

# Office of Consumer Health Insurance 2004 Annual Report

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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) operating within the Illinois Department of Financial and Professional Regulation, Department of Insurance (IDFPR) continued to serve an increasing number of Illinois residents in 2004 by responding to their health related inquiries. For more information concerning IDFPR, see Government Actions Executive Order.

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 insurance fact sheets. Through these medias,

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 and provided appropriate resources to Illinois 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 Division 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.

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## 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 2004, OCHI's fifth year of operation, the office received 17,784 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 Division'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:

- Market Status
- Government Actions
- Recommendations For Improvements To Health Insurance Regulation

[Section 6](#) contains the Exhibits.

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## **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 2004. 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 may not 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 provided consumers with specific information applicable to their plans and their rights relating to options regarding continuation of coverage. OCHI also directed consumers to the Insurance Division's link on the Department of Financial and Professional Regulation's Internet site ([www.idfpr.com](http://www.idfpr.com)) enabling them to gain further knowledge of a particular topic through access to "fact sheets" developed by the Division.

Calls received by OCHI requested information on the following topics:

- How to obtain approval for a particular medical service or approval of benefits for a particular medical service;
- How to understand and file appeals with the health plan;
- How to appeal claims for procedures that were pre-certified by the health plan;
- How to request an external independent review with HMO plans;
- How to file a complaint with the Department of Insurance

OCHI guided HMO enrollees through the external independent review process by explaining the information needed by the independent reviewer, the required time periods involved and the role played by the patient's 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 2003) shows the general summary of HMO complaints for 2003. [Exhibit 6](#) (HMO

Company Complaint Record - Classification Summary 2003) shows the classification breakdown of the HMO complaints. [Exhibit 7](#) (HMO External Independent Review Summary 2003) 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 Division. These exhibits may also be accessed through the Division's Internet site ([insurance.illinois.gov/Complaints/Complaints.asp](http://insurance.illinois.gov/Complaints/Complaints.asp)).

As presented in [Exhibit 5](#), during calendar year 2003, HMOs reported a total of 8,950 complaints, of which 931 (10%) were also filed with the Department of Insurance. The "Disposition of ALL Complaints" section indicates that of the total complaints:

3,851 (43%) were granted relief; 621 (7%) were granted partial relief; 841 (9%) received additional information; and 3,637 (41%) received no relief.

[Exhibit 7](#) shows that HMO enrollees requested 86 external independent reviews that were completed by HMOs in the State of Illinois in 2003. Of these, 20 (23%) were granted relief; 1 (.01%) was granted partial relief; 0 received further information; and 65 (76%) had no change in status. The reporting date for complaint data is March 1 for the previous year. Complaint data for 2004 will be addressed in the 2005 report.

The Department of Insurance office in Chicago also handles many telephone calls and assists consumers who walk into the office requesting information. From January 1, 2004, through December 31, 2004, the Chicago office handled 2,318 calls relating to health insurance complaints; 900 calls regarding general health insurance questions; 81 English-speaking walk-ins with health insurance questions; and 220 calls and 20 walk-ins requiring the services of a translator.

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## **2. Educating enrollees about their health plan rights**

As in the prior calendar year, 2004 saw several employers, large and small, declare bankruptcy, generating many calls regarding COBRA and Illinois Continuation benefits. Upon receiving information from other areas of the Division, 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 federal 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 Division's Senior Health Insurance Plan ([SHIP](#)).

In the past years the Division created "fact sheets" based upon questions we received from Illinois consumers and insurance topics that were important to the consumer. These "fact sheets" are available on the Division's website ([insurance.illinois.gov/healthinsurance/healthinsurance.asp](http://insurance.illinois.gov/healthinsurance/healthinsurance.asp)). For callers unable to access this information via Internet, requested materials were mailed.

Upon request, OCHI personnel gave presentations to a variety of organizations including consumer organizations, community development organizations, employer organizations, and public health organizations. An OCHI representative was also invited to be a guest on several radio talk shows and represented the Division at a Washington D.C. health conference.

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 fact sheet "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 Division's Internet site. Fact sheets revised during 2004 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](#)

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### **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.

The Internet served as a valuable tool in finding information on specific health care 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 continues 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 toll free telephone number. OCHI received coverage on a number of television stations regarding the office and its mission. In addition, the Division'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 17,784 calls on its toll-free telephone line (877-527-9431) for calendar year 2004. Since its inception in 2000, OCHI has received approximately 80,000 phone calls from 1,095 zip code areas throughout the State of Illinois.

## **Other duties as assigned by the Director**

In previous years, benchmarks were established for the OCHI staff to assure prompt assistance is provided to consumers. These benchmarks continue to be met.

During 2004, the OCHI staff began handling written consumer inquiries. These inquiries are received via regular mail, fax, on-line complaint form or through the Division's general e-mail address.

The OCHI staff's broad base of health insurance combined with the database of information compiled by the Ombudsman Program allowed their expert handling of approximately 774 written inquiries in 2004, permitting the Division's Consumer Service staff to focus more on consumer complaints.

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## **4. Uninsured Ombudsman Program**

The Uninsured Ombudsman Program (Program) became effective January 1, 2002. The program was established within the Office of Consumer Health Insurance (OCHI) to provide uninsured Illinois residents assistance and education on health insurance benefits, explain options and rights under state and federal law, inform consumers about the availability of various medical services, and consumer programs throughout this state which provide care that normally would be covered by insurance.

In the first year of operation, the Program contacted local and county Public Health Departments to assist in locating resources that provide medical services to those who are uninsured. In addition, extensive research was conducted by the Program to locate websites and other resources. The information was then compiled and used to properly direct consumers needing medical, dental, mental health, prescription, vision and other health care needs.

The following year, all the information previously compiled was stored in a database created by the Program with assistance from other DOI personnel. This made information easily accessible by all staff for a prompt response. Information can be accessed within the database by county and city. When the various websites are updated, the Program information in the database is automatically changed to ensure the information stays current.

For Calendar year 2004, the Program handled 691 calls. Calls came from a variety of sources including other state agencies, legislators, agents, family and friends, radio stations and others who were assisting the uninsured. In continuing to increase the awareness of the Program, the Ombudsman participated in the National Cover The Uninsured Week Program, several radio talk shows, as a speaker for Central Illinois

Association of Health Underwriters, as a presenter at Memorial Medical Center (Springfield), and as a participant at a round table discussion for small employer health insurance in St. Clair County.

Below is a breakdown by area of the Ombudsman calls received in calendar year 2004:

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## **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. This trend continued in 2004, but at a decreased rate from recent years. The only significant company to cease doing health business in 2004 was Rockford Health Systems (RHP). Under RHP's withdrawal plan, employers were offered the option of receiving replacement coverage through PersonalCare Insurance Company of Illinois, Inc.

Whenever health care coverage is disrupted, the Division and OCHI receive numerous calls from individuals affected by the withdrawal of these companies. The Division explains how these transactions work, the specific processes involved and, for many persons who are losing coverage, what options are available in order to ensure continued health coverage. Further, while not required by the HIPAA law, the Department of Insurance encourages companies to make efforts to assist enrollees in finding alternative coverage. Often, the only alternative for individuals losing coverage in these situations is 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 is to apply for the standard CHIP coverage, which entails the reimposition of preexisting condition

limitations, or go without coverage. For a more complete description of CHIP, please refer to Section 2C of this report on page 11.

The state continues to enjoy a healthy market place in terms of the number of companies that continue to offer coverage to individuals and small and large employers. Currently, Market Share Reports show 455 companies actively selling accident and health insurance in this State. 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 Division will continue to monitor in upcoming years.

## 2. Health Insurance Availability

### 1. Uninsured

The most disturbing trend in the health insurance marketplace is the continuing rise in the ranks of the uninsured. In September, the U.S. Census Bureau released year-end numbers for the uninsured in 2003. According to the report, the ranks of the uninsured nationwide rose to 15.6 percent compared with 15.2 percent in 2002. The trend was mirrored in Illinois where the number of uninsured residents rose to 14.3 percent of the state's population, up from 13.9 percent in 2002. According to the Census Bureau's numbers, more than 1.8 million Illinoisans had no health insurance last year. This trend is reflected in the 691 calls to the Uninsured Ombudsman in 2004. At the time this report is being issued, there are no clear indications that this trend will be altered for 2005 and beyond.

### 2. Employees Losing Group Health Coverage

During the past five years, the Office of Consumer Health Insurance (OCHI) 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 such coverage. In 2002, OCHI received 1,964 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 2003, OCHI received 2,387 continuation calls. This total increased to 2,543 in 2004. 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; chief of which are employers who declared bankruptcy, leaving many employees without health insurance coverage. 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 2003, we reported that some employers stopped offering retirees health insurance coverage. This trend continued in 2004 and many retirees under the age of 65 have been searching the marketplace for coverage. As in previous years, the rising health costs, growing retiree populations, and the uncertainty of business profitability have all played a role in this trend.

The Division continues to actively work to provide information and answer questions on the coverage options for retirees losing coverage. The Office continues to stay abreast of the new Medicare changes that may be applicable to the retiree population by working with the Senior Health Insurance Program (SHIP) office. They also 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 (ICHIP) (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 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.

The Trade Act of 2002 contained provisions that provided grants for high risk pools that met certain criteria. The HIPAA-CHIP pool met the established criteria and received the single largest grant of any state for federal fiscal year 2002 in the amount of \$7.45 million which was supplemented by a grant of \$.693 million. For federal fiscal year 2003 ICHIP received a grant of \$6.6 million. ICHIP is using a portion of the grant money for premium relief for those enrolled in Section 15 HIPAA-CHIP. Beginning January 1, 2005, all participants in that plan will get premium relief in the amount of approximately 6.6% of their premium.

ICHIP 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.

On December 31, 2004, enrollment included 5,888 persons in Traditional ICHIP (Section 7) and 10,521 in HIPAA-CHIP (Section 15). The enrollment in the new TAA-CHIP plans represented 398 of the HIPAA-CHIP total.

#### 4. Synopsis of State Planning Grant

In September 2000, the State of Illinois received a \$1.2 million State Planning Grant (SPG) 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 increase 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 not 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). Also, funds from the grant were used to create a page on the Division's Internet site ([insurance.illinois.gov/spg/](http://insurance.illinois.gov/spg/)), gather information on a variety of potential strategies used in other states, undertake a literature review, and develop a large bibliography. The new data, as well as existing national data, served as a bridge between researchers and stakeholders during the participatory process of developing strategies to provide coverage to all uninsured persons in the state. Data indicates that between 9.85% and 13.4% of Illinoisans had no health coverage in the year 2001. The research and participatory process results were included in a Report to the Secretary of the U.S. Division of Health and Human Services in October 2001.

In September 2001, Illinois received an additional \$194,000 to continue this project and further develop strategies.

The following three options for increasing coverage received strong support from stakeholders during the participatory Illinois Assembly process: provide incentives for small business employers; support the Family Care Program; and enhance education, marketing and enrollment procedures for existing programs to increase enrollment.

Significant progress was made in implementing these options. Illinois received approval to implement the Family Care Program within the Illinois Division of Public Aid. The focus of the planning grant is on developing ways for small employers (25 or less employees) to be able to provide coverage to their employees. We worked with an actuary and small employers to design coverage mechanisms. The draft product designs were reviewed in a series of statewide meetings with both employers and brokers.

In January 2003, the Illinois Department of Insurance –State Planning Grant (SPG) issued a Request For Proposal for the design of a pilot program that would provide an affordable product for small business owners, which incorporates 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 targeted at small business employers that is 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 was 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. HMA has extensive experience and has worked with other notable communities utilizing this model (e.g. Wayne, Kent, Muskegon Counties in Michigan and Winnebago [Rockford], Macoupin Counties in Illinois and others in Kansas and Florida).

The Southern Illinois Healthcare Foundation (SIHF), along with Touchette Regional Hospital in Centreville, sponsored a series of community meetings to determine if a need existed. Representatives from the community (which include local units of government, employers, labor unions, social service advocates, insurance agents and health care providers including medical practitioners) formed a committee to design a benefits package and to explore options for the community subsidy. The consensus of the group was that a need for low cost employer sponsored health coverage for St. Clair County did indeed exist. With the help and support of the SIHF the committee then met several times throughout March, April and May and were able to design a modest benefits package. At each meeting, both representatives from HMA and the Illinois Department of Insurance were present and active participants providing education and technical assistance services.

In September 2003, Illinois received an additional \$185,000 to continue with the development of the pilot project, develop and design a reinsurance pool model and 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 Three-Share program.

Southern Illinois Health Care Access, Inc., a 501(c)(3) entity, was established and will be responsible for the day-to-day operations of the plan and will include marketing the plan to local small business owners within St. Clair County. This entity will also be responsible for defining the enrollment function, provider education and network management functions, defining customer service/beneficiary education functions, determining the role of a third party administrator, finalizing the finance structure and preparing to launch the program on or around July 1, 2005.

#### Current Status of the Pilot Project

In September 2004, Illinois received a \$400,000 Pilot Project Planning Grant from HRSA. The purpose of the grant is to expand the pilot project into two additional Illinois counties, one metropolitan and one rural and to continue to develop and design a reinsurance pool model. In December 2004, a Request for Information (RFI) was sent to the Directors of each County Health Division in Illinois. Counties interested in participating as one of the pilot sites are requested to submit specific quantitative and qualitative information to the Department of Insurance – State Planning Grant for consideration.

### 3. Trends

#### 1. Growth of Consumer Driven Health Plans

As we reported in the previous year, employers continue to search for new ways to provide coverage for their employees. The cost of employer-sponsored health benefits continues to grow and the number of uninsured continues to rise. The term “Consumer Driven Health Plans” means that the employee is offered more choices of health plans and providers. While this may sound attractive, it also means the employee takes on more of the financial risk. The driving force behind these plans is to reduce costs to employers and ensure individuals are provided coverage for catastrophic and emergent conditions. These benefits could range from the costliest first dollar coverage plans, such as HMOs or pure indemnity plans to the least costly high deductible plans and discount plans.

#### 2. Multiple Employer Welfare Arrangements - MEWAs

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 unless fully insured. Some Professional Employer Organizations (PEOs) claim to offer access to a self-funded, single-employer ERISA plan (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 Division is concerned about these plans because employees would be denied benefits mandated by 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.

### 3. Discount Plans

The Division continued to witness an explosion of unlicensed discount plans. Illinois residents have been continually exposed to multimedia and Internet solicitations for enrollment into discount card plans offering a wide array of health care services and supplies. Routinely, these plans offer discounted rates for medical, surgical, hospital, dental, vision, prescription drug, emergency travel, mental health, and substance abuse care.

Employers view these programs as cost effective alternatives to offering supplemental insurance coverage to their employees. Individuals see them as an alternative to costly private coverage. 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 ½ of the Insurance Code, 215 ILCS 5/370 f). The Division 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 are still required to be registered with the Department of Insurance.

#### 4. Non-directed Provider Networks

As the insurance industry struggles to address the ongoing challenge of containing escalating health care costs, they have begun to use contractual relationships with providers to reprice claims submitted through indemnity contracts.

The concept of discounting provider services and passing corresponding savings on to the consumer is not new. Traditionally, these arrangements have been known as a Preferred Provider Organization (PPO). PPO products combine insurance coverage with contracted provider networks, providing the insured with cost savings generated through these arrangements. What is new is that insurers are now administratively applying these discounts to non-PPO products.

The Illinois General Assembly passed legislation in the late 80’s, which established guidelines and consumer protections for PPO products. Insurers are now issuing indemnity contracts which do not contain these safeguards and do not disclose benefit differentials for using contracted versus non-contracted providers. The insurer will simply reprice claims to known discount levels when the insured uses a provider contracted with the insurer. In these cases, the consumer may or may not receive the benefit of such discounts.

This approach has also raised concerns within the provider community. They argue that the insurer may not reprice claims nor take discounts unless the insured is provided contractual incentives to use participating providers.

The repricing of claims, through non-directed provider networks, has left consumers struggling with collection activities of providers who believe that their services have unfairly and extra-contractually reduced.

#### 5. Health Savings Accounts

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 (P.L. 108-173) added Section 223, Health Savings Accounts (HSAs) to the Internal Revenue Code and to the mix of Health Care Options. An HSA is a tax-exempt trust established exclusively to pay for qualified medical expenses of the account beneficiary who is covered under a high-deductible health plan.

So far, the early growth rate of HSAs far exceeds that of medical savings accounts first offered in 1997. Premiums for HSA linked products are much lower than those for traditional plans due to the cost sharing requirements imposed on enrollees. One of the advantages of an HSA is that unspent HSA funds rollover and remain with the employee. It is believed that most employers will seriously consider these new types of arrangements.

#### 6. Employers Require Employees to Use Mail Order Drug Program

Many large employers, as well as state and local governments are requiring the use of mail order drug programs. Any prescription that is considered to be a maintenance medication is required to be filled by mail order companies. The main reason for such requirement is cost. Receiving drugs through mail order companies can be less expensive because of the reduced cost of filling the prescription due to the lower overhead of mail order companies. It is estimated that more than 600 employers and more than 15 million employees use a mail order drug program.

#### 7. Employers Requiring Dependents to Insure Under Their Own Plan

As the cost of employer's health insurance plans increase, employers are looking for ways to cut the cost. In the last few years, we have seen self-funded benefit plans requiring spouses of their employees to obtain health insurance coverage through their own employer when such coverage is available. The self-funded plans refuse to insure those spouses who have other coverage available.

Fully insured plans are now applying similar ideas. They are requiring the spouses of employees to become covered under their own plans if available and the employee's plan will then cover them as secondary. This helps hold down the cost of providing coverage.

#### 8. Employers Requiring Retirees to pay more of the Cost of Health Coverage. Employers Terminating Retirees Health Care Benefits

In an effort to help control the rising cost of employer health coverage, many employers are reducing benefits or terminating retiree health coverage. Employees who have worked for years for an employer thinking they would have benefits available upon retirement are surprised to learn that those benefits are gone or reduced to such a level that they provide little coverage or provided at such a high cost that they are unaffordable.

## 2. GOVERNMENT ACTIONS

### 1. Federal

## 1. Medicare Modernization Act

The Medicare Modernization Act (MMA), enacted in December 2003, creates sweeping changes in the federal Medicare program. The MMA outlines new health plan choices and establishes new preventive benefits, such as cardiovascular screening and diabetes screening tests, and a “Welcome to Medicare” physical. And for the first time, Medicare will offer a prescription drug benefit.

Beginning in 2004 and phasing out in 2006, Medicare beneficiaries, who do not qualify for Medicaid, have the opportunity to purchase Medicare-approved drug discount cards for no more than \$30 annually. The Medicare-approved drug discount card program provides a temporary benefit prior to the implementation of the Medicare Part D prescription drug benefit in 2006. In addition to the discounts provided by the drug discount card program, Medicare beneficiaries with incomes below 135% of the poverty level may qualify for a free discount card and a maximum subsidy for 2004 and 2005 of \$1,200 to help pay for prescription drugs.

People on Medicare can begin enrolling in the voluntary Medicare Part D drug plans from November 15, 2005 through May 15, 2006. Medicare prescription drug plans may vary, but in general, enrollees will pay an estimated \$35 monthly premium. All enrollees will be required to pay annually a \$250 deductible; 25% of their drug costs up to \$2,250; 100% of drug costs from \$2,251 to \$5,100; and 5% of drug costs thereafter until their out-of-pocket costs total \$3,600. The Part D plan will then pay 100% of their drug costs for the remainder of the calendar year. Subsidies will be available to low-income beneficiaries.

An individual who does not join a Medicare Part D prescription drug plan when first eligible, may have to pay a higher premium if they later choose to enroll. They will be required to pay this higher premium for as long as they have a Medicare prescription drug plan.

## 2. Mental Health Parity Reauthorization Act of 2003

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, 2005. The original benefits of the Act remain the same.

## 2. Illinois Executive Order

In 2004, the Governor issued Executive Order 2004-6 creating the Illinois Department of Financial and Professional Regulation. This Department was a merger of the Illinois Department

of Insurance with three other agencies: Department of Professional Regulation, Department of Banks and Real Estate and Department of Financial Institutions.

OCHI continues to perform the same statutory duties under the new arrangement.

### **House Bills**

(Full text of the Public Acts may be viewed at [www.ilga.gov](http://www.ilga.gov).)

1. P. A. 93-0824 – Small Employer Feasibility Study: Effective date

July 28, 2004

The CHIP board shall conduct a feasibility study of establishing a small employer health insurance pool in which employers may provide affordable health insurance coverage to their employees. The board may contract with a private entity or enter into intergovernmental agreements with State agencies for the completion of all or part of the study.

2. P. A. 93-0739 – Use of Social Security Numbers: Effective date July 1, 2006

A person may not do the following:

- Publicly post or display an individual's Social Security Number.
- Print an individual's Social Security Number on any card required for the individual to access products or services (insurance card). The insurance card must contain a unique identification number in a format prescribed by Section 15 of the Uniform Prescription Drug Information Card Act.
- Require the individual to transmit their number on the Internet unless encrypted.
- Require the individual to use the number to access a website.
- Print an individual's Social Security Number on printed material sent by mail unless required by state or federal law.
- The Act does allow continued use of the Social Security Number in limited conditions if it was used prior to this Act and under certain conditions.

### **Senate Bills**

3. P.A. 93-1000 – Qualified Cancer Trials: Effective date January 1, 2005

No individual or group policy of accident and health insurance may be cancelled or non-renewed based on an individual's participation in a qualified cancer trial. There are

specific criteria, which must be met in order for the trial to be considered a qualified cancer trial.

4. P.A. 93-0728 - Use of Social Security Numbers: Effective date January 1, 2005

Amends the Consumer Fraud and Deceptive Business Practices Act to prohibit a person or entity from printing an individual's Social Security Number on an Insurance card. An insurance card issued prior to the effective date of this Act has until January 1, 2006 to come into compliance.

This law is very simliar to P.A. 93-0739, which also addressed the use of Social Security Numbers. P.A. 93-0728 solely focuses on insurance cards.

P.A. 93-0728 was signed 07/14/04 and becomes effective 01/01/05.

P.A. 93-0739 was signed 07/15/04 and becomes effective 07/01/06.

5. P.A. 93-0850 – Discrimination (Travel Experiences): Effective date July 30, 2004

No life insurance company may refuse to insure, refuse to continue to insure, limit the amount or extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely for reasons associated with an applicant's or insured's past lawful travel experiences.

6. P.A. 93-0853 – Osteoporosis: Effective date January 1, 2005

Amends the Insurance Code, HMO Act and Voluntary Health Services Plan Act. Requires coverage in individual and group policies for bone mass measurement and the diagnosis and treatment of osteoporosis on the same terms and conditions that generally apply to other medical conditions.

7. P.A. 93-0018 – Illinois Rx Buying Club: Effective date January 1, 2004

The State of Illinois established the Illinois Rx Buying Club with enactment of Public Act 93-0018. Effective January 1, 2004, the Illinois Rx Buying Club provides access to all prescription drugs approved by the FDA at a lower cost to Illinois seniors and people with disabilities. The program does not have income limitations. Members pay an annual administrative fee and can receive average discount savings of 20% on prescriptions purchased at participating pharmacies. The Illinois Rx Buying Club also offers a mail order service for even larger savings. For more information, or to receive an application call 1-866-215-3462 or log onto the web at [www.illinoisrxbuyingclub.com](http://www.illinoisrxbuyingclub.com).

## Other State Programs

### 8. I-Save Rx

The State of Illinois developed I-Save Rx in 2004 to allow consumers the opportunity to purchase safe and affordable prescription drug refills dispensed by licensed, state-inspected and approved pharmacies in Canada and the United Kingdom. I-Save Rx is available to all Illinois residents and residents of the states of Wisconsin, Missouri and Kansas. Medications dispensed under the I-Save Rx program include the top 100 high-use, brand name drugs used to treat chronic conditions, such as high blood pressure, cholesterol, heartburn, arthritis and diabetes. For more information about I-Save Rx, including a list of drugs available or to enroll visit [www.I-SaveRx.net](http://www.I-SaveRx.net) or call toll-free 1-866-472-8333.

## 3. RECOMMENDATIONS FOR IMPROVEMENTS 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. In Network Payment of Ancillary Providers

Some managed care plans are paying claims for providers of ancillary services at the out-of-plan rate when the services were in fact performed at a plan facility. In the vast majority of cases, the

insured has no voice in who will be the provider of these services. They usually do not understand that these services (pathologist, radiologist, anesthesiologist, emergency room physicians) will be billed separately from the bill of the plan facility. These provider services are arranged by either the facility or the patient's primary care physician. In the case of Preferred Provider Organization plans, the primary care physician is not usually required to provide a referral for services to have the bill covered, and the patient would have limited resources for directing this type of care to a plan provider.

**POSSIBLE REMEDY:** Require ancillary services to be performed at the preferred rate when the beneficiary/insured has the basic service performed by a primary care physician or in-plan doctor at a plan specified facility.

### 3. Notification of HIPAA-CHIP

Currently when an employer terminates the group health plan and does not replace it, or the COBRA or State Continuation rights have been exhausted, there is usually no notice that is sent to the individual who may qualify for HIPAA-CHIP. Under Section 15, an Eligibility and Enrollment Form must be received by the CHIP Board Office within 90 days after the termination. Consequently, an individual will apply in the open market and may be denied coverage due to an uninsurable health condition. Unfortunately, by the time the individual is made aware of HIPAA-CHIP, it is after the 90 day deadline has passed to obtain coverage without a preexisting condition exclusion.

**POSSIBLE REMEDY:** Mandate that employers and insurance companies must provide notice of HIPAA-CHIP when group coverage is being terminated either as a whole or as the consumer exhausts their COBRA or State Continuation right. The employer should be required to give notice with termination and the insurance companies should be required to give notice in the certificate in same area as continuation notice.

### 4. State Continuation Law – Anticipation of Divorce

Prior to divorce, an employee will remove the spouse from the group coverage, thereby taking away state spousal continuation rights. The spouse has no rights to demand that he/she be put back on plan. Cobra has protections for such events. State continuation does not.

**POSSIBLE REMEDY :** Amend the Insurance Code to require the insurance company or employer to give spousal continuation when it is discovered that the employee removed the spouse in anticipation of divorce and it is later confirmed that divorce has occurred.

### 5. State Continuation Laws – Lack of Employer Cooperation

The State Continuation law requires that upon termination of employment, the employer give the employee notification of their right to continue coverage for 9 months. The Spousal Continuation law requires that the spouse notify the employer or the insurance company of the request for continuation. The Dependent Continuation law also requires the dependent or the responsible adult to notify the employer or the insurer. In some instances, the employer refuses to cooperate. This Division does not have authority over the employer and the insurance company will not take responsibility to see that the continuation is provided. The employee, spouse or dependent child should not have to navigate obstacles to obtain their rights under the law. The problem is further exacerbated when an application is made to HIPAA-CHIP and coverage is denied because the employee, spouse, or dependent was unable to fulfill the continuation requirement. HIPAA-CHIP requires exhaustion of continuation in order to be eligible for that plan. Applicants are declined by HIPAA-CHIP when they did not elect continuation even if it was not offered to them.

POSSIBLE REMEDY: Amend the continuation laws to require the insurance company to be a participating partner and give notification when the employer is not cooperative.

#### 6. Company Auditing of Past Claims

Last year, the Division received numerous complaints from providers and insureds regarding recovery practices by insurance companies and HMOs. (Public Act 93-0261) effective January 1, 2004 provided guidelines for companies to recoup payments. Unfortunately, this law (215 ILCS 5/368d) did not stipulate any time frame within which the recoupment must be made. Many times companies request recoupment for claims that are not over two years old. While the company should have the right to request recoupment, they should be required to do so within a reasonable time. In many instances, the claims are so old, the provider cannot identify the patient, the patient is no longer insured under the plan, or the patient's address has changed and the provider has no way to contact the patient and recoup the money for their services.

POSSIBLE REMEDY: The current law (215 ILCS 5/368d) should be amended to require a specific time frame (such as 2 years) within a recoupment may be requested. This would be similar to the insurance company's requirement that claims be submitted within a certain time frame.

#### 7. Proof of Loss

Currently, proof of loss requirements, especially timeframes for the submission of proofs of loss, are limited to individual policies only. Establishing clear parameters for providers, insurers, and insureds would alleviate confusion in the submission of claims and reduce the number of denials for late filing that would otherwise be payable.

POSSIBLE REMEDY: Amend 215 ILCS 5/357.8 of the Illinois Insurance Code to include group policies in the requirements relating to timeframes for submission of proofs of loss and claim settlements.

#### 8. External Independent Review

Currently, insurance companies are not required to have an appeals mechanism or an external independent review process. The Division does not have the medical expertise or the legal authority to review claims or proposed claims that are denied as not being medically necessary. This law would establish a mechanism for insureds and covered individuals to appeal denials and give them access to an external independent reviewer that would render a fair unbiased decision.

POSSIBLE REMEDY: Amend the Insurance Code to require group and individual accident & health and disability policies to include an appeals procedure and an external independent review procedure for any procedures, services or treatments that have been denied as not medically necessary. Similar to the requirements currently in place for the HMOs under the Managed Care Reform and Patient Rights Act.

#### 9. Emergency Care Reimbursement

Currently 215 ILCS 370o requires payment by PPO policies of emergency claims incurred at non-preferred providers at the same benefit level as if the service had been rendered by a preferred provider. Many times the insured incurs a much larger out-of-pocket expense under the terms of the law because non-preferred providers balance bill. We believe the insured should be no more out-of-pocket for emergency services received with a non-preferred provider than he/she would have been if services had been received with a preferred provider.

POSSIBLE REMEDY: Amend the Insurance Code (215 ILCS 5/370o), the Managed Care Reform and Patient Rights Act (215 ILCS 134/65) and add new Section (215 ILCS 5/356z.7) to indicate an insured or enrollee who receives emergency care from an out-of-network provider will be no more out-of-pocket expenses as if they went to a preferred provider. The current language indicates the insured will receive the same benefit level (as opposed to out-of-pocket liability) as if they had received emergency services at a preferred provider.

### 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 2004](#)
6. [HMO Company Complaint Record -- Classification Summary 2004](#)
7. [HMO Independent Review Summary 2004](#)