and provides specific information relating to external independent reviews. This information is provided by the plans and is not independently verified by the Department. These exhibits may also be accessed through the Department's Internet site (insurance.illinois.gov/Complaints/health_care_plan_Complaints02.asp).

As presented in [Exhibit 5](#), during calendar year 2002, HMOs reported a total of 12,450 complaints, of which 1,194 (10%) were also filed with the Department of Insurance. The "Disposition of ALL Complaints" section indicates that of the total complaints: 6,469 (52%) were granted relief; 468 (4%) were granted partial relief; 1,051 (8%) received additional information; and 4,462 (36%) received no relief.

[Exhibit 7](#) shows that HMO enrollees requested 78 external independent reviews that were completed by HMOs in the state of Illinois in 2002. Of these, 25 (32%) were granted relief; 2 (3%) were granted partial relief; 0 received further information; and 51 (65%) had no change in status. The reporting date for complaint data is March 2 for the previous year. Complaint data for 2003 will be addressed in the 2004 report.

The Department of Insurance office in Chicago also handles many calls and assists consumers who walk into the office requesting information. From January 1, 2003, through December 31, 2003, the Chicago office handled 2,598 calls relating to health insurance complaints; 929 calls regarding general health insurance questions; 87 English-speaking walk-ins with health insurance questions; and 149 calls and 16 walk-ins requiring the services of a translator.

2. Educating enrollees about their health plan rights

In calendar year 2003, several large manufacturing companies and various smaller companies declared bankruptcy, generating many calls regarding COBRA benefits. Upon receiving information from other areas of the Department, OCHI communicated the most up-to-date information to consumers. Many of the displaced workers were referred to the [Illinois Comprehensive Health Insurance Plan \(CHIP\)](#) to determine their eligibility under Illinois' HIPAA alternative mechanism for individual health insurance coverage.

When applicable, workers losing their insurance were also informed of the new Trade Adjustment Assistance Reform Act, which offers a tax credit for certain workers and retirees who lose their sponsored health coverage due to international dislocation or increased imports. Retired workers questioned how they could maintain coverage to coordinate with Medicare and were given information on guaranteed issue Medicare supplement coverage through standard insurers. Medicare supplement inquiries were referred to the Department's [Senior Health Insurance Plan \(SHIP\)](#).

Based upon questions we received from Illinois consumers and working with other units of the Department, several new "fact sheets" were developed and added to the Department's Internet site (insurance.illinois.gov/healthInsurance/healthInsurance.htm). For callers unable to access this information via the Internet, requested materials were mailed directly to consumers.

Upon request, OCHI personnel gave presentations to a variety of organizations. Some of these groups included: consumer organizations, community development organizations, employer organizations, and public health organizations. OCHI representatives were also invited to be guests on several radio talk shows and represented the Department at a Washington D.C. health conference. The OCHI staff is available and open to other opportunities to reach interested parties. Presentations by our staff can be arranged by contacting the Office of Consumer Health Insurance at 877-527-9431.

Occasionally, calls to OCHI have required the services of a translator. The OCHI office can generally provide a translator for consumers who need this service. The brochure "Your Rights Under the Managed Care (HMO) Reform and Patient Rights Act" is available in Spanish.

Following is a list of consumer fact sheets and other information currently available on the Department's Internet site. Fact sheets developed or revised during 2003 are shown in bold letters.

[Acronyms for Life, Accident & Health Insurance and Managed Care](#)

[Beware of Fraudulent Insurance Companies](#)

[Cancer](#)

[**Contact the Proper Agency - Where to File Medicare, Medicaid and Other Health Plan Complaints**](#)

[Coordination of Benefits](#)

[Credit Information - How Insurers Use It](#)

[Finding a Reputable Insurance Company - Using Financial Rating Agencies](#)

[**Getting off to a Good Start with Medicare**](#)

[**Health Insurance Continuation Rights - COBRA**](#)

[**Health Insurance Continuation Rights - Dependent Children**](#)

[**Health Insurance Continuation Rights - Illinois Spousal Law**](#)

[**Health Insurance Continuation Rights - Illinois Law**](#)

[**Health Insurance Continuation Rights - Municipal Employees**](#)

[Health Insurance for Small Employers](#)

[Health Maintenance Organizations \(HMOs\)](#)

[Insurance Guaranty Associations](#)

[**Illinois Mandated Benefits, Offers, and Coverages for Accident & Health Insurance and HMOs**](#)

[Insurance for College Students](#)

[Insurance Coverage for Diabetes](#)

[Insurance Coverage for Infertility Treatment](#)

[Insurance Coverage for Newborn Children](#)

[Maternity Benefits in Illinois](#)

[Medical Necessity](#)

[**Pre-Existing Conditions - HIPAA**](#)

[Prompt Pay Law](#)

[**Senior Health Insurance Program**](#)

[Shopping for Individual Disability Income Insurance](#)

[Small Employer Health Insurance Rating Act](#)

[Travel Insurance](#)

[Understanding the Complaint Process](#)

[**Uninsured Ombudsman Program**](#)

[Usual and Customary Fees in Health Insurance Claims](#)

[**Women's Health Care Issues**](#)

[Workers' Compensation Insurance](#)

3. Expanding public knowledge of OCHI and available services

OCHI is constantly searching for new methods of reaching additional consumer groups and new avenues to assist those seeking information on the toll-free line. To accomplish these objectives, we contacted numerous local organizations in 2003 to find resources available in specific areas around the state.

The Internet served as a valuable tool in finding information on specific, health-related topics. We received calls on specific diseases and the need for financial assistance to help pay for the treatment of uncommon diseases or conditions. We were able to provide information in some instances that was helpful to callers.

OCHI continued to identify government agencies and other associations that provide emergency services to persons in need of assistance for specific health care issues and added these resources to our in-house database in order to provide this information to Illinois residents.

A number of the newspapers around the state continued to give us support in our effort to inform the public of our phone number. OCHI received coverage on a number of television stations regarding the office and its mission. In addition, the Department's outreach staff continued to make themselves available for regular talk-radio spots around the state.

Status report of OCHI toll-free telephone number

OCHI received a total of 18,349 calls on its toll-free telephone line (877-527-9431) for calendar year 2003. This represents an increase of 158 calls over the 18,191 calls received in 2002. In fact, there has been a steady

growth in the program from its inception: 10,750 calls were received in 2000; 14,272 in 2001; and 18,191 in 2002. OCHI received calls from 1,095 zip code areas throughout the state.

4. Uninsured Ombudsman Program

The [Uninsured Ombudsman Program \(Program\)](#) became effective January 1, 2002. The program was established within OCHI. The basis of the Program is to provide information regarding medical service and help agencies available throughout the state to uninsured individuals or persons losing their health insurance. This information, gathered mainly from county and local health departments, is used to guide callers who are in need of medical or other health services that health insurance would normally cover. In addition, a library of these services along with other helpful Web sites has been compiled in order to direct callers who have Internet access, or to assist in finding more specific information to those who have no computer access.

In 2003, OCHI and the Ombudsman Program, in cooperation with other DOI personnel, completed the creation of a database that contains the information compiled from prior research about the various local, state, federal and other programs to assist the uninsured. This information is accessible by staff on a city, county, and regional basis and identifies available services by specialty. The purpose of the database is to make information more easily retrievable by the OCHI staff in order to provide prompt assistance to uninsured consumers seeking assistance for medical, dental, mental health, vision, prescription, and other health care needs.

For calendar year 2003, the Ombudsman Program provided assistance to 530 uninsured consumers informing them of programs that might be helpful and accessible in their region of the state.

5. Market Status, Government action and recommendations for improvement to health insurance regulation

1. MARKET STATUS

1. Health Insurance Market Contraction

1. Insurance Companies Withdrawing from the Health Insurance Market

With the passage of the Illinois Health Insurance Portability and Accountability Act (HIPAA) in 1997 ([P.A. 90-0030](#)), health insurance companies desiring to discontinue selling all health insurance products in the individual, small employer, and large

employer markets were required to notify the Department of Insurance. From that time, companies have taken advantage of the law and have reported their withdrawal according to the law. Initially, the companies that withdrew from this market were generally smaller companies that did not provide coverage to a large number of Illinois citizens, and the number of companies exiting the market was relatively small. These early withdrawals did not have a dramatic impact on the market.

More recently, the number of companies exiting these markets has increased, as has the size of the companies leaving. In the last year, this trend was most clearly exemplified by the exit of three major health insurance writers: Right Choice (beginning 12/31/02), Mutual of Omaha Insurance Company, and Country Life Insurance Company.

Whenever insurance coverage is disrupted, the Department and OCHI receive numerous calls from individuals affected by the withdrawal of these companies. The Department was able to explain how these transactions were allowed, what the specific processes entailed and, for many persons who were losing coverage, what options were available in order to ensure continued health coverage. Further, while not required by the HIPAA law, the companies in all three cases made efforts to assist enrollees find alternative coverage. While intended to provide a fallback for individuals losing coverage, the transition to a new company's coverage was not universally understood by insureds and was sometimes seen as discriminatory. This made the Department's role in explaining how these options worked very difficult.

Despite attempts by these companies to find alternative coverage for persons and groups losing coverage, for some groups the only alternative was for individuals in those groups to access the HIPAA alternative coverage available through the state's Comprehensive Health Insurance Plan (CHIP). Unfortunately for persons losing individual coverage, there are few rights under HIPAA. For these individuals, their only recourse was to apply for the standard CHIP coverage, which entails the reimposition of preexisting condition limitations, or to go without coverage.

Even though there appears to be a trend of companies exiting the health insurance market in Illinois, the state continues to enjoy a healthy market place in terms of the number of companies that continue to offer coverage to individuals, small employers, and large employers. Still, as the number of companies in these markets continues to decrease, the ability for consumers to find standard health insurance coverage may be compromised. This trend is one that the Department will continue to monitor in upcoming years.

2. Market Mergers

In addition to companies exiting the health insurance market, 2003 also saw the merger of several large health insurers. Specifically, Anthem's purchase of Wellpoint/Unicare

and United Health Care's purchase of Golden Rule Insurance represented an additional constriction on the number of companies offering coverage to Illinois consumers. As the overall economy continues to fluctuate and as health costs continue to increase, this trend toward market consolidation will also add to the concerns of availability and affordability in the future.

2. Health Insurance Availability

1. Uninsured

The most disturbing trend in the health insurance marketplace is the continuing rise in the ranks of the unemployed. In September, the U.S. Census Bureau released year-end numbers for the uninsured in 2002. According to the report, the ranks of the uninsured nationwide rose to 15.2 percent compared with 14.6 percent in 2001. The trend was mirrored in Illinois where the number of uninsured residents rose to 13.9 percent of the state's population, up from 13.7 percent in 2001. According to the Census Bureau's numbers, more than 1.7 million Illinoisans had no health insurance last year. This trend is reflected in the 530 calls to the Uninsured Ombudsman in 2003. At the time this report is being issued, there are no clear indications that this trend will be altered for 2004 and beyond.

2. Employers Discontinuing Coverage

During the past four years, the Office of Consumer Health Insurance (OCHI) has continued to see an increase in calls relating to employees losing their health insurance coverage and questions relating to the ability of the employees to continue that health insurance coverage. In 2001, the OCHI Office received a total of 1,793 calls relating to the ability to continue health insurance coverage. These calls included questions on the federal COBRA Continuation coverage as well as Illinois Continuation options. In 2002, OCHI received 1,964 calls. This total increased to 2,387 in 2003. This steady increase in calls is a yearly trend that is likely to continue for the foreseeable future.

Employees lose their health insurance coverage for many reasons. During 2003, there were many large employers who declared bankruptcy, leaving many employees without health insurance coverage. High profile closings in 2003 included several steel manufacturers, Eagle Foods and Maytag. A complete list of employer closing notifications by month can be viewed at the Department of Commerce and Economic Opportunity (DCEO) website (<http://www.commerce.state.il.us/wia2/warn/warn.html>).

In addition, some employers have stopped offering retirees health insurance, leaving another sector of individuals without insurance. While nothing requires employers to offer coverage to retirees, the recent trend to remove such coverage once in place is likely due to a combination of rapidly rising health care costs, growing retiree populations, and the uncertainty of business profitability.

The Department continues to actively work to provide information and answer questions on the coverage options for retirees losing coverage. The Department has continued to stay abreast of the new Medicare changes that may be applicable to the retiree population, as well as educate individuals who may be eligible for relief under the new federal Trade Adjustment Assistance Reform Act (TAA). The Act offers a tax credit to be used toward the purchase of health insurance coverage for certain workers and retirees whose employer-sponsored health coverage is lost because of increased imports or trade-related relocations.

3. Illinois Comprehensive Health Insurance Plan

The [Illinois Comprehensive Health Insurance Plan \(CHIP\)](#) (215 ILCS 105) has two pools. The traditional pool (Section 7) is designed for individuals who are unable to purchase health insurance because of medical conditions. This pool is funded partially through annual state appropriations and partially through premiums. The coverage provided includes a six-month, pre-existing condition limitation.

The HIPAA-CHIP (Section 15) pool is the state's mechanism to protect the portability rights of individuals who have satisfied the requirements of HIPAA including prior creditable coverage in a group health plan. Effective June 23, 2003, HIPAA-CHIP was expanded to include the TAA-CHIP program. It became a qualified health plan pursuant to the Trade Act of 2002 for eligible persons allowing participants to claim the Health Coverage Tax Credit (HCTC) equal to 65% of paid premium. HIPAA-CHIP by statute cannot impose preexisting condition limitations. This pool is funded partially by insurance industry assessments and partially by premiums.

CHIP continues to partner with other state and federal agencies on outreach activities in response to situations where employee health plans are affected by business changes. In 2003 this activity included extensive collaboration with state and national labor organizations as information regarding the new TAA-CHIP program was provided to affected Illinois residents.

On December 31, 2003, enrollment included 5,885 persons in traditional CHIP (Section 7) and 10,200 in HIPAA-CHIP (Section 15). The enrollment in the new TAA-CHIP plans represented 339 of the HIPAA-CHIP total. Persons seeking coverage under Section 7 were being placed on a waiting list for approximately six to eight weeks before coverage could be offered.

4. Synopsis of State Planning Grant

In September 2000, the State of Illinois received a \$1.2 million State Planning Grant from the Health Research and Services Administration of the U.S. Department of Health and Human Services. The Illinois Department of Insurance is the state's lead agency for this grant. The purpose of the grant is to develop a plan to assure access to health insurance for all Illinoisans. The grant funded two components of this planning: research on the characteristics of the uninsured in Illinois and development of plans to reduce the number of uninsured individuals in Illinois. The Illinois Assembly on the Uninsured, a participatory process established to take

advantage of the views and talents of employers, insurers, health care providers, and other community representatives from both the public and private sectors from around the state, was used to help focus and prioritize these plans.

The grant gave Illinois the opportunity to gather state-specific data which had not been available before. Several types of research were conducted, including a random digit dial survey, focus groups and key informant interviews, and an expansion of the Behavioral Risk Factor Surveillance System (BRFSS). Data indicated that between 9.8% and 13.4% of Illinoisans have no health coverage. In September 2001, Illinois received an additional grant of \$194,000 to continue this project and further develop strategies. The initial report of the State Planning Grant was issued in March of 2002 and is available at <http://insurance.illinois.gov/spg/>.

In January 2003, the State Planning Grant (SPG) issued a Request For Proposal through the Illinois Department of Insurance for the design of a pilot program that would provide an affordable product for small business owners, while incorporating the concerns, suggestions and recommendations of the Illinois Assembly, small employers and insurance brokers.

Health Management Associates Inc. (HMA) was awarded a contract in February 2003 to develop a pilot program targeting small employers and designed to reduce the number of working uninsured. The selected location for the pilot project was St. Clair County, which is one of the most economically disadvantaged areas in the state. HMA's approach has been to design a community based, three-share concept for employer sponsored health coverage, with premium costs shared by the employer, employee and a community subsidy. The Southern Illinois Healthcare Foundation (SIHF), along with Touchette Regional Hospital in Centreville, sponsored a series of community meetings (attended by representatives of units of local government, employers, labor unions, social service advocates, insurance agents, health care providers, and medical practitioners) to determine if a need existed for the plan envisioned by HMA. The consensus of the group was that a need for low cost employer sponsored health coverage for St. Clair County did indeed exist. Representatives from the community formed a committee and, with the help and support of the SIHF, designed a benefits package and began exploring options for the community subsidy. Representatives from HMA and the Illinois Department of Insurance were present at each meeting, providing education and technical assistance.

5. Current Status of the Pilot Project

In September 2003, Illinois received an additional grant of \$185,000 to continue developing the pilot project, to develop and design a reinsurance pool model, and to continue to develop and maintain the SPG website. The committee, based on the benefits plan they developed, issued a Request For Proposal (RFP). Two carriers responded to the RFP: Crossroads Consulting & Brokerage/Pan American Insurance Company, and UNICARE Life and Health Insurance

Company. The committee selected Crossroads/Pan American as the carrier for the St. Clair County Three-Share program.

The next phase of the process will include the development and design of a non-profit entity to administer the plan. This entity will be responsible for the day-to-day operations of the plan including marketing the plan to local small business owners within St. Clair County. Other tasks will include: establishing a provider network, developing a 501(c)(3) organization and a marketing plan, defining the enrollment process, establishing provider education and network management functions, defining customer service and beneficiary education functions, determining the role of a third party administrator, and finalizing the finance structure for launch on or around July 1, 2004.

3. Trends

1. Growth of Consumer Driven Health Plans

As the number of uninsured rises, and employers continue to search for ways to provide coverage to their employees, insurers are developing new products to attempt to fill the needs of the marketplace. One type of product that is growing in popularity among employers is "consumer driven health plans." The driving force behind these plans is to increase the options available to employers, reduce costs, and ensure individuals are provided coverage for catastrophic and emergent conditions. Under these plans, employers and their employees are generally provided with a smorgasbord of options with varying benefits and costs. These benefits could range from the costliest first dollar coverage plans, such as HMOs or pure indemnity plans, through various permutations of preferred provider plans, to the least costly high deductible plans or innovative products which provide a modicum of first dollar preventative care. The consumer is then responsible for all payments through a specified gap-deductible after which full, or nearly full, coverage is reinstated.

In large groups, the benefits of such choices are evident: the employer may be able to reduce the cost of coverage and employees have the ability to opt into a plan that best suits their needs and income. As the size of the employer group diminishes, however, the range of choices available to employees decreases as well. Further, the basis of utilizing consumer driven plans is the need for enrollee education so that individuals are able to properly assess their options. For large employers, this may be relatively easy as enrollees may have easy access to integrated, computer-friendly education programs. As the ability to supply access to electronic media is reduced, enrollee education may suffer leading to inefficient utilization and enrollee dissatisfaction.

2. Multiple Employer Welfare Arrangements - MEWAs

The alarming trend of unauthorized insurers providing what they purport to be health insurance coverage to Illinois consumers, first noted in the [2002 OCHI Annual Report](#), continued in 2003.

The dual pressures of rising costs of health insurance, coupled with employers' legitimate desires to provide their employees with health insurance, continue to lure less-than-ethical individuals to take advantage of what seems to be easy money. Generally, these arrangements which purport to provide low cost coverage to numerous, unassociated employers are in violation of the Illinois Insurance Code, as they are unauthorized insurers presenting products that they claim either qualify for ERISA preemption or are state-approved health insurance. Often these arrangements are fly-by-night scams designed to bilk as much money as possible in the shortest amount of time from employers and employees, while providing little, if any, actual payment for health claims. The Department's Financial Division, the financial divisions of departments across the United States, and the federal government have been actively working to ensure these types of plans are promptly shut down. Unfortunately, because these are not legitimate insurance plans, when they are closed down they do not fall under the state's Guaranty Association, and individuals covered under these plans are generally left without coverage for their health care costs.

In 2003, a twist on this problem became a growing concern for the Department. In most states, entities called employee leasing companies or professional employment organizations (PEOs) are legitimate entities providing labor resources to employers who face short-term or long-term employee shortages and are forced to "lease" employees from one of these organizations. The problem arises when PEOs provide health insurance to leased employees.

Under the Employee Retirement Income Security Act of 1974 (ERISA), Multiple Employer Welfare Arrangements (MEWAs) are subject to state regulation. In Illinois, as in many states, such arrangements are not permitted. Some PEOs claim to offer access to a self-funded, single-employer ERISA plan that is exempt from Illinois insurance laws to companies that lease employees from the PEO. Applicability of state law, however, is not based on the claims of a PEO but on the reality of which employer (the PEO or the lessor) "controls" the employee. If, in fact, control is the responsibility of the company that leases the employee, the PEO's health coverage may be a MEWA and therefore in violation of Illinois law. In addition to violating the letter of the law, the Department is concerned about these plans because employees would be denied benefits due them under state law, and financial harm could be passed on to the employees when these plans fail. These plans would probably not be able to look to the Illinois Guaranty Association as a safety net. As such, unpaid claims would be the responsibility of the employee to pay regardless of any premium the employee might have already paid. Employers seeking to provide health insurance coverage for their employees need to be wary when entering into such contracts.

For additional information, see the Department's Illinois Insurance Newsletter, April 2002 #2, "Producers - Just Say No." (http://insurance.illinois.gov/newsLetter/NL02/NewsLetter_0402.pdf)

3. Discount Plans

The Department continued to witness an explosion of health, dental, vision and prescription drug discount plans in 2003. Employers view these programs as cost effective alternatives to offering supplemental insurance coverage to their employees. Many of these plans are legitimate, but there are some that provide only minimal coverage through marginal or non-existent provider networks, and at a great profit margin for the program sponsors.

Although there are exceptions, Illinois law generally requires discount plans to be registered as preferred provider administrators under the Health Care Reimbursement Act (Article XX 1/2 of the Insurance Code, 215 ILCS 5/370 f). The Department continues to actively work to get these plans registered as preferred provider organizations. Unfortunately, other states often lack oversight authority of discount plans. This sometimes leads sponsors of these plans to believe they do not have to register under the Illinois law. This belief is reinforced by existing state mandates that require discount programs to disclose, on their membership cards, that discount programs are not insurance. Preferred provider administrators are not insurance companies, but they are still required to be registered with the Department.

4. Physical Network Conflicts with HMOs

Beginning in 2002 and continuing through 2003, the Department continued to monitor trends relating to physician networks, usually referred to as Independent Practice Associations (IPAs) or Physician Hospital Organizations (PHOs), which resulted in an increase in complaints to the Department. These complaints generally took two forms.

Many complaints stem from situations in which an IPA or PHO could not reach agreement with an HMO to continue a contract for the delivery of health care services, such as in the case of Advocate Healthcare and Northwestern Medical Faculty Foundation in their contract negotiations with United Health Care. When an HMO's contract with a provider network is not renewed, providers once available to enrollees may no longer be available through the HMO and enrollees may be forced to switch plans or select a new provider. The provision of services under an HMO plan is determined by the contractual relationship between the HMO and the various providers, freely entered into by both parties. As such, either party may decide not to renew such contracts.

While these contractual issues will continue to be negotiated between the HMOs and provider networks, it is hoped that recent legislation will address some of the issues that have contributed to past contractual conflicts between the provider and the health care plan. With the passage of Public Act 93-0261, effective January 1, 2004, providers are entitled to: appropriate time frames in which to review their contracts, samples of specialty-specific fee schedules, detailed billing statements, as well as an explanation of any financial offset taken by the health care plan. These steps should significantly reduce future conflicts between providers and payors.

The second continuing trend in Department complaints in 2003 related to the financial impairment of IPAs and PHOs. The Department does not currently have the authority to regulate these entities for financial solvency. Because such insolvencies are occurring nationally, the National Association of Insurance Commissioners (NAIC) has developed a model for individual states to consider for adoption. The implementation of the NAIC's Downstream Risk Registration and Contracting Requirements Model would require health maintenance organizations to provide documentation to the Director of Insurance that IPAs and PHOs are financially able to fulfill their contractual obligations. By helping to insure that the parties responsible for the delivery and reimbursement of health care to enrollees in an HMO are financially responsible, consumers will be removed from claim payment debates that arise when medical services are provided, but payment has not been made to the treating provider.

4. GOVERNMENT ACTIONS

1. Federal

1. Medicare Modernization Act

Congress passed the Medicare Modernization Act to provide more choices in health care coverage and better health care benefits. The Act is designed to strengthen the existing Medicare program, add new coverage for prescriptions and preventive benefits, and bring new features for coverage under modern insurance plans.

The new drug benefit which is the major provision included within the Act will begin in 2006. In the spring of 2004, seniors may purchase a drug discount card for \$30 per year. Seniors with an income below 135% of poverty will qualify for a free discount card. This discount card will allow a savings on drugs until the program begins in 2006. When the prescription drug benefit begins, seniors will sign up for a stand-alone drug plan or join a private health plan that offers drug coverage. The estimated cost is \$35 per month with a deductible of \$250. The insurance will pay 75% of drug costs up to \$2,250. There are provisions for low-income subsidies and tax-free subsidies for employers who maintain drug coverage for retirees.

In 2004, Medicare Advantage replaces the existing Medicare+Choice plans, and in 2006 they will expand the coverage options to include regional preferred provider organizations (PPO).

The new bill will also provide additional benefits for the initial doctor's appointment for new Medicare beneficiaries and screening for diabetes and cardiovascular disease. It will provide benefits for coordinated care for people with chronic illness and increase payments for doctors administering mammograms.

2. Mental Health Parity Reauthorization Act

The original Mental Health Parity Act sunset on September 30, 2001. Each year Congress has passed a bill to extend the sunset date. Most recently, the Act has been extended until December 31, 2004. The original benefits of the Act remain the same.

3. HIPAA Federal Privacy Act

The first-ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. These new standards are designed to protect consumers' health histories, provide patients with access to their medical records, and establish limits on how personal health information is used and disclosed.

4. HIPAA Administrative Simplification Act

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security of health data. The Act took effect on October 16, 2003.

5. Trade Adjustment Assistance Reform Act

The Trade Adjustment Assistance Reform Act offers tax credits to be used toward the purchase of health insurance coverage for certain workers and retirees whose employer-sponsored health coverage is lost because of increased imports or trade-related relocations. The tax credit covers 65% of the cost of the health insurance for those who are eligible. The tax credit pays for qualified health coverage, which includes COBRA, and coverage determined to be qualified health coverage by a state. The Act became effective August 8, 2002. With the passage of HB 3298, the state formally designated the Illinois Comprehensive Health Insurance Plan as qualified coverage effective June 23, 2003. (SEE BELOW AND SECTION 5A OF THIS REPORT DEALING WITH THE COMPREHENSIVE HEALTH INSURANCE PLAN).

2. Illinois

1. [P. A. 93-0033](#)- Comprehensive Health Insurance Plan Act

House Bill 3298 changes the Comprehensive Health Insurance Plan Act to add coverage for federally eligible individuals who attain eligibility pursuant to the federal Trade Adjustment Act of 2002 and sets forth criteria for determining creditable coverage. The bill became effective June 23, 2003.

2. [P. A. 93-0034](#) - Trade Adjustment Act Revisions (CHIP)

House Bill 707 changes the definitions of "creditable coverage" and "federally eligible individual" contained in HB 3298 to change the references from the federal Trade Adjustment Act of 2002 to the federal Trade Act of 2002. In the section concerning

alternative portable coverage for federally eligible individuals, the bill adds certain persons who qualify to enroll in the Comprehensive Health Insurance Plan under the portability provisions. The bill became effective June 23, 2003.

3. [P.A. 93-0102](#) - Contraceptive Coverage

House Bill 211 requires coverage for insureds and covered dependents of insureds for all outpatient contraceptive services and all outpatient contraceptive drugs and devices designed to prevent unintended pregnancies when coverage is provided for other outpatient services, drugs and devices. The law excludes coverage for abortions as defined by the Illinois Abortion Law of 1975 and services related to permanent sterilization that require a surgical procedure. This law affects both individual and group policies. The bill became effective January 1, 2004.

4. [P. A. 93-0261](#) - Fairness in Contracting

House Bill 1074 provides that a health care professional or health care provider, offered a contract for signature after the effective date of this amendatory Act by an insurer, health maintenance organization, independent practice association, or physician hospital organization, shall be provided with the proposed health care professional or health care provider services contract. Makes numerous other changes to the contracting requirements between insurers and providers. The bill became effective January 1, 2004.

5. [P. A. 93-0318](#) - Small Business Advisory Act

House Bill 3209 creates the Small Business Advisory Act to require state agencies to create and make available on the World Wide Web a small business advisory page. This bill also requires agencies to post items that affect small businesses on the agencies' small business advisory Web pages. These items include: 1) a plain language explanation of proposed and adopted rules, and 2) legislation that the agency is designated to administer. Provides that the explanation must remain posted on the Web page for six months after the effective date of the rule or legislation. Each agency is required to notify the Department of Commerce and Community Affairs when it updates its small business advisory Web page. The Department of Commerce and Community Affairs will serve as a clearinghouse for notifying the small business community of rulemakings and to seek input from the small business community on those rulemakings. The Department of Commerce and Community Affairs will maintain a small business advisory Web page that serves as a coordinated point of access to other agencies' small business advisory Web pages. The bill also requires state agencies to post plain language versions of advisory opinions and interpretations on their small business advisory Web pages. The bill became effective January 1, 2004, but the advisory pages need not be implemented until six months after the effective date.

6. [P. A. 93-0326](#) - Life and Health Guaranty Association

Senate Bill 1104 provides that, if the Illinois Life and Health Insurance Guaranty

Association elects to succeed to the rights of an insolvent insurer arising after the date of an order of liquidation or rehabilitation under a contract of reinsurance to which the insolvent insurer was a party, the Association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation (now the Association must pay premiums for coverage relating to periods after the date of the order of liquidation or rehabilitation). The bill became effective January 1, 2004.

7. [P.A. 93-0333](#) -Slaveholder Policies

House Bill 2379 requires the Department of Insurance to request and obtain information from insurers licensed and doing business in this state regarding any records of slaveholder insurance policies issued by any predecessor corporation during the slavery era and make the names of any slaveholders or slaves described in those records available to the public and General Assembly. Insurance companies are required to research their records and provide any information to the Department of Insurance relating to insurance policies issued to slaveholders that provided coverage for damage to or death of their slaves. The bill became effective January 1, 2004.

8. [P. A. 93-0477](#) - Health Insurance Continuation

House Bill 3661 provides that, for continuation purposes, a notice of death or entry of a judgment of dissolution of marriage to be given to the employer or insurer rather than both and requires an employer to give notice of death or dissolution to the insurer. The bill provides for continuation coverage for certain dependents and requires group policies to provide a continuation privilege for covered dependents of a deceased employee. The bill establishes continuation privileges for employees whose work hours have been reduced.

The bill also resections Section 367e of the Illinois Insurance Code relating to continuation of group, hospital, surgical, and major medical coverage after termination of employment by establishing a separate Section 367e.1 relating to the group accident and health insurance conversion privilege. These sections of the bill became effective January 1, 2004.

9. [P. A. 93-0529](#) - Inhalants

Senate Bill 467 provides that, if a policy provides coverage for prescription drugs, it may not restrict coverage for prescription inhalants based upon refill limitations if the treating physician prescribes the inhalants in a manner contrary to the insurer's refill limitations. Provides that the inhalants must be medically appropriate. The bill became effective August 14, 2003.

10. [P. A. 93-0568](#) - Colorectal Cancer

Senate Bill 1417 provides that health insurance policies must provide coverage for

colorectal cancer examinations and laboratory tests for colorectal cancer in accordance with the published guidelines of the American Cancer Society. The bill became effective January 1, 2004.

5. RECOMENDATIONS FOR IMPROVMENTS TO HEALTH INSURANCE REGULATION

1. Medicare Supplement Insurance for Under 65 Disabled

Under federal Medicare law, persons over age 65 and those under 65 and disabled, under the federal definition, are qualified to enroll in Medicare. However, persons under age 65 and disabled do not have the same rights as those over 65 when purchasing Medicare supplement policies and as such are often left underinsured.

POSSIBLE REMEDY: Amend 215 ILCS 5/363 to mandate availability of coverage for those insureds who are covered under the federal Medicare program due to disability and are under age 65. Companies that sell Medicare supplement policies for persons over age 65 would be required to make all Medicare supplement policies that they sell also available to disabled Medicare-eligible individuals under age 65. These policies would be at no greater premium than that charged to individuals who are over age 65. This change should also allow for those persons under 65 years of age who become eligible for Medicare by reason of disability to make application and receive a Medicare supplement policy within six months of the first day on which the person enrolls for benefits under Medicare Part B, or within six months of receiving notification of retroactive eligibility from the Social Security Administration. Any amendment should also provide guaranteed issue rights to those under-65, disabled persons who apply for a Medicare supplement policy during the six month period beginning with the first day of the month in which the applicant enrolls for benefits under Medicare Part B.

2. Morbid Obesity

Many plans deny treatment for morbid obesity on the basis the treatment is cosmetic in nature or experimental and investigational. The number of overweight and obese Americans has continued to increase and with this increase the Department has received complaints requesting payment for weight reduction treatment, including gastric bypass surgery. The complaints have included documentation from providers indicating the medical necessity of the procedures. Currently, Illinois does not have a statute specifically requiring the coverage of weight reduction services for morbidly obese individuals when such treatment has been determined by a physician to be medically necessary.

POSSIBLE REMEDY: Amend the Insurance Code, the HMO Act, and the Voluntary Health Services Plans Act to require all plans to pay for medically necessary weight reduction services for morbidly obese individuals. The requirement should include a definition of what constitutes morbid obesity. The benefit should be provided at the same level as other diseases covered under the insurance contract. Since this remedy would establish a mandated benefit, the Department

defers to the General Assembly and the Governor's Office to establish public policy in this area. In establishing such a policy, the benefits of the mandate to those desiring the coverage need to be weighed against the cost of the mandate to all covered individuals.

3. Out Of Network Reimbursement

Currently, the Illinois Insurance Code ([215 ILCS 5/370i](#)) requires disclosure to beneficiaries when they seek services from a non-participating provider. The disclosure requires the contract to have warning language explaining that limited benefits will be paid when a non-participating provider is used. The Department continues to see complaints on the reimbursements levels beneficiaries receive when a non-participating provider is utilized. The beneficiary must often pay over 50% of the billed charges.

POSSIBLE REMEDY: Amend 215 ILCS 5/370i to strengthen and condense the disclosure language to ensure beneficiaries realize the significant decrease in benefits they may receive if they seek services from a non-participating provider. The amendment should establish a requirement that insurers, upon request of the insured, provide the beneficiaries a reasonable idea of how much a plan will pay for a specific treatment of service prior to the treatment or service being provided. This estimate should be based on the reimbursement amount the insurer anticipates it will be paying the non-contracted provider. Given a more precise mechanism for evaluating out-of-pocket expenses, the beneficiary will have a better idea of their expenses for covered services and supplies and be better able to determine if pursuing out-of-network treatment is in their best interest.

6. Action Taken on Past Recommendations

The following action has been taken on recommendations in last year's report. The remaining items continue to warrant attention. A list of items from past reports can be accessed in those reports on the Department's Internet site (http://insurance.illinois.gov/Reports/report_links.asp).

1. Insurer Recovery of Overpayments to Providers

There have been countless complaints from providers and insureds regarding recovery practices by the insurance and HMO industries. Companies are asking for reimbursement for claims that were overpaid many years previously. They are withholding benefits for other patient's claims for the past claims that they state were overpaid. Many times the providers no longer have information on the previous claims or patients and are not able to recover the money from the patient. Also, the notices provided by the insurers often do not contain enough information for the providers to reconcile their accounts, nor do they always contain the specific reason for the overpayment.

ACTION TAKEN: With the enactment of [Public Act 93-0261](#), guidelines for companies to recoup payment from providers were established ([215 ILCS 5/368d](#)). While these guidelines do not establish a timeframe for the recoupment of payments, they do require the provision of specific information relating to the claim payment for which recoupment is being sought and provides for an appeal process whereby providers can object to the recoupment. The bill became effective January 1, 2004.

2. Medicare Supplement Insurance for Under 65 Disabled

Under federal Medicare law, persons over age 65 and those under 65 considered disabled under the federal definition are qualified to enroll in Medicare. However, persons under age 65 and disabled do not have the same rights as those over 65 when purchasing Medicare supplement policies and as such are often left underinsured.

ACTION TAKEN: At the request of the Department, Representative Frank Mautino introduced House Bill 3658. The bill passed out of Committee, but was never voted on by the full House of Representatives.

Exhibits:

1. [Zip Code Listing](#)
2. [Top Ten Subject Categories of Phone Calls](#)
3. [Top Ten Informational Items Requested](#)
4. [Number of Phone Calls per Month](#)
5. [HMO Company Complaint Record -- General Summary 2002](#)
6. [HMO Company Complaint Record -- Classification Summary 2002](#)
7. [HMO Independant Review Summary 2002](#)