

Office of Consumer Health Insurance 2006 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 Illinois residents in 2006 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, health fairs, radio and television interviews, and the distribution of insurance fact sheets. Through these media, 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 residents who need assistance.

In assessing the overall state of the health insurance marketplace in Illinois, OCHI reviews 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 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, comparing options when buying health insurance coverage and providing information on non-insurance resources that are available throughout the state.

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 2006, OCHI's seventh year of operation, the office received 13,696 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 2006. 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 2006, 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 2005) shows the general summary of HMO complaints for 2005. [Exhibit 6](#) (HMO

Company Complaint Record – Classification Summary 2005) 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/healthCarePlan_complaints/HealthCarePlanComplaints04.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:

- 2,724 (41%) complaints were granted relief;
- 786 (12%) were granted partial relief;
- 817 (12%) received additional information; and
 - 2,339 (35%) received no relief.

[Exhibit 7](#) shows that HMO enrollees requested 71 external independent reviews that were completed by HMOs in the State of Illinois in 2005. Of these:

- 15 (21%) were granted relief;
- 0 (0%) were granted partial relief;
- 2 (.03%) received further information; and
- 54 (76%) had no change in status.

The reporting date for complaint data is March 1 for the previous year. Complaint data for 2006 will be addressed in the 2007 report.

The Department of Insurance office in Chicago also handles many telephone calls and visitors requesting information. From January 1, 2006, through December 31, 2006, the Chicago office handled 1,150 calls relating to health insurance complaints; 462 calls regarding general health insurance questions; 73 English-speaking visitors with health insurance questions; and 183 calls and 13 visitors requiring the services of a translator.

2. Educating enrollees about their health plan rights

As in previous years, several large and small employers declared bankruptcy in 2006, 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 Division's Senior Health Insurance Plan ([SHIP](#)).

The Division continues to create and provide "fact sheets" in response to questions received 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, and employer 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 sheets entitled, *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 2006 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](#)

[Mental Health Coverage - New 2006](#)

[Pre-Existing Conditions – HIPAA](#)

[Prompt Pay Law](#)

[Self-Insured Health Plans - New 2006](#)

[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.

Participation on radio talk-shows, participation at Rapid Response Meetings for dislocated workers who have lost insurance coverage, interaction with local agencies that provide services to Illinois residents, increased coverage by newspapers, and increased interaction with government officials, insurance agents and companies have all been helpful in raising consumer awareness about OCHI and the toll free telephone number. OCHI staff increased its availability as a regular guest on scheduled talk-radio programs around the state.

OCHI received calls from consumers regarding specific diseases or conditions and the financial burden that

resulted from the cost of treatment that was not covered by insurance. The internet served as a valuable resource for OCHI in its quest for information regarding specific health care related topics. Local agencies and public health offices were also helpful resources. In some instances, OCHI was able to provide or direct consumers to information regarding available resources.

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.

Status report of OCHI toll, free telephone number

OCHI received a total of 13,696 calls on its toll-free telephone line (877-527-9431) for calendar year 2006. Since its inception in 2000, OCHI has received approximately 108,600 phone calls.

Other duties as assigned by the Director

During the early years of OCHI, 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 1272 written inquiries in 2006. 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 175 Director email inquiries in 2006.

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 and continued to be high during 2006. 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 2,086 Medicare Part D calls in 2006.

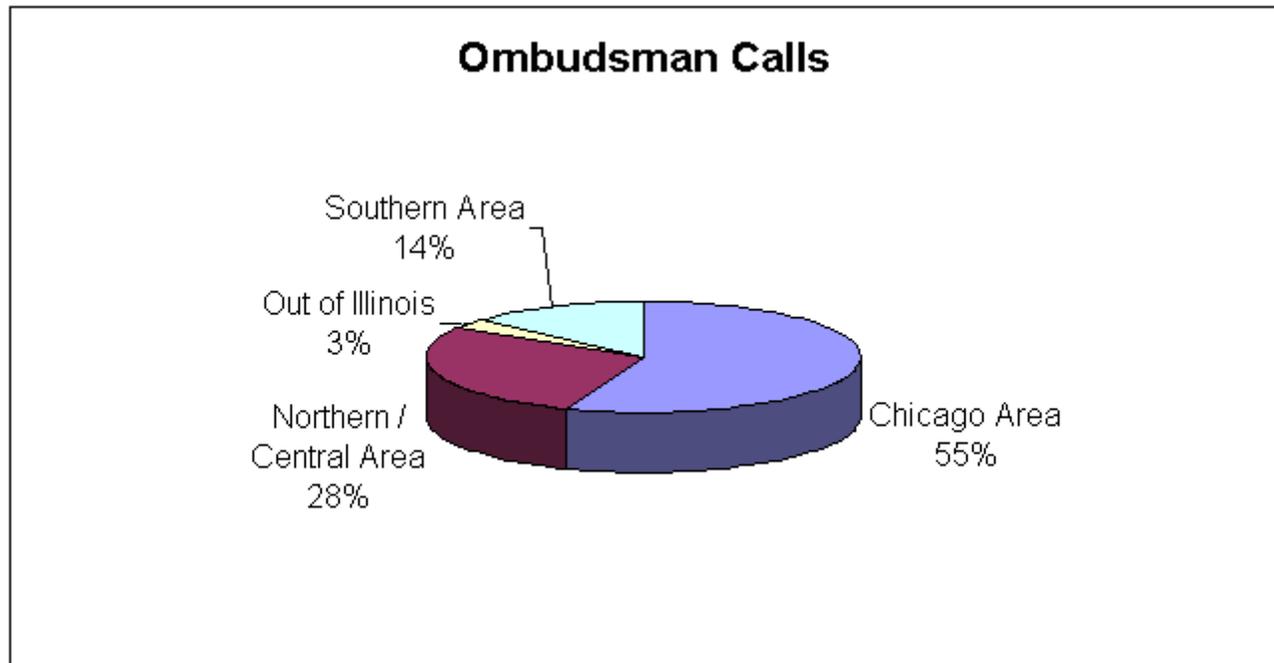
4. Uninsured Ombudsman Program

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 Actions and Recommendations For Improvements To Health Insurance Regulation

Market Status

1. Health Insurance Market Contraction

Insurance Companies Withdrawing from the Health Insurance Market

The Illinois Health Insurance Portability and Accountability Act (HIPAA) of 1997 (P.A. 90-0030) requires 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 and 2006, there was little activity in this area and the market appears to be stabilizing.

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 those individuals who are losing coverage, what options are available in order to ensure continued health coverage. Effective August 8, 2005, 215 ILCS 97/40(a)(iii) requires insurers leaving the individual health market provide notice to each affected individual, at least 180 days prior to the date of

expiration of coverage, of the individual's option to purchase all other individual health benefit plans that are offered by any affiliate of the carrier. 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). For a more complete description of CHIP, please refer to Section 2C of this report on page 13.

For persons losing individual coverage, there are few rights under HIPAA. For those individuals who cannot obtain other coverage on the open market due to health conditions, the options are limited to:

- applying for the standard CHIP coverage, which entails the reimposition of preexisting condition limitations;
- going without health coverage; or
- seeking employment with an employer that offers group health insurance as a benefit.

2. Health Insurance Availability

a. 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 2006, the U.S. Census Bureau released 2005 year-end statistics for the uninsured. According to the report, entitled *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, the percentage of people without health insurance coverage increased from 14.9% in 2004 to 15.3% in 2005. The percentage of uninsured individuals in Illinois remained at 14.2%, the same as 2004. 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 925 calls to the Uninsured Ombudsman in 2006. At the time this report is being issued, there are no clear indications that this trend will be altered for 2007 and beyond.

- **Employees Losing Group Health Coverage**

In 2006, the number of calls to OCHI relating to employees losing their health insurance coverage remained at nearly the same level as 2005, 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 2006, OCHI received 2,007 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 2006.

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 2006, the Rapid Response Team received 137 notices of layoffs, closings or employer bankruptcies, affecting over 19,640 workers. The Rapid Response Team held 78 initial on-site meetings and 200 pre-layoff workshops, which were attended by 4,643 affected workers.

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.

- **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 has received \$15.6 million in federal grants over the first two years of the grant program. A portion was returned to the participants in the form of premium reductions of 6.6% in 2005 and 7.18% in 2006. The High Risk Pool Funding Extension Act provided funding for a third year for which Illinois received almost \$4.2 million allowing premium reductions for calendar year 2007 of 5.08%.

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, 2006, enrollment included 5,823 persons in Traditional ICHIP (Section 7) and 10,768 in HIPAA-CHIP (Section 15). The enrollment in the new TAA-CHIP plans represented 374 of the HIPAA-CHIP total.

d. 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 (<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 participatory process resulted in three general areas being identified for priority consideration in specific strategy development:

COVERAGE OPTION A. FamilyCare: This option was to extend health benefits to parents of children covered through the state's All Kids (formally KidCare).

COVERAGE OPTION B. Incentives for Small Employers: Small employer incentives received a considerable amount of support throughout the Illinois Assembly process. This option continues to be an important component of the current activities of the State Planning Grant.

COVERAGE OPTION C. Education and Marketing of Insurance Programs and Products: There was also interest for increased education about both public and private insurance programs. The SPG has partnered with OCHI to provide ongoing information and education on public and private insurance programs, enrollment issues and processes.

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.

Completion of an eligibility and benefits package for the St. Clair County project occurred from June of 2003 to September 2004. A carrier was selected and a 501 (c) (3) not for profit entity, Southern Illinois Health Care Access, Inc., (SIHCA) was established. SIHCA will provide the framework for administering the plan and will be responsible for marketing the plan, enrollment, network management, claims adjudication and subsidy administration. The final component before launching the program will be securing the public financing mechanism, which will be the "third share"/community share of the 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 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.

With the new funding, the expansion of the pilot began in Southern Illinois and in McLean County (Bloomington), based on the three-share concept used in the St. Clair County Model.

Progress in Southern Illinois – Jackson, Franklin and Williamson Counties

- The SPG partnered with Southern Illinois Healthcare (SIH), which operates 3 hospitals and 13 healthcare facilities in Jackson, Franklin and Williamson counties;
- Eligibility and benefit packages were completed;
- A carrier was selected;
- A 501(c) (4) not for profit entity was established (Healthy SI), which will provide the framework for administering the plan and be responsible for marketing the plan, enrollment, network management, claims adjudication and subsidy administration;
- The final component before launching the program will be securing the public financing mechanism, which will be the "third share"/community share of the project.

Progress in Bloomington

- SPG partnered with representatives from the City of Bloomington and the McLean County Health Department for the development of a three share program;

- Eligibility guidelines have been designed;
- Benefit package is in the design process.

The financing mechanism for the “community share”/third share for the St. Clair County and the Jackson, Franklin and Williamson County projects will be to make additional funds available to public Medicaid providers through a Certified Public Expenditure (CPE) process. CPEs allow Medicaid providers who are funded with non-federal tax dollars to be reimbursed using local tax dollars to cover for the costs of providing care to Medicaid eligible patients. Although Medicaid reimburses providers for providing medical care to eligible patients, the program’s reimbursement rates are often lower than the costs that providers incur in providing these services. As a result, public providers use local tax dollars to finance some of the costs of providing Medicaid services. Since Medicaid allows local dollars to be used as the state’s share of Medicaid financing, the amount of local tax funds used to pay for Medicaid services can be certified in financial reports to the federal government as state share dollars to draw down additional federal matching funds for public entities. Public entities can use these funds as they choose, including using them to finance the public subsidy portion of Three Share.

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.

The goal was to design a product that will compliment the SPG Pilot Program in St. Clair, Jackson, Franklin 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.

Current Status of the Pilot Project

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 design and evaluation of the expansion for the three-share plans in St. Clair, Jackson, Franklin and Williamson counties as the 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.

The focus of the activities of the State Planning Grant has been to remain faithful to the ideals, goals and recommendations of the individuals who served as members of the Illinois Assembly on the Uninsured. Especially, as the SPG seeks to find creative and innovative solutions to reducing the number of uninsured in Illinois.

3. Trends

a. PPO Plans Low Reimbursement for Non-Contracted Providers

PPO plans pay the optimum benefit to the insured when a preferred provider is utilized. The PPO plan does allow the insured the flexibility to use non-participating providers; however, this flexibility is increasingly very costly to consumers. Many PPOs now pay non-participating providers based upon the negotiated rate that would have been paid to a participating provider had one been used.

For example, suppose a PPO policy pays 70% for non-participating surgeon charges and the insured incurs a bill for \$5,000 from a non-participating surgeon. A preferred provider has agreed to a contractual rate of \$2,000 for the service in question. Using the contracted or negotiated rate as a basis for payment, the insurer will pay 70% of \$2,000 (\$1,400) for the surgery. The insured will incur out-of-pocket expenses in the amount of \$600.00 for the 30% copayment and another \$3,000 for the amount over the contracted rate. Note that the \$3,000 does not accrue to the insured's out-of-pocket maximum on the policy.

Another fee methodology being used by some insurers is payment for non-participating provider claims based on a percentage (for example 200%) of the Medicare published rate for the same or similar service. This methodology can result in very low reimbursement of the non-participating provider claim because Medicare rates are relatively low rates established by the federal government for payment of Medicare claims.

The Division is experiencing increased complaints regarding the methodologies being used by PPO plans to pay non-participating providers. The plans are required by law (215 ILCS 356z.2) to include prominent disclosure in the policy regarding the limited benefit available when using non-participating providers; however, the consumer is genuinely surprised at the low payments by these plans.

- **Discount Plans**

Illinois currently has approximately 200 active Preferred Provider Administrator (PPA) licenses, covering in excess of 30 million lives. Approximately half of these entities report offering health care services on a discounted basis. Despite this statistic, the Division continues 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, leading 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”. While it is true that preferred provider administrators are not insurance companies, they still are required to be registered with the Division.

The Division continues to address this issue, which is national in scope.

- **PPO Plans Accessing Inappropriate Provider Discounts**

The Division continued to receive complaints in 2006 regarding PPO Plans that either accessed discounts to which they are not entitled or accessed discounts through networks other than those approved by the Director and published on the Division’s PPO Provider Network website. In both cases, plans inappropriately accessed health care providers and their discounts. For the consumer, their health care dollar goes to pay for a delivery system that does not exist or they participate in a provider fee repricing scheme whereby the payor, not the member, benefited from discounts taken. For the provider, a plan may access discounts through a contractual relationship with a third party, of which the provider is not given proper notice, nor provided contractual consent. The Division continues to address this issue, which is national in scope.

- **Non-Directed Provider Networks By Indemnity Plans**

As the insurance industry struggles to address the ongoing challenge of containing escalating health care costs, it has 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.

- **Consumer Driven Health Plans – Health Savings Accounts**

Rising costs for health insurance benefits are causing employers to search for new methods to control costs and still provide quality health benefits to employees. The most common Consumer Driven Health Plan (CDHP) has been a catastrophic (high deductible) insurance plan combined with a health care spending account such as a Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA).

The use of the HSAs appears to be an increasing trend in the Illinois marketplace. The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 (P.L. 108-173) added Section 223, Health Savings Accounts, 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. Employers and employees may contribute to the HSA account.

The money from the account may be used for some permitted first dollar benefits such as preventive care and it may be used to satisfy the deductible for the catastrophic insurance policy. Any money in the account at the end of the contract year carries over to the next year and is the employee's to keep, even upon retirement. HDHPs are believed to provide more flexibility and discretion to the consumer over how health care benefits are utilized.

HRA accounts are similar. Under an HRA, the employee is prohibited from contributing to the account by IRS rules. Only the employer may contribute to the HRA account. Also, an individual on Medicare or with other health coverage may enroll in a HRA account but may not enroll in a HSA account. Under IRS rules; if the individual becomes eligible for Medicare or other health coverage after enrolling in a HSA account, that individual may no longer contribute to the HSA account.

- **Mail Order Programs for Prescription Drugs**

Many insurers, large employers and state and local governments are requiring the use of mail order drug programs for maintenance prescription drugs. The use of these programs saves money for the employer, insurer and insured, due to the quantities involved and the lower overhead costs incurred.

- **Retiree Benefits**

In an effort to help control the rising cost of employer sponsored health coverage, many employers are increasing premiums, increasing cost sharing, reducing benefits or terminating retiree health coverage. According to the Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace Report* of 2004, the premiums for retiree coverage increased 13% in 2003. The retiree contributions increased 27% during that time period. The percentage of firms offering retiree health coverage has decreased to 33% in 2005, down from 66% in 1988. Illinois has witnessed this trend as well. As noted earlier in this report, The Ombudsman for the Uninsured, in partnership with the Illinois Rapid Response Team, conducts meetings for retirees of employers who have terminated health benefits to retirees or significantly increased the costs of health benefits for retirees.

- h. **Cost Shifting to Employees**

As the cost of employer sponsored group health insurance continues to rise, employers are looking for alternatives to minimize their cost. Costs of health care coverage are being shifted to employees through (1) increased premium share, (2) increased deductibles and copayments, (3) copayments being accessed as percentages instead of flat dollar amounts, and (4) limiting prescription drug benefits.

Government Actions

B. GOVERNMENT ACTIONS

1. Federal

- a. **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.

The annual enrollment for people with Medicare in the voluntary Medicare drug program begins November 15 and runs to December 31 each year. Medicare drug plans will be offered by insurance companies and other private companies approved by Medicare. There are two types of Medicare plans:

- Medicare Prescription Drug Plans that add coverage to Original Medicare Plan, Medicare Private Fee-for-Service Plans (PFFS) that don't offer Medicare prescription drug coverage, and Medicare Cost Plans.
- 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.

Medicare prescription drug plans may vary, but for standard **coverage in 2007 enrollees will pay:**

- A monthly premium (varies depending on the plan)
- The deductible which is from \$0 to \$265 per year.

After any applicable deductible, enrollees pay:

- 25% of yearly drug costs up to \$2,400 and the plan pays the other 75% (this is known as the initial coverage phase).
- 100% of an additional \$3,051.25 in drug costs (this is the coverage gap phase), then
- 5% of the drug costs (or a small co-payment) for the rest of the calendar year. This occurs after \$5,451.25 in drug costs and is known as the catastrophic phase. To be in the catastrophic phase, a beneficiary will have incurred \$3,850 in True Out of Pocket expenses, (TrOOP). Once the catastrophic phase occurs, the plan pays 95% for the rest of the calendar year.

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 national average premium at the time of enrollment and will be re-calculated every year. People with proof of creditable drug coverage, will NOT pay this higher premium penalty.

b. 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, 2007. The original benefits of the Act remain the same.

- **HIPAA Final Rules on Health Nondiscrimination**

On December 13, 2006, the U.S. Department of Labor and other federal agencies published the final regulations governing nondiscrimination 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. The final rules also provide guidance on the implementation of wellness programs.

These final regulations will be effective on the first day of the plan year beginning on or after July 1, 2007. For calendar year plans, the new rules generally apply beginning January 1, 2008.

2. State - Public Acts

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

- **P.A. 94-0858 Firemen's continuance privilege: enforcement provision.**

Senate Bill 2375 adds a new paragraph at the end of 215 ILCS 5/367f that serves as an enforcement provision for the Department of Insurance. Effective June 15, 2006.

b. P.A. 94-0906 Coverage for Autism

House Bill 4125 amends the serious mental illness provision in 215 ILCS 5/370c.(4)(A) by adding a subparagraph (iii) to provide for an additional 20 outpatient visits for speech therapy for the treatment of pervasive developmental disorders that is above and beyond the benefit required by (ii) of this subsection. The legislation also adds reference to 215 ILCS 5/370c in the HMO Act. Effective January 1, 2007.

c. P.A. 94-00921 Serious Mental Illness

House Bill 4202 amends 215 ILCS 5/370c(4)(A)(ii) by expanding the number of outpatient visits for serious mental illness from 35 to 60. Effective June 26, 2006.

- **P.A. 94-1037 Military service member: insurance reinstatement**

Senate Bill 916 adds a new section, 215 ILCS 5/368f, to the Insurance Code by stipulating that no Illinois resident who is activated for military service (and no spouse or dependent of that resident), and who becomes eligible for a federal government-sponsored program, may be denied reinstatement to that same individual coverage with the health insurer after discharge unless discharge is due to other than honorable conditions. A request for reinstatement must be received no later than 63 days after deactivation or loss of coverage under the federal government-sponsored program. Effective July 20, 2006.

e. SB 2917 Multiple sclerosis preventative physical therapy

Amended the insurance code to require insurers to cover medically necessary preventative physical therapy for insureds diagnosed with multiple sclerosis to the extent the physical therapy is prescribed by a physician and includes reasonably defined goals. Coverage is subject to same physical therapy benefit as provided for other conditions under the policy.

3. Other State Actions -Division Regulations

a. 50 IAC 5421, Health Maintenance Organization, effective 03/02/06

This amendment requires that all capitated provider agreements between HMOs and MCOs contain provisions whereby (1) the MCO agrees to fully cooperate and disclose information to the HMO's actuaries; (2) the HMO acknowledge that in the event of the MCO's insolvency, the HMO has certain obligations as expressed under the definition for "Health care plan" in section 10 of the Managed Care Reform And Patient Rights Act [215 ILCS 134/10]; and (3) the MCO agrees to hold the enrollee harmless for unpaid provider services, so that enrollee is not held liable for such payments.

b. 50 IAC 2025, Illinois Health Insurance Portability and Accountability Standards, effective 02/15/2006

The Illinois Health Insurance Portability and Accountability Act sets forth requirements for companies to renew individual and group policies. This rule provides uniformity for health insurance issuers by defining notice requirements, as well as requirements for modification; termination; discontinuance and rescission provisions to which all health insurance issuers must adhere.

Recommendations for Improvement To Health Insurance Regulation

C. RECOMMENDATIONS FOR IMPROVEMENTS TO HEALTH INSURANCE REGULATION

1. Illinois Covered

Governor Blagojevich's "Illinois Covered" proposal, introduced as Amendment 1 to Senate Bill 5 on March 30, 2007, would bring needed change to health insurance regulation in Illinois. The regulatory improvements found in the Illinois Covered legislation include: 1) affordable and accessible coverage for individuals and small business through the Covered Choice and Covered Rebate programs; 2) creation within the Department of Insurance of an Office of Patient Protection, which will enforce health insurance consumer protection laws and help consumers understand the coverage for which they paid; 3) expanded coverage options for dependents covered under a group insurance policy or HMO contract; 4) a requirement that employers with more than 10 employees maintain a cafeteria plan that complies with Section 125 of the Internal Revenue Code; 5) additional transparency and legal rights for consumers challenging a claim denial through the internal or external

independent review process, including expansion of the external independent review process to insurance companies and protections specific to those with denied mental health claims; 6) new health insurance application regulations that will bring more certainty and fairness to the application process.

For more detailed information about the Illinois Covered proposal, including the specific reforms listed above, see Amendment 1 to SB5, 95th General Assembly.

2. In Network Payment of Ancillary Providers

Many ancillary providers (radiologists, anesthesiologists, pathologists, emergency room physicians) will not contract with a managed care plan (HMO or PPO) for inclusion in a provider network. HMOs are required to pay these providers at the billed rate due to the fact that the HMO must provide Basic Health Care Services, which includes the services rendered by these providers.

More and more PPO plans are paying these providers at the non-preferred benefit level, even though the services are provided at a PPO hospital and directed by a PPO primary care physician and the patient has no control over the ancillary provider utilized. In many instances, there is no contracted ancillary provider available. This results in very low payment for these claims when the insured has made every effort to properly utilize the PPO network for optimum benefit. When a PPO pays the out-of-network benefit based on network contractual amounts (for example, pays 60% of what a preferred provider would have accepted), this results in out-of-pocket expenses in excess of 80% in some cases for these bills. For example, a non-contracted ancillary provider charges \$100.00 for a service and the benefit is 60% for out-of-network benefits. The plan may determine that the service would have been discounted to \$50.00 for a preferred provider, so the plan pays 60% of the \$50.00 or \$30.00, leaving a balance of \$70.00 for the consumer.

POSSIBLE REMEDY: Require charges for ancillary services to be paid at no greater out-of-pocket expense than would have been incurred had the beneficiary utilized a preferred provider when the beneficiary/insured has the basic service performed by a preferred provider at a PPO hospital or facility.

3. External Independent Review

Illinois law does not require insurance companies to have an external independent review process. The insurance company determines medical necessity, including whether or not a treatment is experimental. The Division does not have the medical expertise or the legal authority to review medical records and overturn or affirm determinations made by the insurer. The only remedy for the consumer in this situation is to pursue the matter through the courts, which is costly and time consuming.

POSSIBLE REMEDY: Amend the Insurance Code to require group and individual accident and 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 (215 ILCS 134/45).

Governor Blagojevich adopted this recommendation, along with other necessary and important changes to

internal and external independent review processes, in his Illinois Covered proposal, which was introduced as Amendment 1 to Senate Bill 5 on March 30, 2007.

4. Emergency Care Reimbursement

Currently 215 ILCS 5/370(o) 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 and claims payments are increasingly based on what a contracted provider would have accepted. One specific complaint resulted in out-of-pocket expense in the amount of \$21,687.57 for an insured for billed charges that totaled \$29,899. The charges were paid at 100% of the amount that would have been paid to a preferred provider. The Division does not believe this was the intent of 215 ILCS 370(o).

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 require that out of pocket costs incurred by an insured or enrollee who receives emergency care from an out-of-network provider will be no greater than if treatment had been rendered by a preferred provider.

5. Medicare Supplement Insurance for Under Age 65 Disabled

Under federal Medicare law, persons age 65 and older, and those under age 65 with certain disabilities, are qualified to enroll in Medicare. However, Medicare beneficiaries under age 65 disabled do not have the same rights as Medicare beneficiaries age 65 and older with regard to purchasing a Medicare Supplement policy. 50 IAC 2008.74 requires an open enrollment period of six months for individuals turning age 65 and enrolling in Medicare Parts A and B. There is no such requirement for Medicare beneficiaries who are under age 65 disabled. There are only two companies in Illinois that sell to the under age 65 disabled population, and those applications are subject to underwriting requirements.

POSSIBLE REMEDY: Amend 215 ILCS 5/363 to mandate availability of Medicare Supplement coverage for Medicare Under age 65 beneficiaries by requiring companies that sell Medicare supplement policies for persons age 65 and older to also sell those policies to Medicare Under age 65 disabled beneficiaries. An open enrollment period of six months from the first day on which the person enrolls for benefits under Medicare Part B or from receiving notification of retroactive eligibility from the Social Security Administration should be required. Guarantee issue requirements should be applied during the six-month open enrollment period.

6. Notification of HIPAA-CHIP

Currently when an employer terminates the group health plan and does not replace it, or when COBRA or State Continuation rights have been exhausted, there is usually no notice sent to the affected individual regarding Section 15 HIPAA-CHIP. This Section provides coverage to individuals who have lost group coverage and exhausted continuation coverage and are uninsurable on the open market due to health conditions. Section 15 HIPAA-CHIP does not impose a waiting period or pre-existing condition limitations. Under Section 15 HIPAA-CHIP, an Eligibility and Enrollment Form must be received by the CHIP Board Office within 90 days after the

termination of coverage. Individuals who are not aware of this option shop the open market for coverage and those individuals who are uninsurable are declined coverage. The declination letter contains CHIP notification but unfortunately, the deadline for HIPAA-CHIP has passed by that time and coverage is not available.

POSSIBLE REMEDY: Mandate notice of HIPAA CHIP by employers and insurance companies when group coverage is being terminated without replacement coverage or when COBRA or State Continuation rights have been exhausted.

7. State Continuation Law – Anticipation of Divorce

The state spousal continuation law (215 ILCS 367.2) requires that continuation of group coverage be offered to the spouse upon legal judgment for dissolution of the marriage. In many instances, the employee removes the spouse from insurance prior to the legal judgment for dissolution of the marriage. This action eliminates the spouse's right under the Spousal Continuation law. COBRA has protections for such events whereas state continuation does not.

POSSIBLE REMEDY: Amend the Insurance Code to mirror the COBRA requirements.

7. State Continuation Laws – Lack of Employer Cooperation

The state continuation laws require certain action by employers to ensure affected individual are provided health insurance continuation rights. For example, the State Continuation law (215 ILCS 367e) requires employers to notify employees of health insurance state continuation rights upon termination of the employee's employment. The Spousal Continuation law (215 ILCS 367.2) requires that the spouse notify the employer or the insurance company of the request for continuation. The Dependent Continuation law (215 ILCS 367.2-5) requires the dependent or the responsible adult to notify the employer or the insurer. In some instances, the employer refuses to cooperate. The Department of Insurance does not have regulatory authority over the employer and, in some instances, the insurance company will not assist when this situation occurs. 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, which requires exhaustion of continuation in order to be eligible.

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

8. Insurer Audits of Paid Claims

In 2006, 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. The Division does not dispute the insurer's right to recover monies that have been paid in error; however, a reasonable time limit should be imposed. The Division has received complaints wherein the claims being recovered are so old that the provider no longer has current patient records and cannot locate the patient to recover the money.

POSSIBLE REMEDY: The current law (215 ILCS 5/368d) should be amended to require a specific time frame (such as 2 years) within which a recoupment may be requested.

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 2005](#)
6. [HMO Company Complaint Record -- Classification Summary 2005](#)
7. [HMO Independant Review Summary 2005](#)