

Office of Consumer Health Insurance 2005 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 2005 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 and television interviews, and the distribution of insurance fact sheets. Through these medias, OCHI helps consumers understand the terms and meanings of their insurance coverage, advises

persons of their rights under insurance policies, assists insureds in filing appeals and complaints and provides 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 Illinois Department of Insurance expanded OCHI to include the administration of the Uninsured Ombudsman Program established by Public Act 92-0331 (20 ILCS 1405/1405-25). The Ombudsman is responsible for providing assistance and education to individuals regarding health insurance benefit options and rights under state and federal laws. The Ombudsman Program also counsels 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 2005, OCHI's sixth year of operation, the office received 15,558 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 and television 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.

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

The Office of Consumer Health Insurance (OCHI) responded to a wide array of questions from consumers during calendar year 2005. Calls came from a variety of groups including consumers, employers, agents, associations, attorneys, health care providers and advocacy groups.

OCHI provides information and education on insurance-specific terminologies that the average consumer may not understand. Members of the OCHI staff also 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). Consumers were provided specific information applicable to their plans and their rights relating to continuation of coverage options. OCHI also directed consumers to the Insurance Division's link on the Department of Financial and Professional Regulation's Internet site (www.idfpr.com) enabling them to gain further knowledge of a particular topic through access to "fact sheets" developed by the Division.

In 2005, OCHI received calls requesting information on many topics, including:

- 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, mandated by the Managed Care Reform and Patient Rights Act, 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 2004) shows the general summary of HMO complaints for 2004. [Exhibit 6](#) (HMO

Company Complaint Record – Classification Summary 2004) shows the classification breakdown of the HMO complaints. [Exhibit 7](#) (HMO External Independent Review Summary 2004) 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 <http://insurance.illinois.gov/Complaints/Complaints.asp>.

As presented in [Exhibit 5](#), during calendar year 2004, HMOs reported a total of 8,951 complaints, of which 993 (11%) were also filed with the Department of Insurance. According to the data submitted by the companies, the “Disposition of ALL Complaints” section indicates that of the total complaints:

- 3,167 (35%) complaints were granted relief;
- 512 (6%) were granted partial relief;
- 1931 (22%) received additional information; and
- 3,336 (37%) received no relief.

[Exhibit 7](#) shows that HMO enrollees requested 94 external independent reviews that were completed by HMOs in the State of Illinois in 2004. Of these:

- 19 (20%) were granted relief;
- 2 (.02%) were granted partial relief;
- 4 (.04%) received further information; and
- 69 (73%) had no change in status.

The reporting date for complaint data is March 1 for the previous year. Complaint data for 2005 will be addressed in the 2006 report.

The Department of Insurance office in Chicago also handles many telephone calls and visitors requesting information. From January 1, 2005, through December 31, 2005, the Chicago office handled 1,402 calls relating to health insurance complaints; 530 calls regarding general health insurance questions; 82 English-speaking visitors with health insurance questions; and 112 calls and 22 visitors requiring the services of a translator.

2. Educating enrollees about their health plan rights

As in previous years, several employers, large and small, declared bankruptcy in 2005, generating many calls to OCHI 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 federal Trade Adjustment Assistance Reform Act of 2002, 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](#)).

The Division continues to create and provide "fact sheets" in response to questions we receive from Illinois consumers in an effort to simplify complex insurance issues that are important to consumers. These "fact sheets" are available on the Division's website (http://insurance.illinois.gov/Main/Consumer_Facts.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 and television 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" and the Ombudsman Brochure for the Uninsured are 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 2005 are shown in bold letters.

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

[Beware of Fraudulent Insurance Companies](#)

[Birth Control Is Now Covered](#)

[Cancer](#)

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

[Coordination of Benefits](#)

[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 Consumer 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 continues to explore new avenues for reaching consumers and consumer groups and continues to perform valuable research in an effort to assist consumers seeking information.

The Internet served as a valuable tool for OCHI in its quest for information regarding specific health care related topics. OCHI received calls from consumers regarding specific diseases or conditions and the related financial burden that resulted from the cost of treatment that was not covered by insurance. OCHI was able to provide information regarding available resources in some of those instances.

OCHI continues to identify government agencies and associations that provide emergency services to persons in need of assistance for specific health care conditions. As new information is obtained, it is assimilated into the OCHI database as an additional resource to provide to future callers.

Newspapers around the state continued to provide support in our effort to inform the public of our toll free telephone number. Also, OCHI received coverage on television stations regarding the office and its mission. In addition, OCHI staff increased their availability for regularly scheduled talk-radio programs around the state.

Status report of OCHI toll, free telephone number

OCHI received a total of 15,558 calls on its toll-free telephone line (877-527-9431) for calendar year 2005. Since its inception in 2000, OCHI has received approximately 96,000 phone calls from 1,095 zip codes throughout the State of Illinois.

Other duties as assigned by the Director

During the early years, benchmarks were established for the OCHI staff to ensure prompt assistance is provided to consumers. These benchmarks established the desired levels of consumer service to be met or exceeded. OCHI continues to meet those benchmarks.

During 2004, the OCHI staff began handling written consumer inquiries. These inquiries are received via regular mail, fax, or electronically, via on-line complaint or via the Division's consumer email address (consumer_complaints@ins.state.il.us).

The OCHI staff's broad base of health insurance knowledge, combined with the database of information compiled by the Ombudsman Program, allowed the handling of approximately 1135 written inquiries in 2005. The handling of inquiries by OCHI allows the Division's Consumer Service staff to focus on more complex consumer complaints.

OCHI also assists in responding to inquiries to the Director's email. This email address, director@ins.state.il.us, is posted on the Department of Insurance website for consumers to write with any questions regarding insurance. OCHI staff replied to 146 Director email inquiries in 2005.

In 2005, Medicare Part D became available to Medicare eligible individuals throughout the United States. Consumer calls to the Divisions' Senior Health Insurance Plan (SHIP) rose dramatically. OCHI staff assisted SHIP by returning calls and assisting consumers by answering questions and providing information about Medicare Part D options. The OCHI staff responded to 2,168 Medicare Part D calls in 2005.

OCHI staff participated in training for the I-SaveRx program created by Governor Blagojevich. OCHI used the knowledge from the training to provide information and applications for the program to interested consumers.

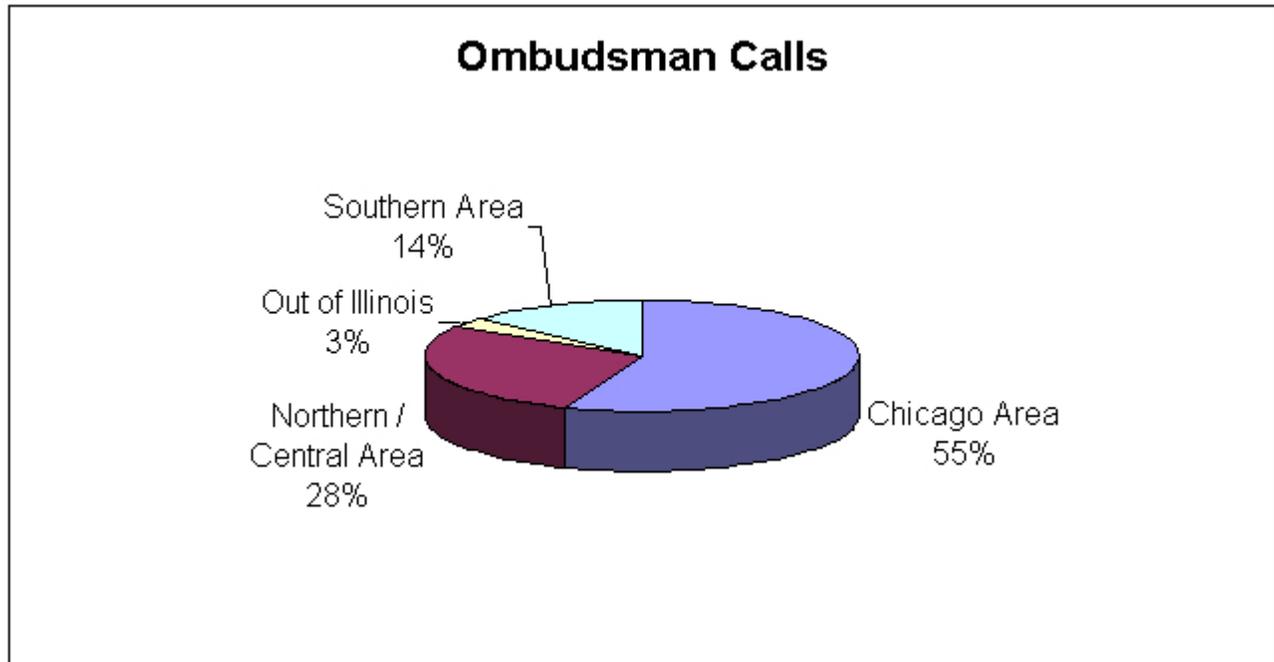
4. Uninsured Ombudsman Program

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

Since its inception, the Program has gathered information regarding resources that provide medical services to those who are uninsured and compiled that information into a database that is easily accessible to all staff. Information in the database includes resources for medical, dental, mental health, prescription drugs, vision and other health care needs and can be accessed by county and city. Information was gathered from the local and county Public Health Departments, as well as from various websites on the Internet. Information is continually added to the database by the Program and the database automatically refreshes if a website address contained therein is changed.

For Calendar year 2005, the Program handled 935 calls. As in previous years, 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. Continued efforts to increase the awareness of the Program included participating in the “National Cover the Uninsured Week Program”, being a guest on several radio and television talk shows; and attending the Illinois Primary Health Care Association (IPHCA) Conferences, Pre-Layoff Workshops, KidCare Conferences, the Third Annual Illinois Legislative Latino Caucus Foundation Conference, and numerous health fairs. The Ombudsman also served as a speaker for the Black Chamber of Commerce in Decatur, Illinois and was a round table participant at the Academy of Health. Goals for 2006 include increasing awareness about the Program and establishing a network with local organizations providing assistance to the uninsured.

The following page contains a breakdown by area of the Ombudsman calls received in calendar year 2005:



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**
2. The Illinois Health Insurance Portability and Accountability Act (HIPAA) of 1997 (P.A. 90-0030) required that health insurance companies desiring to discontinue selling all health insurance products in the individual, small employer, and large employer markets must provide proper notification to the Department of Insurance and the insureds. Between 1997 and 2004, the trend by health insurers to terminate business continued to rise. In 2005, there was little activity in this area and the market appears to have stabilized.
3. 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 prior to August 8, 2005 (see PA 94-0502 on page 24), 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 Illinois Comprehensive Health Insurance Plan (CHIP).

4. 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 12.
5. 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 442 companies actively selling accident and health insurance in Illinois. Still, if 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 continues to be the large number of uninsured both nationwide and in Illinois. In August, the U.S. Census Bureau released year-end numbers for the uninsured in 2004. According to the report, the ranks of the uninsured nationwide essentially remained the same at 15.7 percent compared with 15.6 percent in 2003. The trend was mirrored in Illinois where the number of uninsured residents decreased slightly to 14.2 percent of the state's population, down from 14.3 percent in 2003. 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 935 calls to the Uninsured Ombudsman in 2005. At the time this report is being issued, there are no clear indications that this trend will be altered for 2006 and beyond.

2. Employees Losing Group Health Coverage

In 2005, the number of calls to OCHI relating to employees losing their health insurance coverage increased, as did calls regarding the ability of employees to continue such coverage through the federal COBRA continuation health law or the various Illinois continuation health laws. In 2005, OCHI received 2,279 calls regarding continuation of group health coverage.

Employees lose their health insurance coverage for a variety of reasons, including layoffs, business closings or employer bankruptcy. A complete list of employer closing notifications by month can be viewed at the Department of Commerce and Economic Opportunity (DCEO) website

http://www.ildceo.net/dceo/Bureaus/Workforce_Development/WARN/

As reported in previous years, many employers are no longer offering retirees health insurance coverage and have terminated the retiree coverage for current retirees. This trend continued in 2005.

In response, the State has created a Rapid Response Team whose objective is to inform and educate the dislocated workers and retirees about the various services available to help ease their transition. In 2005, the Rapid Response Team received 105 notices of layoffs, closings or employer bankruptcies, affecting 15,031 workers. The Rapid Response Team held 230 workshops across Illinois, which were attended by 5,869 workers. The Rapid Response Team will continue its activities in 2006.

OCHI continues to actively work to provide information and answer questions regarding coverage options for retirees losing coverage. OCHI continues to stay abreast of the new Medicare changes that may be applicable to the retiree population by working with SHIP. OCHI also educates individuals who may be eligible for relief under the federal Trade Adjustment Assistance Reform Act (TAA). TAA 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.

TAA contains provisions that provide grants for high risk pools that meet certain criteria. The HIPAA-CHIP pool met the established criteria and has received \$15.6 million in federal grants over the two years of the grant program. A portion has been returned to the participants in the form of premium reductions of 6.6% in 2005 and 7.18% in 2006.

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, 2005, enrollment included 5,857 persons in Traditional ICHIP (Section 7) and 10,849 in HIPAA-CHIP (Section 15). The enrollment in the new TAA-CHIP plans represented 396 of the HIPAA-CHIP total.

4. Synopsis of State Planning Grant

In September 2000, Illinois received a \$1.2 million State Planning Grant (SPG) from the Health Research and Services Administration (HRSA) 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. SPG 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.

SPG 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. SPG provided for the expansion of the Behavioral Risk Factor Surveillance System (BRFSS). Also, funds from SPG were used to create a page on the Division's Internet site (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 Illinois. 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 current focus of SPG is developing ways for small employers (25 or less employees) to be able to provide coverage to their employees.

In January 2003, 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 General 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. The pilot program 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.

In September 2003, Illinois received an additional \$185,000 to continue with the development of the pilot project, including developing and designing a reinsurance pool model and continuing to develop and maintain the SPG website.

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 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 were requested to submit specific quantitative and qualitative information to the Department of Insurance – SPG for consideration.

Current Status of the Pilot Project

With the new funding, the expansion of the pilot began in Southern Illinois. The SPG contracted with HMA to continue with the community based, three-share concept for employer sponsored health coverage, with premium costs shared by the employer, employee and a community subsidy, which was used for the development of the St. Clair County Model.

The SPG also partnered with Southern Illinois Healthcare (SIH). SIH operates 3 hospitals and 13 healthcare facilities in Jackson, Franklin and Williamson counties. These counties are also the location for the expansion of the pilot program.

The reinsurance pool model that the SPG has been developing is basically a mechanism for disseminating high costs over a large population. This stabilizes the variances in the costs of health care from year to year and from group to group. The goal is to spread the risk for high cost individuals (those with illnesses or conditions that result in costly claims) and make health insurance more affordable for those individuals and/or the small employers that employ them. High cost individuals can cause the premium for a small group to increase significantly. When this happens the group's premium may become unaffordable forcing the employer to drop coverage for everyone.

Currently, our consultant, Donna Novak, is using a model/format that was developed by American Academy of Actuaries (AAA) and published in their 2004 Uninsured Guidebook. Using this format, Ms. Novak has entered data from our pilot project (St. Clair County 3-share model) and other similar projects in other states such as Maine's Dirigo project. This has allowed the comparison of several factors including benefit design, eligibility, costs, subsidies and the impact on the health insurance market (e.g. adverse selection, crowd-out, risk sharing, cost to states, impact on overall health costs, etc.).

The goal is to design a product that will compliment the SPG Pilot Program in St. Clair, Franklin, Jackson and Williamson counties and more specifically, to estimate the annual cost per person that would be borne by a reinsurance entity/pool. Once completed, policymakers can use the information to determine the viability of a small group health reinsurance pool as an option for increasing the availability of better insurance to small employers. The reinsurance pool model is expected to be completed by mid February 2006.

In March 2005, the Division, in concert with the Illinois Department of Public Health (IDPH), applied for and received a \$250,000 HRSA Limited Competition Planning Grant. The goal of the grant is two-fold:

1. Develop and promote a consensus on new policy options for expanding health care coverage in Illinois, as outlined in the Health Care Justice Act (Public Act 93-0973).
2. Develop a measurement tool that will evaluate the Illinois three-share model for providing health insurance coverage. The SPG will contract with the State Health Access Data Assistance Center (SHADAC) for assistance in design and implementation of an evaluation strategy.

The SPG along with the IDPH plans to engage academic research expertise from Illinois universities, health services research entities, and the state data and policy center to

synthesize data regarding the uninsured: analyze potentially viable policy options to address aspects of the Illinois uninsured and underinsured problem; and produce data and analysis reports suitable for publication, web distribution, and presentation at meetings and hearings of the Illinois Adequate Health Care Task Force, as well as at national meetings of HRSA-SPG grantees, the State Coverage Initiatives project, Academy Health, and similar forums.

The primary focus of SHADAC's contribution will be to complete the first phase by designing the evaluation of the expansion of the three-share plans into additional counties. The evaluation planning and implementation will be key considerations in the design and redesign of programs. The development of an evaluation design will be linked to program design wherever possible to facilitate the evaluative work to minimize conflicts among stakeholders.

3. Trends

1. Growth of Consumer Driven Health Plans

As in previous years, 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 administrators. 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 Division.

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 re-price 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 Preferred

Provider Organizations (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 re-pricing of claims, through non-directed provider networks, has left consumers struggling with collection activities of providers who believe that their fees 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 in the future.

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 lower overhead of mail order companies versus that of a pharmacy.

7. 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.

8. Cost Shifting to Employees

As the cost of employer sponsored group health insurance continues to rise, employers are looking for alternative to minimize their cost. One way employers are offsetting costs is by transferring more of the financial burden to employees. This is being accomplished by shifting benefit structures from flat copayment amounts to percentage coinsurance amounts, by increasing the amounts of copayments and deductibles, by limiting prescription drug benefits and by increasing the employee contributions for premiums.

2. Government Actions

1. Federal

5. Medicare Modernization Act

The Medicare Modernization Act (MMA), enacted in December 2003, made sweeping changes to the federal Medicare program, including offering prescription drug coverage to the Medicare population.

Enrollment for people with Medicare in the voluntary Medicare drug program (Medicare Part D) began November 15, 2005 and continues through May 15, 2006. Medicare drug plans will be offered by insurance companies and other private companies approved by Medicare. There are two types of Medicare plans

1. Medicare Prescription Drug Plans that add coverage to Original Medicare Plan, Medicare Private Fee-for Service Plans that don't offer Medicare prescription drug coverage, and Medicare Cost Plans.
2. Medicare prescription drug coverage that is a part of Medicare Advantage Plans (like HMO, PPO, or a PFFS Plan) and other Medicare Health Plans. Individuals

will receive all health care, including prescription drug coverage, through these plans.

6. Medicare prescription drug plans may vary, but **for standard coverage in 2006 enrollees will pay:**

1. a monthly premium (varies depending on the plan)
2. the first \$250 per year for drug costs. This is called the "deductible."

After the \$250 deductible, **enrollees pay:**

3. 25% of yearly drug costs from \$250 to \$2,250, and the plan pays the other 75% of these costs, then
4. 100% of the next \$2,850 in drug costs, then
5. 5% of the drug costs (or a small copayment) for the rest of the calendar year after \$3,600 out-of-pocket has been met. The plan pays the rest.

People with limited income and resources, may qualify for extra help to pay for their Medicare drug plan costs. Persons who don't enroll in Medicare prescription drug coverage when first eligible and later choose to enroll, in most cases, will pay 1% more a month in premium for every month eligible but not enrolled. This additional amount will be based on the current monthly premium at the time of enrollment. People with current drug coverage as good as or better than the standard Medicare prescription drug coverage will not pay this higher premium penalty.

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, 2006. The original benefits of the Act remain the same.

HIPAA Final Portability Regulations

On December 30 2004, the U.S. Department of Labor and other federal agencies published final regulations governing portability requirements for group health plans and issuers of health insurance coverage offered in connection with a group health plan. The rules implemented changes made to the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act enacted as part of the Health Insurance Portability and Accountability Act of 1996. While the final regulations did not greatly alter the interim regulations, they do mark the end to the multi-year process for encoding the federal requirements.

These final regulations became effective February 28, 2005 for plan years beginning on or after July 1, 2005.

2. State

House Bills (Full text of the Public Acts may be viewed at www.ilga.gov.)

0. **P.A. 94-0402 – Mental Health Illness**

House Bill 59 removed the sunset provision contained in the mental health mandate (December 31, 2005). The mandate requires coverage for serious mental illness in large group policies. Effective August 2, 2005.

1. **P.A. 94-0017 - Comprehensive Health Insurance Plan Act**

House Bill 197 amended the Comprehensive Health Insurance Plan Act to increase the threshold settlement amount for eligibility. The law now provides that a person is not eligible for coverage under the Comprehensive Health Insurance Plan if the person has received or later receives benefits or funds from a settlement, judgment, or award resulting from an accident or injury and the remaining amount exceeds \$500,000 (rather than \$100,000). Effective January 1, 2006.

2. **P.A. 94-0584 - Mental Health Illness**

House Bill 2190 revised the definition of serious mental illness to include post-traumatic disorders (acute, chronic, or delayed onset). Effective August 15, 2005.

3. **P.A. 94-0502 - Illinois Health Insurance Portability and Accountability Act**

House Bill 2375 provides that if a health insurance carrier elects to discontinue all individual health insurance coverage in the market in Illinois and in the case where the issuer has affiliates in the individual market, the issuer must give notice to each affected individual at least 180 days prior to the date of the expiration of coverage of the individual's option to purchase all other individual health benefit plans offered by the affiliate. The coverage is issued on a guaranteed basis if the individual applies no later than 63 days after the discontinuation of coverage. The issuer must provide notice to the Department, plan sponsors, participants, beneficiaries and covered individuals in the case where they uniformly modify, terminate, or discontinue coverage. Effective August 8, 2005.

4. **P.A. 94-0121 – Mammograms**

Senate Bill 12 amended the Illinois Insurance Code and the Health Maintenance Organization Act to require coverage of mammograms for women under 40 years of age with a family history of breast cancer or other risk factors at the age and intervals deemed medically necessary by the woman's health care provider. Effective July 6, 2005.

5. **P.A. 94-0122 – Ovarian Cancer Testing**

Senate Bill 521 amended the Illinois Insurance Code to require insurers to cover surveillance tests for ovarian cancer for female insureds that are at risk for ovarian cancer. The bill provides a definition for "at risk for ovarian cancer" and "surveillance tests for ovarian cancer". Effective January 1, 2006.

3. **Other State Actions**

0. **Infertility Mandate Regulation**

Effective September 9, 2004, the Department of Insurance amended the regulation for infertility coverage (50 IAC 2015). The amendments to the rule clarify benefits available under the Infertility Act and the rule put in place at the inception of the mandate. Issues addressed include:

1. Waiver of one-year waiting period for benefits in the event conception is impossible due to an existing condition, such as absence of ovaries;
2. Clarification of the definition of unprotected sexual intercourse;
3. Clarification of the completed oocyte retrieval limitation and clarification that the infertility benefit requirement is exhausted once the maximum completed oocyte retrievals have been received, regardless of the source of payment;
4. Clarification that medical expenses of sperm and egg donors must be covered and that the infertile couple may use a known donor, if one is available and that the completed oocyte retrieval for an egg donor shall count against the infertile recipient for purposes of benefit limitation;
5. Clarification of medical services for impregnation of a surrogate;
6. Clarification that reversal of voluntary sterilization is not covered, but that if such procedure is successful and the one-year waiting period is met, benefits for infertility are required;
7. Exclusion of infertility treatments rendered to minor dependents.

1. **Discretionary Clause Prohibition**

Effective July 1, 2005, the Department of Insurance amended the rule Construction and Filing of Accident and Health Insurance Policy Forms (50 IAC 2001). The Division had long held that discretionary clauses were prohibited under 215 ILCS 5/143. These clauses established a legal basis for companies to interpret ambiguous language in insurance contracts often to the detriment of the insured. With the introduction of the NAIC model relating to discretionary clauses and the continued attempts by insurers to get these products approved, the Division addressed this issue directly. The amendment is a simple prohibition on these clauses.

3. **Recommendations for Improvement To Health Insurance Regulation**

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. **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. These requirements would be similar to the requirements currently in place for the HMOs under the Managed Care Reform and Patient Rights Act.

4. **Emergency Care Reimbursement**

Currently 215 ILCS 5/370o 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 than if they had been treated by 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.

5. **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.

6. **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.

7. **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 whereas state continuation does not.

Possible remedy: Amend the Insurance Code to mirror the COBRA requirements.

8. **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.

9. **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 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.

10. 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.

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 Independant Review Summary 2004](#)