

**Office of  
Consumer Health Insurance  
2009 Annual Report**



# Illinois Department of Insurance

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**PAT QUINN**  
Governor

**Michael T. McRaith**  
Director

January 31, 2010

**To:** Pat Quinn, Governor  
Michael T. McRaith, Director of Insurance  
Honorable Members of the General Assembly

**From:** The Office of Consumer Health Insurance/Uninsured Ombudsman

**Re:** The Office of Consumer Health Insurance 2009 Annual Report

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The Office of Consumer Health Insurance (OCHI) is pleased to submit its 2009 Annual Report as required by the Managed Care Reform and Patient Rights Act (215 ILCS 134/90).

OCHI has completed ten full years of operation within the Department of Insurance and continues to act as an essential resource for consumers with health insurance questions and as a valuable ally for individuals and businesses seeking health insurance.

We anticipate continued success in the upcoming years and value any comments or suggestions you may have.

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## PREFACE

Established on January 1, 2000, by the Managed Care Reform and Patient Rights Act, the Office of Consumer Health Insurance (OCHI) operating within the Illinois Department of Insurance (Department) continued to serve Illinois residents in 2009 by responding to their health-related inquiries. In 2009, OCHI was staffed by four insurance analysts, including one analyst who spent over 50% of the time traveling and representing OCHI and the Uninsured Ombudsman to the public.

The responsibilities of OCHI, as set forth by the Managed Care Reform and Patient Rights 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 a toll-free, consumer inquiry telephone number and through other outreach mechanisms including speaking engagements, health fairs, radio and television interviews, and the distribution of consumer-friendly fact sheets. Through these media, OCHI helps consumers understand 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 specific recommendations to address those problems.

In 2002, the Department expanded the OCHI mission to include the administration of the Uninsured Ombudsman Program (Ombudsman) 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 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 available throughout the state.

## EXECUTIVE SUMMARY

The Managed Care Reform and Patient Rights Act (215 ILCS 134/1 *et seq.*) established the Office of Consumer Health Insurance (OCHI) in January 2000. In 2009, OCHI's tenth year of operation, OCHI received 20,785 calls (increased from 14,229 calls in 2008 and 10,750 since its inception in 2000) and provided consumers with a broad range of health coverage information. OCHI staff also performed outreach activities, including assisting health insurance consumers at the State Fair and providing information on various radio and television talk programs.

Section 1 of this report describes the types of calls received by OCHI and the kinds of assistance provided to callers.

Section 2 describes the various activities of the OCHI staff, including steps taken to educate consumers about their health plans, and the production of consumer fact sheets made available on the Department's internet site.

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

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

Section 5 contains information about the status of the state's health insurance marketplace, government actions affecting health coverage options, and recommendations for improving health insurance regulation.

Section 6 contains the Report's exhibits.

## 1. Helping Consumers Understand 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 2009. Calls came from a variety of individuals and groups, including consumers, employers, agents, associations, attorneys, health care providers, and advocacy groups.

OCHI provides the information and education that consumers need to understand their health coverage. OCHI staff often help consumers define in practical terms the meaning of complex, insurance-specific words and phrases. OCHI staff also explain differences between rights and benefits available in individual, small group, and large group insurance products, and related rights guaranteed by the Health Insurance Portability and Accountability Act (HIPAA)(215 ILCS 97/1 *et seq.*). Consumers are also provided plan-specific information, including continuation of coverage options. In addition to providing one-on-one consumer consultations, OCHI also refers consumers to the Department of Insurance (Department) internet site (<http://www.insurance.illinois.gov/>), enabling them to learn more about a particular topic from one of the Department's many user-friendly fact sheets.

In 2009, OCHI received calls requesting information on many topics, including information about new laws passed by the Illinois General Assembly and how to:

- obtain approval for a particular medical service or approval of benefits for a particular medical service;
- understand and file appeals with the health plan;
- appeal a claim denial for pre-certified services;
- request an external independent review with HMO plans; and
- file a complaint with the Department of Insurance.

OCHI guided HMO enrollees with denied claims as the enrollees initiated the external independent review process, a process mandated by the Managed Care Reform and Patient Rights Act. Among other things, OCHI staff explained the information needed by the independent reviewer, the relevant time periods, and the role played by the patient's primary care physician.

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. Exhibit 5 (HMO Company Complaint Record – General Summary 2008) contains a general summary of HMO complaints for 2008. Exhibit 6 (HMO Company Complaint Record – Classification Summary 2008) contains a listing of HMO complaints by category. Exhibit 7 (HMO External Independent Review Summary 2008) is derived from Exhibits 5 and 6 and provides specific information relating to external independent reviews. The external independent review data found in Exhibit

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7 is provided by the plans and is not independently verified by the Department. These exhibits may be accessed through the Department's website at

[http://www.insurance.illinois.gov/Complaints/healthCarePlan\\_complaints/CompanyComplaint2008.pdf](http://www.insurance.illinois.gov/Complaints/healthCarePlan_complaints/CompanyComplaint2008.pdf)

and

[http://www.insurance.illinois.gov/Complaints/healthCarePlan\\_complaints/ExternalReview2008.pdf](http://www.insurance.illinois.gov/Complaints/healthCarePlan_complaints/ExternalReview2008.pdf)

As detailed in Exhibit 5, during calendar year 2008, HMOs reported a total of 4,793 complaints, of which 403 (8.5%) were also filed with the Department. According to data submitted by the companies and displayed in the "Disposition of ALL Complaints" section of Exhibit 5, of the 4,793 total complaints:

- 1,835 (38.3%) complaints were granted relief;
- 207 (4.3%) were granted partial relief;
- 1,249 (26%) received additional information; and
- 1,502 (31.3%) received no relief.

Exhibit 7 shows that HMO enrollees requested and received 85 external independent reviews of claims denied by Illinois HMOs in 2008. Of the 85 external independent reviews:

- 11 (13%) were granted relief;
- 3 (3%) were granted partial relief;
- 0 (0%) received further information; and
- 71 (84%) had no change in status.

The reporting date for 2009 complaint data is March 1, 2010. Complaint data for 2009 will be addressed in the 2010 report.

## 2. Educating Enrollees About Their Health Insurance Rights

As in previous years, several large and small employers declared bankruptcy or laid off employees in 2009, generating many calls to OCHI regarding federal COBRA and Illinois laws granting rights to continue group coverage. Questions about continuation rights continued to be the major topic of concern for OCHI callers, totaling over 4,600 calls.

The federal American Recovery and Reinvestment Act (ARRA), signed by President Obama on February 17, 2009, provided a subsidy that reduced by 65% the cost of COBRA and other state continuation coverage for workers who lost their jobs. Illinois subsequently amended the state continuation law (Public Act 096-0013) to extend all rights provided by ARRA to those individuals in small employer groups (less than 20 employees). The law created a second election period for those individuals who lost group coverage due to involuntary termination that took place after September 1, 2008 and who did not have continuation coverage in effect as of June 18, 2009. OCHI staff communicated the most up-to-date information regarding both laws to over 1,250 callers.

OCHI referred over 1,000 callers to the Illinois Comprehensive Health Insurance Plan (CHIP), the state health benefits program established to provide coverage to Illinois residents who cannot otherwise obtain insurance due to preexisting health conditions. CHIP provides coverage under the Traditional CHIP pool for residents who do not have creditable coverage or who do not otherwise qualify under HIPAA. CHIP also provides coverage to federally eligible individuals as Illinois' HIPAA alternative mechanism for individual health insurance coverage. [215 ILCS 105/1 *et seq.*]

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 employer-sponsored health coverage due to trade-related job losses.

Many retired workers asked OCHI staff about purchasing or otherwise coordinating other health coverage with Medicare. After providing the retired workers with basic information on guaranteed issue Medicare supplement coverage offered by standard insurers, OCHI staff referred the retired workers to the Department's Senior Health Insurance Plan (SHIP).

OCHI staff fielded over 4,100 calls related to general group and individual health insurance questions including but not limited to:

- Pre-existing condition limitations;
- Creditable coverage under HIPAA;
- Applicability of mandates to policies;
- Interpretation of benefits contained in the policy;

- Coordination of benefit provisions and applicable laws;

Claim problems continued to be the major concern for callers to the OCHI hot-line. OCHI staff assisted over 2,750 callers by discussing claim problems, advising of appeal procedures, directing to the proper agency(if applicable) and providing guidance for filing complaint with the Department.

A new law effective June 1, 2009 ([Public Act 95-0958](#)) provided parents with insurance policies that cover dependents the right to elect coverage for qualifying dependents up to age 26 and up to age 30 for military veteran dependents. OCHI staff assisted nearly 2,000 callers seeking information about various complexities of the new law.

OCHI, in conjunction with the Department, continues to create and provide fact sheets in response to questions received from Illinois consumers. These fact sheets, which effectively explain complex insurance issues important to consumers, are available on the Department's website ([http://insurance.illinois.gov/Main/Consumer\\_Facts.asp](http://insurance.illinois.gov/Main/Consumer_Facts.asp)). For callers unable to access this information via the internet, requested materials were mailed.

OCHI staff gave presentations to a variety of organizations including consumer organizations, community development organizations, and employer organizations. An OCHI representative also spoke on several radio talk shows.

Occasionally, calls to OCHI require the services of a translator. The OCHI office can generally provide a translator for consumers who need this service.

The following is a list of health insurance related consumer fact sheets and other information currently available on the Department's Internet site.

- Acronyms for Life, Accident & Health Insurance and Managed Care
  - Autism - Insurance Coverage
  - Beware of Fraudulent Insurance Companies
  - Birth Control
  - Cancer
  - Claim Denial - What To Do If an Insurer Denies Your Claim
  - COBRA – Federal Subsidies Under Stimulus Plan
  - Contact the Proper Agency – Where to File Medicare, Medicaid and Other Health Plan Complaints
  - Continuation Rights - COBRA
  - Continuation Rights - Illinois Law
  - Continuation Rights - Illinois Spousal Law
  - Continuation Rights - Dependent Children
  - Continuation Rights - Municipal Employee
  - Coordination of Benefits (COB)
  - Dependent Child Coverage Fact Sheet - HB 5285
  - Diabetes
  - Disability Income Insurance
  - Finding a Reputable Insurance Company – Using Financial Rating Agencies
  - Getting off to a Good Start with Medicare
  - HIPAA - Preexisting Conditions
  - Health Insurance for Small Employers
  - Health Maintenance Organizations (HMOs)
  - Individual Accident and Health Insurance - Frequently Asked Questions
  - Individual Major Medical Insurance
  - Infertility Treatment
  - Insurance Guaranty Associations
  - Insurance Coverage for College Students
  - Making the Claims Process Easier
  - Managed Care Reform and Patient Rights Act
  - Mandated Benefits, Offers, and Coverages for Accident & Health Insurance and HMOs
  - Maternity Benefits in Illinois
  - Medical Necessity
  - Medicare Supplement Insurance
  - Mental Health Coverage
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- Newborn Children
- Prompt Pay Law
- Self-Insured Health Plans
- Senior Health Insurance Program
- 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/ Status Report of OCHI Toll-Free Telephone Line**

OCHI continues to use new venues and technologies to reach consumers and consumer groups, and continues to perform valuable research for consumers seeking answers to general and specific health insurance questions.

Awareness of OCHI services has been promoted in various ways, including: speaking on radio talk-shows and with local newspapers, taking part in Rapid Response Meetings for dislocated workers who have lost insurance coverage, coordinating with local agencies that provide services to Illinois residents, and actively engaging government officials, insurance agents, and insurance companies.

OCHI receives calls from consumers regarding the entire spectrum of health coverage issues, issues that often concern specific diseases or conditions and the related financial burdens faced by those who are uninsured or underinsured. To provide answers to consumer questions, OCHI staff is trained to understand relevant sections of the Illinois Insurance Code and the Illinois Administrative Code. General familiarity with certain federal laws and regulations (e.g., the Employee Retirement Income Security Act (ERISA) and COBRA (federal health coverage continuation rights)) is also a necessity. Given the unique coverage questions and challenges faced by consumers, particularly relating to disease specific mandates, OCHI staff utilize additional resources, including the Internet and other state and local agencies (e.g., state and local public health departments), to provide clear and helpful answers. In many cases, OCHI directs uninsured and underinsured consumers to providers of low-cost or subsidized medical services.

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 entered into the OCHI database as a potential resource for future callers.

#### **Status Report for OCHI's Toll-Free Telephone Number**

OCHI received a total of 20,785 calls on its toll-free telephone number (877-527-9431) during calendar year 2009, up from 14,229 calls in 2008. This represents a 46% increase compared to 2008.

Since its inception in 2000, OCHI's toll-free telephone number has received approximately 157,818 phone calls. Exhibit 8 depicts calls received by OCHI each year since 2000. The numbers of calls in 2008 (20,785) was nearly double the number of calls received in OCHI's first year, 2000 (10,750). The complexity of health care issues has resulted in longer duration of the calls. It is not uncommon for a call to last several minutes and to encompass numerous topics. For example, a caller may initially inquire about continuation of group health insurance; however, depending on the situation, the OCHI staff person may inform the caller about HIPAA rights, CHIP, the COBRA subsidy law and Uninsured Ombudsman services within that same call.

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## Other Duties as Assigned by the Director

During the early years of OCHI, benchmarks were established for OCHI staff to ensure prompt consumer assistance. For example, OCHI staff immediately responds to approximately 85% of incoming calls; OCHI returns more than 99% of all voicemail messages within one hour of receipt; OCHI strives to directly answer the consumer's questions while on the phone or researches the issue of concern and responds to the consumer within 24 hours. OCHI continues to meet all its consumer assistance benchmarks despite the increased volume and complexity of the calls.

In 2009, OCHI continued to assist the Department's Consumer Services Section in reviewing correspondence from consumers. Written correspondence may be determined to be an inquiry or a formal complaint. Several types of correspondence are categorized as inquiries such as: (i) a letter from a consumer addressed to an insurer with a copy to the Department; (ii) a letter of complaint that does not contain enough information for the Department to begin a formal investigation; (iii) a general question about insurance or insurance law; or (iv) a letter requesting assistance on a matter that is not within the jurisdiction of the Department. OCHI staff reviews the correspondence and determines if it is an inquiry or a formal complaint. If it is determined to be a formal complaint, an insurance analyst is assigned, computerized clerical tasks are selected to notify the insurer of the complaint and to acknowledge receipt of the complaint to the consumer. If it is determined to be an inquiry, a letter is sent back to the consumer explaining what information is needed, what action has been taken or answering the general question involved.

In 2009, OCHI staff continued assisting the Life, Accident and Health Complaint Unit with handling of written consumer inquiries. These inquiries are received via regular mail, fax, or electronically, via on-line complaint or via the Department's consumer email address ([consumer\\_complaints@ins.state.il.us](mailto:consumer_complaints@ins.state.il.us)). OCHI staff handles basic consumer complaints received through these channels.

The OCHI staff's broad base of health insurance knowledge, combined with the database of information compiled by the Uninsured Ombudsman Program, allowed OCHI to handle approximately 933 written inquiries and 108 complaints in 2009. Handling of inquiries and basic complaints by OCHI allows the Department's Consumer Service staff to focus on more complex consumer inquiries and complaints.

OCHI also assists in responding to inquiries sent to the email address of the Director of the Department of Insurance (Director). This email address, [DOI.Director@illinois.gov](mailto:DOI.Director@illinois.gov), is posted on the Department's website for consumers to send insurance questions. In 2009, OCHI staff replied to 165 consumer inquiries sent to the Director's email address.

## 4. Uninsured Ombudsman Program

In January 2002, the Uninsured Ombudsman Program (Ombudsman) was established within OCHI to educate uninsured and underinsured Illinois residents about health insurance options and benefits, including an explanation of rights guaranteed by state and federal law. The Ombudsman also informs uninsured and underinsured consumers about available low-cost or subsidized medical services.

Since its inception, the Ombudsman staff has worked with various state and local agencies to build a database of local resources that provide medical services to the uninsured and underinsured populations. Information in the database includes resources for medical, dental, mental health, prescription drug, vision, and other available health care services by county and city.

For calendar year 2009, the Ombudsman staff handled 1,343 telephone calls. As in previous years, calls came from the uninsured, individuals, and organizations providing assistance to the uninsured. These included other state agencies, legislators, insurance agents, radio stations, and families. The Ombudsman staff continues to heighten the program's public profile by regularly participating on radio talk shows and pre-layoff workshops for dislocated workers. In 2009, an Ombudsman representative spoke at the AFL-CIO Central Labor Council and Community Services Conference (Grafton) and for the Campaign for Better Health Care (Bloomington). In addition, an Ombudsman representative participated in the Greene County Health Fair, Lincoln Community Health Fair, and Seminar for Legislators' District Office Staff and the Richland Community College Expo for Dislocated Workers. Along with all the other venues to help consumers, an Ombudsman representative toured with the Illinois Department of Healthcare and Family Services to various parts of the state to discuss health insurance options.

As in previous years, the Ombudsman staff actively participated on the Rapid Response Team for Dislocated Workers. At meetings organized by the team, members from various agencies answered dislocated workers' questions and provided the most current information about local resources and services. The Ombudsman staff provided: critical information about continuation rights available through the employer group health insurance plan; tips on how to shop for health insurance; information regarding special enrollment rights under HIPAA (e.g., the right to enroll in a spouse's employer group health plan); and the Department's contact information in case the dislocated worker needs further assistance.

The right of dislocated workers to continue health insurance coverage through their former employer, whether pursuant to state continuation laws or federal COBRA laws, is a major topic of discussion if the employer group health plan remains in existence. The Ombudsman representative provided detailed information about continuation of coverage to workers and their families, which also included information regarding the ability of

qualified beneficiaries to enroll separately under COBRA. The separate enrollment information is valuable at a time of financial hardship, particularly when the employee has a dependent (e.g., son, daughter, or spouse) who insurers refuse to cover in the individual market due to the dependent's past or present medical condition.

Goals for 2010 include continuing to increase public awareness of the Ombudsman Program, establishing new and strengthening existing relationships with local organizations, and continuing to effectively assist the uninsured population, especially in this time of economic turmoil.

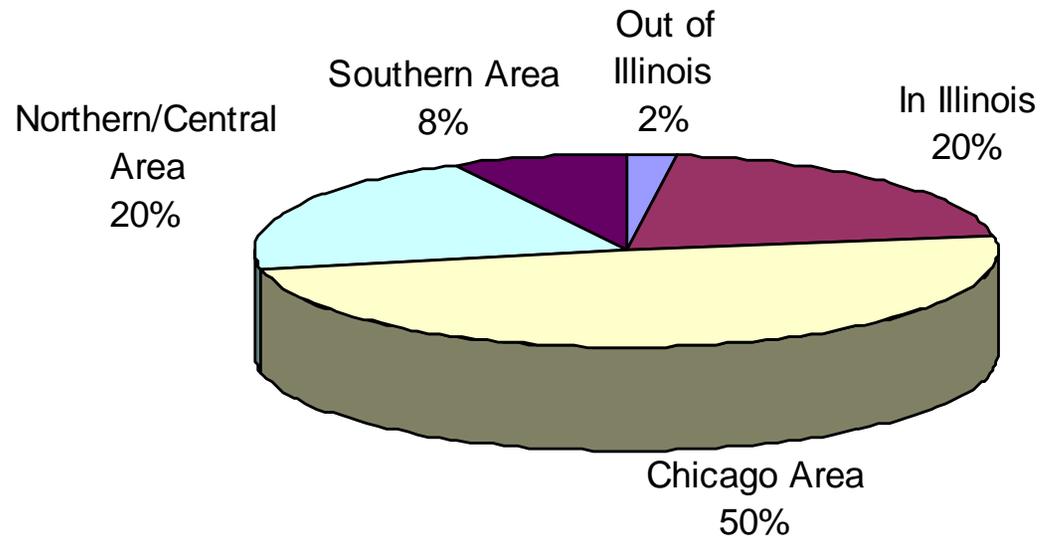
**Table 1 - 2009 Media Outreach**

<b>City</b>	<b>Station</b>	<b>Number of Visits</b>	<b>Est. Listening Audience</b>
Alton	WBGZ	9	25,000
Canton	WBYS	4	10,000
Centralia	WILY	4	10,000
Danville	WDAN	10	20,000
Danville	WITY	8	15,000
Decatur	WZUS	1	10,000
Dixon	WIXN	3	5,000
Effingham	WXEF	1	15,000
Galesburg	WGIL	5	13,000
Greenville	WGEL	7	5,000
Jacksonville	WLDS	7	10,000
Kewanee	WKEI	4	15,000
Macomb	WJEO	2	10,000
Monmouth	WMOI	5	10,000
Monmouth	WRAM	5	10,000
Mt. Vernon	WMIX	4	15,000
Oglesby	WLPO	1	20,000
Princeton	WZOE	4	10,000
Quincy	WTAD	3	25,000
Vandalia	WPMB	2	10,000
Watseka	WGFA	3	10,000

**Table 2 - Rapid Response Workshops for Dislocated Workers**

<b>Company</b>	<b>Location of Workshop(s)</b>	<b>Number of Impacted Employees</b>
ACH Food Companies	Champaign/ Jacksonville	360
AFS Keystone Steel	Granite City	569
Altamont Wholesale	Altamont	14
Ameren Power Station	Meredosia	36
Anheuser-Busch	Mt. Vernon	85
Baltimore Aircoal Company	Paxton	223
Casey Tool and Machine	Mattoon	150
Caterpillar Inc.	Decatur/ Peoria	1100
Champion Laboratories Inc.	Albion	180
Cerro Flow Products Inc.	East St. Louis	15
Circuit City Stores Inc.	Marion	175
Department of Corrections	Springfield	25
Eaton Corporation	Lincoln	60
Egyptian Concrete Co	Salem	129
EMI	Jacksonville	103
Great Central Lumber	Alton	50
Honeywell	Spring Valley	102
Jacobson Companies	Champaign	51
Johnson Control	Dixon	200
Krogers	Effingham	52
Littelfuse Inc.	Mattoon	5
Madison County Building Admn	Edwardsville	30
Madison County Sheltered Care Home	Edwardsville	27
Metro	St. Louis	384
Midcoast Aviation	Sauget	150
Miller Group	Dupo	24
Mueller Co	Decatur	38
North American Lighting	Mattoon/Centralia	302
Olin Brass/GBC Metals	East Alton	70
Orgill Inc.	Vandalia	140
PPG Industries	Decatur	44
Progress Tank Manufacturing Co.	Arthur	150
Quebecor Petty Printing Co	Effingham	102
Saturn	Springfield	20
Spartan Light Metals Products, Inc.	Sparta	200
Steven Industries	Effingham	55
THQ-Volition Inc.	Champaign	86
TRW Automotive	Mattoon/ Marshall	155
TSI Graphics	Effingham	7
U.S. Steel	Granite City	373
Vesuvius U.S.A	Mattoon/ Fisher	159
ZF Boge	Mattoon	217
Xenia Manufacturing Inc.	Olney	34

## Ombudsman Calls



## **Market Status**

## A. 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 seeking to discontinue the sale of all health insurance products in the individual, small employer, and large employer markets must provide proper notification to the Department and the insureds. Between 1997 and 2004, insurance companies terminated business in Illinois with increasing frequency. From 2005 until 2008, there was little activity in this area.

In 2009, the following companies discontinued sale of a product or withdrew from the market:

#### Discontinuance of a Product:

**Time Insurance Company** discontinued Policy Form 225 in late 2008. This was not reported in the 2008 report.

**John Alden Life Insurance Company** (an affiliate of Time Insurance Company) discontinued Policy Form 390 in late 2008. This also was not reported in the 2008 OCHI Report. The discontinuation of the two forms impacted 23,398 certificate holders. Members were offered other products available from each carrier.

**Guarantee Trust Life** discontinued coverage under Form GR0591, impacting 738 insureds in Illinois. All affected individuals were offered replacement plans.

#### Withdrawal from Market

**First Health Life and Health Insurance Company** withdrew from the small group health market, impacting 318 enrollees in the small group market in Illinois.

**Mega Life and Health Insurance Company** withdrew from the small employer group market impacting 15 small employers (32 employees)

**Chesapeake Life Insurance Company** withdrew its status as a small group market carrier. The company had no existing business in Illinois in the small group market.

**Midwest Security Life Insurance Company** discontinued all group health coverage in both the small and large group market, impacting 157 groups and 1,380 employees and dependents. Members were offered products with UnitedHealthcare who had recently acquired Midwest Security Life Insurance Company.

**Unicare Health Insurance Company of the Midwest  
Unicare Life & Health Insurance Company  
Unicare Health Plans of the Midwest Inc.**

The most significant disruption to the Illinois marketplace occurred when the three Unicare companies listed above exited the commercial, individual, small group and large group markets in Illinois beginning in fall 2009. Notices were sent to certificate holders and policyholders in October 2009. The exit impacts 183,000 members, including 38,700 individuals, 51,500 small group members, 83,600 large group members and 9,200 student members. This includes 7,600 ASO (Administrative Services Only) members. Blue Cross Blue Shield of Illinois offered comparable products to interested individuals on a guaranteed issue basis and with no pre-existing condition limitations. To be eligible for the Blue Cross Blue Shield of Illinois coverage, the member had to apply no later than December 1, 2009 and coverage would be effective January 1, 2010.

Whenever a health insurance company withdraws from the market, the Department and OCHI receive numerous calls from individuals whose health care coverage is disrupted. The Department explains how these transactions work and the applicable consumer protections. For individuals losing coverage, the Department identifies available options to ensure continued health coverage. A law enacted in 2005 (215 ILCS 97/50(c)(2)) requires insurance companies leaving the individual health market to notify each affected individual of the individual's option to purchase any other individual health benefit plan offered by any affiliate of the carrier. This notification must take place at least 180 days prior to the date of expiration of coverage. When the exiting carrier does not have any affiliates that must offer coverage, the only alternative for individuals losing coverage due to carrier withdrawal 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 Page 19 of this report.

Persons losing individual coverage enjoy few rights under HIPAA. For individuals who cannot obtain coverage in the individual marketplace due to past or present medical conditions, options are limited to:

- applying for standard CHIP coverage, in which a six-month waiting period for coverage of pre-existing conditions may apply;
- going without health coverage; or
- securing employment with an employer that offers group health insurance as a benefit.

## 2. Health Insurance Availability

### a. Uninsured

In September 2009, the U.S. Census Bureau released 2008 year-end statistics for the uninsured. According to the report, titled "[Income, Poverty, and Health Insurance Coverage in the United States: 2008](#)," the percentage of people without health insurance coverage in 2008 (15.4%) was not significantly different from 2007 (15.3%). The number of uninsured increased from 45.7 million in 2007 to 46.3 million in 2008.

The report further stated the number of people with health coverage increased to 255.1 million in 2008, from 253.4 million in 2007. The number of people covered by private health insurance decreased in 2008 to 201.0 million (66.7%) from 202.0 million (67.5%) in 2007. The number of people covered by employment-based health insurance decreased to 176.3 million (58.5%) in 2008, from 177.4 million (59.3%) in 2007. The number of people covered by government plans increased from 83.0 million (27.8%) in 2007, to 87.4 million (29%) in 2008.

The uninsured rate and number of uninsured for children under age 18 were reported at the lowest since 1987, when data was first collected. In 2008, 7.3 million (9.9%) of children under 18 were without health insurance compared to 8.1 million (11.0 %) in 2007.

As explained in the October 2009 Kaiser Commission report titled "[Health Insurance Coverage in America 2008](#)" children are much less likely than adults to be uninsured because of the availability of Medicaid and the Children's Health Insurance Program. Those public programs cover children whose family's income is below twice the poverty level.

In Illinois, the All Kids Health Insurance Program was expanded by law on November 15, 2005. Under the expansion, children at any income level are eligible for healthcare benefits if they have been uninsured for extended periods of time or if they meet the criteria for certain exceptions. According to the [Illinois Department of Healthcare and Family Services 2008 Annual Report](#), at the end of fiscal year 2008, over two million children and their parents were covered by one of the six All Kids and FamilyCare plans.

The January 2009 Kaiser Commission Report titled, [Rising Unemployment, Medicaid and the Uninsured](#), highlights the link between economic conditions and insurance status. The report demonstrates that

growth in the unemployment rate results in increased enrollment in Medicaid and the State Children's Health Insurance Programs. For example, the report estimated that if unemployment hit 10.0%, employer sponsored insurance would fall by 13.2 million, enrollment in Medicaid and State Children's Health Insurance Programs would increase by 5.4 million, and the number of uninsured would increase by 5.8 million. Increased enrollment in the public programs occurs at the same time that state revenues are declining, placing significant strain on state budgets and important safety net programs like Medicaid.

According to the United States Department of Labor's [Economic News Release](#) dated January 8, 2010, the unemployment rate for the United States was 10.0% at the end of December 2009. [The Regional and State Employment and Unemployment – November 2009](#) release dated December 18, 2009 indicated an unemployment rate of 10.9% for Illinois as of the end of November 2009.

#### **b. Underinsured**

A continued disturbing trend is the growth of the underinsured population. The underinsured are commonly defined as individuals who are exposed to significant financial losses or are unable to obtain needed care because of inadequate health coverage.

The Department continues to see a trend of complaints from consumers who purchased high deductible limited benefit policies because of the lower premiums. While some consumers purchase limited benefit plans to supplement another policy, most make the purchase because it is the only policy they are offered or can afford.

Most consumers shop for health insurance based on price, and many of those price-conscious consumers, even after receiving an outline of policy coverage, do not fully understand the policy's benefits. For example, consumers often learn too late that the maximum out-of-pocket limit is only for covered benefits and not for all medical treatments a person might need. Consumers may also be surprised to learn that a plan imposes a deductible per occurrence, not per calendar year.

Complaints involve issues related to claim payments, including denial of claims, unsatisfactory claim payments and claim payment delays. Related to these complaints are allegations of misrepresentation of the policy at the time of sale by the agent, association or insurer.

Examples of limits contained in a policy include but are not limited to:

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- limit for outpatient lab and x-ray services (including radiation) to a specified amount such as \$300.00 per year;
- limit of 3 office visits to a physician's office per year;
- limit of 1 physician visit per day while hospital confined; and
- ambulance transport limited to \$500.00 Maximum Benefit per trip.

According to a March 2009 article titled [Underinsured Americans: Cost to You](#), one estimate is that 25 million Americans can't afford to cover the gap between what their insurance covers and their medical bills demand. As reported in the 2008 OCHI Report, this problem is not limited to low-income families. The underinsured rate for middle-income families with annual incomes of \$40,000 to \$59,000 reached double digits in 2007.

### **c. Employees Losing Group Health Coverage**

In 2009, OCHI continued to receive calls from employees losing their group health coverage and asking about continuation options. In 2009, OCHI received over 4,600 calls regarding continuation of group health coverage. OCHI also responded to over 1,250 calls regarding the federal American Reinvestment and Recovery Act (ARRA).

Employees lose their health insurance coverage for a variety of reasons, including layoffs, business closings, and 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/](http://www.ildceo.net/dceo/Bureaus/Workforce_Development/WARN/).

As reported in previous years, many employers no longer offer retiree health insurance coverage and have terminated coverage for current retirees. This trend continued in 2009.

To address this persistent and growing problem, the State created a Rapid Response Team which informs and educates the dislocated workers and retirees about services available to ease their transition. Section 4 of this Report details the Uninsured Ombudsman Program's active membership on this team.

OCHI continues to provide information and coverage options to retirees losing coverage. OCHI works with SHIP to stay abreast of Medicare changes applicable to the retiree population. OCHI also educates individuals who may be eligible for relief under the federal Trade Adjustment Assistance Reform Act (TAA). TAA provides tax credits to

certain workers and retirees who purchase health insurance after losing employer-sponsored health coverage due to trade-related job losses.

**d. Illinois Comprehensive Health Insurance Plan**

The Illinois Comprehensive Health Insurance Plan (CHIP) (215 ILCS 105/1 *et seq.*) operates two pools. The Traditional CHIP pool is designed for individuals who are denied health insurance coverage in the conventional market because of past or present 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 pool is the state's mechanism to protect the portability rights of individuals who have satisfied HIPAA requirements (e.g., prior creditable coverage in a group health plan). Effective June 23, 2003, HIPAA-CHIP was expanded to include the HCTC-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% (80% until December 31, 2010) of paid premium. HIPAA-CHIP by statute cannot impose pre-existing condition limitations. This pool is funded partially by health insurance industry assessments and partially by premiums.

Enrollment data for both the Traditional CHIP and HIPAA-CHIP pools can be found in the CHIP Annual Report. The CHIP Annual Report can be viewed at [www.chip.state.il.us](http://www.chip.state.il.us)

**e. Cost of Health Insurance**

The cost of health insurance coverage has impacted everyone, including large groups, small groups and individuals. Rates for all types of health insurance, including comprehensive major medical, limited benefit health plans and long term care insurance have skyrocketed in the past few years. The rising cost of health insurance has contributed to the uninsured and underinsured population in Illinois and throughout the United States.

**f. Cost of Continuation Coverage/Shift of Cost of Care to Communities and Providers**

Loss of health insurance benefits can result from many events such as loss of a job, reduction in benefits by an employer, loss of dependent status due to divorce, death of employee, retirement of the employee, or other circumstances. Federal and state laws require employers to offer

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employees and dependents who lose coverage the right to continue coverage as a member of the group for specified time periods. The obstacle for most individuals is the cost of the coverage: those who elect to continue coverage must pay the full cost out of their own pockets.

The federal American Recovery and Reinvestment Act (ARRA), signed by President Obama on February 17, 2009, provided a subsidy that reduced by 65% the cost of COBRA and other state continuation coverage for workers who lost their jobs. Illinois subsequently amended the state continuation law ([Public Act 096-0013](#)) to extend all rights provided by ARRA to those individuals insured by small employer groups (less than 20 employees). The law created a second election period for those individuals who lost group coverage due to involuntary termination after September 1, 2008, and who did not have continuation coverage in effect as of June 18, 2009. Initially ARRA provided for up to nine months of premium subsidy for qualified individuals who lost coverage prior to January 1, 2010. ARRA was recently amended by Public Law 111-118 to increase the maximum subsidy period to 15 months and to extend the eligibility period to March 1, 2010. OCHI staff communicated the most up-to-date information regarding ARRA to over 1,250 callers. Absent further extensions, the cost of continuation coverage will most certainly re-surface as an issue in 2010.

OCHI and the Uninsured Ombudsman received over 1,300 requests in 2009 for information regarding resources available to the underinsured and uninsured. Many of those individuals have lost employer-based group health insurance and are unable to afford continuation coverage or coverage available under the HIPAA-CHIP plan.

**g. Cost of Guaranteed Coverage Under HIPAA**

Federal and state HIPAA laws guarantee access to health coverage for individuals who lose their employer-sponsored group health coverage. Illinois residents who lose group health coverage are eligible for HIPAA-CHIP plan coverage. However, the individual must exhaust all coverage available under federal COBRA or state continuation laws before becoming eligible for HIPAA-CHIP. As discussed previously, federal COBRA and state continuation coverage is unaffordable for many Illinoisans. The high cost of continuation coverage, therefore, acts as a barrier to HIPAA-CHIP eligibility.

### 3. Trends

#### a. Rate Increases

In 2009, OCHI received 500 calls regarding rate increases for health insurance policies. The Department counted 137 complaints regarding rate increases in 2009; 39% (or 53 complaints) related to for long term care policies, 23% (or 32 complaints) related to group policies (including association groups), 20% (or 28 complaints) related to individual health policies and 11% (or 15 complaints) related to Medicare Supplement policies. In many instances, consumers are faced with reducing their benefits on their current policy to make the premium more affordable, buying a more affordable policy with limited benefits or dropping coverage altogether.

#### b. Underwriting Unavailability and Rescissions in the Individual Health Market

In 2009, OCHI received 1,940 phone calls regarding individual health insurance coverage. In addition, 602 calls were received regarding underwriting. In the individual market, an insurer may “underwrite” an applicant, using health status as a reason for declining coverage. The Department receives complaints each year from individuals who are unable to obtain an offer of health insurance due to health status. The options for these individuals are limited, but include: seeking coverage through CHIP, finding employment that offers health coverage, purchasing a limited plan that does not offer comprehensive coverage, or going without coverage entirely.

Rescission of individual health insurance policies has been more prevalent in Illinois recently. A rescission is an action taken by an insurance company to void an individual health policy if the company determines that information was omitted from or misrepresented on the application, and that the omission or misrepresentation was material to the issuance of the coverage. The Department closed approximately 43 complaints regarding rescission of individual health policies in 2009. A December 2009 data call by the National Association of Insurance Commissioners (NAIC) reported Illinois with the second highest rescission rate in the nation with a total of 5,279 rescissions for the five year period from 2004 through 2008.

**c. PPO Plans Low Reimbursement for Non-Contracted Providers**

PPO plans pay the optimum benefit to the insured when the insured utilizes a preferred provider. The PPO plan allows the insured flexibility to use non-participating providers; however, exercising this flexibility is increasingly very costly to consumers. Many PPOs pay for those services based upon “usual and customary” rates, a methodology that is supposed to reflect the prevailing market rate for a doctor visit or medical service in a given geographic area. Reimbursement amounts based upon usual and customary rates have fallen drastically in the last several years.

Some plans are paying non-participating providers based upon the negotiated rate that would have been paid to a participating provider. This significantly decreases the amount paid by the insurer and increases the insured’s out of pocket costs because the doctor will bill the insured for the difference. In-network providers are generally prohibited from billing an insured except for applicable copayments, coinsurance or deductibles.

Another fee methodology being used by some insurance companies is payment for non-participating provider claims based on a percentage (e.g., 110%) of the Medicare published rate for the same or similar service. Because Medicare reimbursement rates are relatively low, this methodology can result in very low reimbursement of non-participating provider claims. This again leaves insureds vulnerable to unexpected and costly bills for medical services.

The Department is experiencing increased complaints regarding the methodologies used by PPO plans to pay non-participating providers. The plans are required by law (215 ILCS 5/356z.3) to prominently disclose in the policy that limited benefits are available when using non-participating providers; however, the consumer is genuinely surprised by the low payments made by these plans.

**d. Discount Health Care Plans**

Illinois currently has approximately 138 registered Preferred Provider Administrators (PPAs) operating in the state of Illinois. Approximately half of these entities report offering health care services on a discounted basis. The Department of Insurance continues to see an increase in unauthorized discount health care plans. Illinois residents are being repeatedly exposed to fax blasting, multimedia presentations, and internet solicitations for enrollment into discounted health care programs which

promise access to a wide array of health care services and supplies at reduced prices. Routinely, these plans offer discounted rates for medical, surgical, hospital, dental, vision, prescription drug, emergency travel, mental health, and substance abuse care.

Many employers view discount health care programs as cost effective alternatives to offering supplemental insurance coverage to their employees. Individuals often see these types of plans as an alternative to costly private coverage. Many discounted health care programs provide legitimate and useful discounts, but others provide only minimal coverage through marginal or non-existent provider networks, and at a great profit margin for the program sponsors. The Department has found that in many instances, the “discounts” Illinois consumers pay for are unavailable because the purported contractual relationship between the discount program and the health care provider does not exist. In such cases, consumers are out-of-pocket for the cost of the discount program and suffer additional financial loss when they are denied access to promised reductions in the cost of health care services, supplies and pharmaceuticals.

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 5/370f *et al.*). The Department continues to actively work to register these plans as preferred provider administrators. Unfortunately, other states often lack oversight authority of discount plans, leading plan sponsors to believe they do not have to register under the Illinois law. This belief may be further reinforced by unrelated state mandates requiring discount programs to disclose on their membership cards that the marketed discount program is “not insurance.” While it is true that a preferred provider administrator is not an insurance company, it is still required to be registered with the Department.

The Department continues to address this issue, and encourages consumers to verify that a discount program is authorized to conduct business in Illinois before purchasing the product. A listing of authorized preferred provider program networks is available on the Department’s website: <http://insurance.illinois.gov/PPA/>.

**e. PPO Plans Accessing Inappropriate Provider Discounts**

The Department continued to receive complaints in 2009 regarding PPO plans that either accessed discounts to which they were not entitled or accessed discounts through networks other than those approved by the

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Director (all networks approved by the Director are published on the Department's PPO Provider Network website). In both cases, plans inappropriately accessed health care provider discounts. This type of plan behavior is harmful to the consumer, whose health care dollars pay for a nonexistent health care delivery system or one whose repricing only benefits the plan, not the member. For the provider, an inappropriate discount plan may access discounts of which the provider has not been given proper notice, nor provided contractual consent. The Department continues to address this issue and actively works with state agencies to protect consumers.

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

As the insurance industry struggles to contain escalating health care costs, it has placed particular focus on health care provider reimbursements. For example, plans have begun to use contractual relationships with providers to re-price claims submitted through indemnity contracts.

The concept of discounting provider services and passing 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 insurance companies now apply these same discounts to non-PPO products.

The Illinois General Assembly passed legislation in the late 1980's which established guidelines and consumer protections for PPO products. Insurance companies 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. Providers argue that insurance companies may not reprice claims or 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 initiated by providers who believe that their fees have been unfairly and extra-contractually reduced.

### **g. High Deductible Health Plans – Health Savings Accounts**

The rising cost of health insurance benefits is causing employers to search for new, lower-premium coverage options that still provide quality health benefits to employees. One such option is the High Deductible Health Plan (HDHP), which is a catastrophic insurance plan often combined with a health care spending account such as a Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA).

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173) added Section 223 to the Internal Revenue Code, which established HSAs as an alternative benefit design. An HSA is a tax-exempt trust established exclusively to pay for qualified medical expenses of an account beneficiary covered under a high-deductible health plan. Employers and employees may contribute to the HSA account.

Money stored in the account may be used to cover permitted first-dollar benefits (e.g., preventive care) and to satisfy the high deductible associated with 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. Proponents of HDHPs believe HSAs provide more flexibility and discretion to the consumer over the utilization of health care benefits.

HRA accounts resemble HSAs. Under an HRA, the employee is prohibited from contributing to the account by Internal Revenue Service (IRS) rules; only the employer may contribute. Also, an individual with Medicare or other health coverage may enroll in a HRA account but may not enroll in a HSA account. 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.

The Kaiser Family Foundation 2009 Employer Health Benefits Survey (<http://ehbs.kff.org/pdf/2009/7937.pdf>) reported 12% of surveyed firms offered health benefits through HDHPs with savings options.

The growth of HDHPs has brought with it growth in the underinsured population. Individuals and employees with significant financial resources sometimes prefer the financial flexibility offered by HDHPs; they pay lower premiums to the insurance company in exchange for managing and paying for health care costs below their high deductible. Many Illinoisans, however, enroll in HDHPs not as a result of a sophisticated financial

decision but because it is either the only individual market plan they can afford or because it is the only plan sponsored by their employer. These individuals, often underinsured, delay or struggle to pay for necessary medical care.

#### **h. Cost Shifting to Employees**

As the cost of employer-sponsored group health insurance continues to rise, employers continue to search for lower-cost alternatives. The [Kaiser Family Foundation Employer Health Benefits 2009 Survey](#) illustrated that the majority (98%) of employer-based health insurance is now provided through a managed care plan such as a preferred provider organization, health maintenance organization or Point of Service Plan. These plans steer covered members to a provider network; failure to use the network can result in no coverage or limited coverage by the insurance policy.

Costs of health care coverage continue to be shifted to employees through: 1) increased percent-of-premium contribution; 2) increased deductibles and copayments; 3) copayments being calculated as a percent of charges instead of flat dollar amounts; and 4) out of network benefits being based on specific definitions contained within the policy which vary tremendously from the actual cost charged to the consumer by the health care provider.

The [Kaiser Family Foundation Employer Health Benefits 2009 Survey](#) reported that in 2009, the average annual premium for employer-sponsored health insurance remained steady for single coverage (\$4,824) but increased 5% for family coverage (from \$12,680 to \$13,375). The report stated that the average annual worker contributions are \$779.00 for single and \$3,515.00 for family coverage.

According to the same survey, the average deductible for single coverage was \$634 for PPO coverage, \$699 for HMO coverage and \$1,838 for high deductible health plan coverage. The percentage of covered workers in a plan with a deductible of at least \$1,000 for single coverage increased from 18 to 22% in the past year.

The Department has identified a clear trend of increasing copayments for all services, including office visits, emergency room visits, inpatient hospital visits and prescription drugs. The increased copayments can be attributed to the increased cost of these services as well as the employee being held accountable for a portion of the medical services received.

## **Recommendations to Improve Health Insurance Regulation**

## C. RECOMMENDATIONS TO IMPROVE HEALTH INSURANCE REGULATION

### 1. Denials of Coverage and Affordability of Coverage in the Individual Market

Illinois law does not prohibit insurance companies from using the age and health status of individuals and their families to deny or rate individual market health coverage. The health status information used to price premiums and support coverage denials is usually found by insurance companies in an individual's health insurance application and/or medical records. Current Illinois law does not prohibit insurance companies from using any past or present medical condition, no matter its severity or how long ago resolved, to support an unaffordable offer of coverage or coverage denial. A 12-year-old child can be rejected or charged a much higher premium because of a repaired birth defect with no present-day health effects; a 22-year-old woman can be rejected or charged a much higher premium based on asthma; a 28-year-old man can be rejected or charged a much higher premium based on an allergy; a 34-year old man can be rejected or charged a much higher premium because, ten years ago, he sought treatment from a psychiatrist after the death of his father; a 49-year-old woman can be rejected or charged a much higher premium based on breast cancer that has been in remission for more than a decade; a 54-year old man can be rejected or charged a much higher premium because his doctor noticed early signs of arthritis.

State law neither requires nor prohibits insurance companies from pricing or denying individual market coverage because of minor or long-ago resolved medical conditions. State law does not require that insurance companies maximize shareholder or company profits. State law does, however, require that insurance companies meet minimum solvency requirements. Insurers assuming higher risk individuals - those who, in actuarial terms, are more likely to incur high medical costs – must charge higher premiums in to maintain adequate financial reserves.

In addition to the solvency problem, an insurer may also face marketplace or competition problems if, under current state law, it stopped denying coverage or risk-pricing altogether. If Insurer X stops denying coverage and pricing coverage based on age and health status in a state that allows Insurer X's competitors to issue age and health-related coverage denials and premium offers, Insurer X would soon find itself as the "insurer of last resort" for high-risk and high-cost individuals. Soon, Insurer X would find itself paying more and more claims and would be forced to raise premiums. Higher premiums would cause lower-cost, lower-risk individuals (at least in actuarial terms) to seek coverage elsewhere, leaving Insurer X with an even greater concentration of higher-cost, higher-risk enrollees. Premiums would continue

to increase along with claims, leading to skyrocketing rates (*i.e.*, the so-called “death spiral”).

Individuals and families who receive affordable offers of individual market coverage can face unaffordable premium increases upon renewal. State law does place limited restrictions on the methods used to calculate annual premium increases, but it does not restrict the amount of increase. For example, if an insurance company wants to close an unprofitable block of business, it can annually impose dramatic, actuarially-based premium increases on remaining policyholders, causing healthy consumers to choose other products and forcing less healthy or older consumers to pay more for or drop the now unaffordable coverage. Less healthy or older consumers who lose the coverage may be denied conventional market coverage for the rest of their lives.

CHIP, the high risk pool for those denied coverage by insurers, does not provide an affordable alternative. For instance, a 55-year-old man who has been denied coverage by an insurance company qualifies for the Traditional (Section 7) CHIP pool. If he lives in Chicago, his monthly CHIP premium for a PPO product with a \$500 annual deductible would be \$1,109 (less expensive CHIP premiums are available, but require the imposition of a higher deductible). A 35-year-old woman in Lincoln, Illinois would pay less for the same coverage, but would still owe \$454 per month.

Illinois must modernize its health insurance marketplace. The legal foundation of Illinois’ current approach to individual market regulation was built in the early 1970s. The health coverage struggles facing sole proprietors, employees, and small and large businesses have changed dramatically in the last four decades. For instance, the percentage of employers offering health coverage has decreased significantly, leaving more Illinoisans looking to purchase individual or family coverage in the individual market. The last thirty years has also produced a dramatic increase in the number of individuals who work for a company on a contract basis rather than as an employee. Left without employer-sponsored coverage, these individual contractors and their families also seek coverage in the individual market. Unfortunately, the growing number of individuals and families looking for individual coverage in Illinois will encounter a dysfunctional individual market, as market forces created by current state law and insurance company profit pressures make it difficult for many Illinoisans and their families to purchase affordable coverage.

**POSSIBLE REMEDY:** Ensuring that all Illinoisans, regardless of present or past medical conditions, have access to affordable individual market coverage is a complex and difficult task that requires reforming not just

insurance laws, but the health care delivery system itself. For example, all experts agree health insurance reforms would be complemented by simultaneous and systematic efforts to reduce health care costs. Nonetheless, to restore basic fairness, reform of Illinois laws governing the individual marketplace should focus on reducing “adverse selection” (*i.e.* encouraging individuals to purchase insurance before they become sick) and spreading risks across larger pools of insured lives.

## **2. Rescissions of Individual Health Insurance**

In Illinois, an individual health insurance policy may be “rescinded” or retroactively cancelled within the first two years after the policy is issued. To rescind a health insurance policy in Illinois, a health insurer must show only that “the insured has withheld material information or answered material questions incorrectly on an application which would have resulted in the insurer, at the time of the original application: (1) denying coverage; (2) restricting the level of coverage as applied for; or (3) rating up the premium normally charged for the coverage as applied for” (50 Ill. Admin. Code 2005.40(d)). The Illinois standard does not require a nexus between any alleged misrepresentation and the actual claim. Rather, current Illinois law vests the insurer with broad discretion and ability to rescind, or to engage in post-claim underwriting that results in the policyholder receiving less coverage than that for which she originally bargained. With such broad discretion, terms such as “withheld” or “answered material questions incorrectly” are subject to multiple interpretations, perhaps dependent upon the nature and cost of the policyholder claim.

According to a recent NAIC survey, Illinois had by far the most rescissions of any state in the country (nearly 50% more than California) over the five year period from 2004 to 2008.

The Department received 383 rescission-related consumer complaints from 2003-2007, with an additional 50 complaints in 2008 and approximately 43 in 2009. The Department has limited success (less than 10%) in overturning rescission-related complaints. In many cases, the individual did not intentionally omit information from the application. Many consumers report that the selling insurance agent advised them to withhold the information. Illinois law allows the policy to be rescinded if the company’s underwriting guidelines substantiate that the policy would not have been issued had the application been accurately completed.

**Possible Remedy:** Amending Illinois law to prohibit rescission except in cases of fraud or intentional misrepresentation of fact. Individual should also be able to request a hearing before the Department to challenge a rescission,

similar to the hearing process established for the cancellation or nonrenewal of property and casualty policies.

### **3. Affordability of Coverage in the Small Group Market**

State laws governing small group (*i.e.*, small businesses with 2-50 employees) health coverage differ from the state laws governing individual market health coverage in two key respects. First, while individuals can be denied coverage in the individual market, state and federal law requires small group carriers to offer coverage to small businesses. Second, while state law does not regulate premiums for individual market products, it does use rate bands to restrict premium variation for small businesses.

While guarantee issue and premium variation restrictions brought some stability to the small group market, small businesses still struggle to find affordable coverage for their employees. Some small businesses simply cannot afford to provide coverage based on the available offers. Other small businesses provide coverage only to find that premium increases upon renewal are not only unpredictable (making it hard to budget for health care expenses) but are sometimes unaffordable.

How can a small business whose coverage is guaranteed and whose premiums are restricted be faced with unaffordable and unpredictable premiums? The answer, again, is found by examining current state law. For example, consider a small business in rural Illinois that decides to offer its 11 employees health coverage. The employer, hoping to keep and attract skilled employees and believing that state law protects him against dramatic premium increases upon renewal, decides to provide coverage based upon first-year premiums offered by an insurance company. Premiums rise by 12% in the second and third year; a steep rise, but the employer continues to pay. However, for the fourth year, the small business owner, who has been struggling to pay expensive premiums for three years, is asked to pay an additional 40%. The insurance company explains that the increase is due to rising medical costs, claims submitted by the employees, and the increased average age of the employees. The employer must either pay the premiums or lose the coverage.

Like current state law governing the individual market, current state law governing small group insurance does place some marketplace pressure on companies to increase rates on small businesses with employees who, in actuarial terms, are likely to incur high medical costs. Again, a hypothetical example helps demonstrate this rating pressure.

If Small Group Insurer Y prices coverage below what is actuarially justified and within the rating limits imposed by the state's Small Employer Health

Insurance Rating Act (215 ILCS 93/1 *et seq.*), the company would, because of its relatively low rates, become the insurer of choice for small businesses with higher-cost, higher-risk employees. Soon, Small Group Insurer Y would find itself paying more and more claims and would be forced to raise premiums. Higher premiums would cause small businesses with lower-cost, lower-risk employees to seek coverage from an insurance company that employed actuarially based pricing, leaving Small Group Insurer Y with an even greater concentration of higher-cost, higher-risk enrollees. Premiums would continue to increase along with claims, leading to skyrocketing rates (*i.e.* the so-called “death spiral”).

**POSSIBLE REMEDY:** Ensuring that all Illinois small businesses have access to affordable coverage is a complex and difficult task that requires reforming not just insurance laws, but the health care delivery system itself. For example, all experts agree health insurance reforms would be complemented by simultaneous and systematic efforts to reduce health care costs. Nonetheless, to restore basic fairness, reform of Illinois laws governing the small group marketplace should focus on further reducing rate variation between small businesses and preventing unpredictable and unaffordable premium increases upon renewal.

#### **4. Notification of HIPAA-CHIP**

Currently when an employer terminates and does not replace its group health plan, 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 (215 ILCS 105/15). This plan provides coverage to individuals who have lost group coverage, 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 limitation. 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. The 90-day time limit is problematic for individuals who, unaware of Section 15 HIPAA-CHIP, shop the individual market for coverage only to find that insurance companies deny them coverage or offer only unaffordable coverage. Ninety days may have passed by the time these individuals find out about Section 15 HIPAA-CHIP coverage, making them ineligible. While insurance companies are required to notify individuals about CHIP in any declination of coverage letter, this notice often arrives too late.

**POSSIBLE REMEDY:** Mandate that insurance companies and employers notify employees of the availability of the Section 15 HIPAA-CHIP plan when an employer terminates group coverage without replacement coverage.

Notice should be provided prior to exhaustion of benefits under federal COBRA or state continuation laws.

#### **5. 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 of a covered employee upon legal judgment for dissolution of the marriage. In many instances, the covered employee removes the spouse from the insurance prior to the legal judgment for dissolution of the marriage. This action prevents the spouse from taking advantage of the right to elect coverage under the state spousal continuation law. Federal COBRA law protects spouses under these circumstances whereas state continuation does not.

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

#### **6. State Continuation Laws – Lack of Employer Cooperation**

The state continuation laws require certain actions by employers to ensure affected individuals are provided health insurance continuation rights. For example, the state continuation law (215 ILCS 5/367e) requires employers to notify employees of health insurance state continuation rights upon termination of the employee's employment. The spousal continuation law (215 ILCS 5/367.2) requires that the spouse notify the employer or the insurance company of the request for continuation. The dependent continuation law (215 ILCS 5/367.2-5) requires the dependent or the responsible adult to notify the employer or the insurer of the request for continuation.

Often the employers turn to the agents or brokers that sold the policy to them for clarification of the law only to be given incorrect or incomplete information. In some instances, the employer refuses to cooperate. The Department does not possess regulatory authority over the employer and, in some instances, the insurance company refuses to assist by contacting the employer to reaffirm the employer's responsibility to offer continuation. The problem is further exacerbated when an application is made to HIPAA-CHIP and coverage is denied because the employee, spouse, or dependent did not exhaust his or her continuation rights, as required.

**POSSIBLE REMEDY:** Amend State continuation laws to require the insurance company to notify terminated employees of their continuation rights when the employer is not cooperative or not properly providing notification.

## **7. State Continuation Laws – Lack of Standardized Form**

The Department routinely receives requests from employers for a standardized form to use when providing employees notification of their state continuation rights. Many insurance companies do not provide a form to the employer and no standardized form is required by law.

**POSSIBLE REMEDY:** Adopt a regulation that provides a standardized form for employer-to-employee notification of state continuation rights.

## **8. Insurer Audits of Paid Claims**

In 2009, the Department continued to receive numerous complaints from providers and insureds regarding recovery practices by insurance companies and HMOs. A law passed in 2004 provided guidelines for insurance companies to use when recouping payments. Unfortunately, this law (215 ILCS 5/368d) does not stipulate any time frame within which the recoupment must be made. Many times insurance companies request recoupment for claims that are over two years old. While the Department does not dispute the company's right to recover monies that have been paid in error, a reasonable time limit should be imposed. The Department 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 (e.g., 2 years) within which a recoupment may be requested.

## **9. Pre-certification of services**

a. Calls and complaints from consumers regarding pre-certification of services followed by claim denials are steadily increasing. "Pre-certification" requires that the consumer or health care provider call the insurance company in advance of a service and receive a certification of coverage. Some plans provide consumers this pre-certification and then deny the claim due to lack of medical necessity, a pre-existing condition limitation, or lack of coverage under the policy. This action leaves the consumer and health care provider liable for the service.

**Possible Remedy:** Enact legislation that requires insurance companies to review the insured's individual membership file before pre-certifying benefits. In addition, insurance companies should be required to specifically advise individuals if pre-certified benefits may not be reimbursed due to: 1) a pre-existing condition limitation; 2) lack of

medical necessity 3) failure to pay premiums at the time of pre-certification; or 4) an exclusionary rider.

- b. The Department has received an increasing number of calls and complaints from consumers who call insurance companies to pre-certify services and are not advised of important benefit limitations. Consumers are not told, for example, that their provider is not a PPO provider and/or that the policy pays limited benefits when consumers choose non-preferred providers. For example, the plan may tell the consumer it pays 80% of non-preferred provider charges, but the plan does not disclose that the 80% benefit is based on a very low reimbursement rate (sometimes it is 80% of what a preferred provider charges the plan). The consumer believes the 80% benefit is based on billed charges or usual and customary fees.

**Possible Remedy:** Require insurance companies to inform the consumer or health care provider of the preferred or non-preferred status of the provider when a consumer calls to pre-certify services. Require the insurer to verbally advise the caller of benefit limitations that must be disclosed pursuant to 215 ILCS 5/356z.2. Also, require insurance companies to explain to callers the ramifications of seeking services outside the PPO network so the caller is well informed about the financial consequences of visiting preferred and non-preferred providers.

#### **10. Disclosure of products being sold to consumers.**

Consumers looking for affordable individual market major medical health insurance policies are unknowingly purchasing limited benefit policies such as a Basic Hospital/Medical-Surgical Expense or a catastrophic plan. Most consumers do not understand or carefully review the policies and information provided to them at the time of the sale, and often become confused or upset when claims are processed and they are left with a large medical bill. Consumers complain that they were misinformed or misled by the agent who sold them the product.

**Possible Remedy:** Require that information be provided by the agent or insurer about OCHI at the time of the proposed sale of any individual health insurance product, including products sold through trusts or association groups. The disclosure should contain OCHI's toll-free telephone number and a statement encouraging the consumer to call OCHI with questions before or after purchasing any health insurance policy.

## **Government Actions**

## **B. GOVERNMENT ACTIONS**

### **1. Federal**

#### **a. American Recovery and Reinvestment Act (ARRA)**

On February 17, 2009, President Barack Obama signed the American Recovery and Reinvestment Act (ARRA), commonly called the Stimulus Plan. ARRA provides a subsidy that may reduce by 65% the cost of COBRA and other state group continuation coverage for workers who lost their jobs during the period of September 1, 2008 through December 31, 2009. Eligible individuals could receive assistance for a period of not longer than nine months.

On December 19, 2009, President Obama signed Public Law 111-118 (the ARRA Subsidy Extension), which amended ARRA to increase the maximum duration of the subsidy from 9 to 15 months, and to extend the eligibility period from December 31, 2009, to February 28, 2010.

#### **b. Medicare Improvements for Patients and Providers Act (MIPPA) (P.L.11-275)**

The federal Medicare Improvements for Patients and Provider Act of 2008 included a number of changes to the standardized Medicare Supplement insurance plans. MIPPA charged the NAIC with the task of updating the standards for Medicare Supplement insurance. On September 24, 2008, the NAIC adopted a revised Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.

Beginning June 1, 2010 Medicare Supplement Insurance plans will include two new standardized plans. Consumers will have the option to purchase Medicare Supplement "M" and Medicare Supplement "N". At the same time, Medicare Supplement plans "E", "H", "I", and "J" will be eliminated from the options to purchase.

Medicare Supplement Plan "M" will cover 50% of the Part A deductible, none of the Part B deductible, but will not have copayments for doctor visits or ER visits.

Medicare Supplement Plan "N" will have a \$20.00 copayment for doctor visits and a \$50.00 copayment for emergency room visits. The changes in both plans are an attempt to lower the premiums for the two plans.

Preventative and At-home Recovery benefits have been deleted from the plans. Medicare Part B has changed in the past years to cover many of these services and the benefit for these services in the Medicare Supplement policy has been reduced.

Hospice benefits have been added to all standardized Medicare Supplement plans as a Basic “Core” benefit.

Current Medicare supplement policyholders may continue to keep the policies they have purchased. Changes to the Medicare Supplement plans, including the addition of plans “M” and “N” and the elimination of plans “E”, “H”, “I” and “J”, will take effect June 1, 2010.

**c. Mental Health Parity Reauthorization Act (Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act)**

As reported in the 2008 OCHI Report, the new federal mental health parity legislation (Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act) became effective October 3, 2009. The law requires group health plans of 50 or more employees (including self-insured employer plans) that cover mental health or substance abuse treatment to provide those benefits with the same cost-sharing and treatment limitations applicable to physical illness. (For plans that are maintained pursuant to a collective bargaining agreement, the amendments apply for plan years beginning when the collective bargaining agreement expires or January 1, 2010, whichever is later.) The federal law does not apply to employer groups with 50 or fewer employees.

The amendments require insurance companies and employers that offer coverage for mental health services to apply cost sharing requirements (deductibles, co-payments, coinsurance) and treatment limitations (limitations on the frequency of treatment, number of visits, etc.) to mental health services that are no more restrictive than the predominant financial and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

The Illinois mental health parity law (215 ILCS 5/370c), also known as the “Serious Mental Illness Mandate,” requires group insurance policies covering more than 50 employees and all group HMO contracts to both: 1) cover serious mental illnesses (not substance abuse disorders); and 2) provide parity with respect to that coverage. The new federal parity law does not replace Illinois mental health parity. Instead, federal and Illinois parity laws will be harmonized by preserving the features of each law that best protect consumers.

**d. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)**

Signed on February 4, 2009, CHIPRA allows states to subsidize premiums for employer-provided group health coverage for eligible children, but it also imposes certain requirements on plan sponsors.

**e. Genetic Information Nondiscrimination Act (GINA)**

As reported in the 2008 OCHI Report, the Genetic Information Nondiscrimination Act (GINA) (Public Law 110-233) was signed by President Bush on May 21, 2008. The provisions of GINA apply to individual and group health plans.

For group health plans and health issuers, the law is effective for plan years beginning after May 21, 2009. The law applies to individual health insurance policies sold, issued, renewed, in effect, or operated in the individual market after May 21, 2009. For GINA to apply to Medicare Supplement coverage, states must appropriately amend their regulations no later than July 1, 2009.

GINA prohibits insurance companies in the group marketplace from using genetic information to adjust premium or contribution amounts. In the individual marketplace, the Act prohibits insurance companies from using genetic information to deny coverage, determine premium rates, or impose pre-existing condition exclusions. In the Medicare Supplement marketplace, insurance companies will be prohibited from using genetic information to deny or condition coverage, to determine premium rates, or to impose pre-existing condition exclusions. GINA's prohibitions against the use of genetic information do not prevent insurance companies from using information about a manifestation of a disease or disorder, even if genetically based.

GINA also prohibits group health plans and health issuers from requesting or requiring an individual or family member of an individual to undergo a genetic test.

**f. Michelle's Law**

Michelle's Law (Public Law 110-381) was signed into law on October 9, 2008. This federal law is effective for all insured and self-funded health plans on the first day of plan years beginning on or after October 9, 2009. Under the law, dependent children who are full-time students at a post-secondary educational institution are allowed to extend eligibility as a dependent child under a group health plan for up

to one year during a medically necessary leave of absence from school due to a serious medical condition.

## **2. State - Public Acts**

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

### **a. P.A. 95-973 Eating Disorders**

[Public Act 95-0973](#) (House Bill 1432) amends the State Employees Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Illinois Insurance Code, the HMO Act, and the Voluntary Health Services Act. Specifically, the law amends 215 ILCS 5/370c to include both “anorexia nervosa” and “bulimia nervosa” in the list of serious mental illnesses subject to certain coverage requirements.

The law applies to group policies covering more than 50 employees issued or renewed after the effective date of January 1, 2009.

### **b. P.A. 95-0978 Shingles Vaccine**

[Public Act 95-0978](#) (House Bill 4602) amends the State Employees Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Illinois Insurance Code, the HMO Act, and the Voluntary Health Services Act to provide coverage for a federally approved shingles vaccine for enrollees 60 years of age or older when ordered by a physician licensed to practice medicine in all its branches.

The law does not designate a benefit level.

The law became effective for group and individual policies amended, delivered, issued or renewed after the effective date of January 1, 2009.

### **c. P.A. 95-0958 Young Adult Dependent Coverage**

[Public Act 95-0958](#) (House Bill 5285) amends the State Employees Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Illinois Insurance Code, the HMO Act, and the Voluntary Health Services Act. The new law (215 ILCS

5/356z.12) gives parents with insurance policies that cover dependents the right to elect coverage for qualifying young adult dependents up to age 26 and up to age 30 for military veteran dependents.

The law was effective June 1, 2009. Any individual or group insurance policy issued, delivered or renewed on or after that date must include coverage required by the new law. A fact sheet regarding the new law is available at <http://insurance.illinois.gov/pressRelease/pr08/HB5285DependentCoverage.pdf>

d. **P.A. 95-1045 Breast Cancer Pain Medication and Therapy and Mammograms (Cost to Consumer)**

[Public Act 95-1045](#) amends the Illinois Insurance Code, HMO Act, Voluntary Health Services Plans Act, State Employees Act, Counties Code and Municipality Code. The law, effective March 27, 2009, requires that all group and individual health insurance and HMO policies must provide coverage for all medically necessary **pain medication and pain therapy** related to the treatment of breast cancer. The coverage must be provided on the same terms and conditions that are generally applicable to coverage provided for other conditions. "Pain therapy" is therapy that is medically based, includes reasonably defined goals (e.g., stabilizing or reducing pain), and provides for the periodic evaluation of the therapy's effectiveness in meeting those goals.

This law also requires coverage for mandated mammograms and ultrasound screenings be provided **at no cost to the insured** (i.e., co-pays or deductibles may not be applied). The cost of the mammogram or screening must not count against any annual or lifetime benefit limits contained in the insurance policy or HMO contract. [215 ILCS 5/356g(a-5) and 215 ILCS 125/4-6.1]

e. **P.A. 96-0766 Organ Transplant Medication Notification Act**

[Public Act 96-0766](#) amends the Illinois Insurance Code, HMO Act, Voluntary Health Services Plans Act, State Employees Act, Counties Code and Municipality Code. It provides that at least 60 days prior to making any formulary change that alters the terms of coverage for a patient receiving immunosuppressant drugs or discontinues coverage for a prescribed immunosuppressant drug that a patient is receiving, a policy or plan sponsor must, to the extent possible, notify the prescribing physician and the patient. This law was effective January 1, 2010.

**f. P.A. 96-0457 Drug Reference Compendia**

[Public Act 96-0457](#) amends the Illinois Insurance Code, HMO Act and State Employees Group Insurance Act to set forth certain reference compendia and other authoritative compendia, as identified by the federal Secretary of Health and Human Services or the insurance commissioner, in which a drug must be recognized for the treatment of the specific type of cancer for which the drug has been prescribed. The law was effective on August 14, 2009.

**g. P.A. 96-0013 State Continuation Amendment**

[Public Act 96-0013](#) amended the Illinois Insurance Code and HMO Act to provide that an employee or member is eligible for continuing coverage under a group insurance policy for up to 12 months (instead of 9 months) after the date the employee's or member's insurance under the policy would have terminated because of termination of employment or membership or reduction in employment hours. Provides that the employer must give written notice of the employee's option to elect continuation coverage to the employee and the insurer within 10 days after the employee's termination or reduction in hours. Provides that an employee or member who wishes continuation of coverage must make the request in writing within a 30-day period. The law provided that until January 1, 2010, if the employer failed or refused to provide notice of continuation rights to the employee or member, the insurer was required to mail notice of the continuation rights to the employee or member at the employee's last known address. The law was effective June 18, 2009.

**h. P.A. 96-0639 Wellness Coverage**

[Public Act 96-0639](#) amends the Illinois Insurance Code, HMO Act and State Employees Group Insurance Act. The law, effective January 1, 2010, provides that a policy or plan that provides coverage for hospital or medical treatment on an expense incurred basis, may offer a reasonably designed program for wellness coverage that allows for certain incentives for participation in health behavior wellness programs that are approved or offered by the insurer or plan. Wellness coverage, as defined in the Act, shall satisfy the requirements for an exception from the general prohibition against discrimination based on a health factor under the federal Health Insurance Portability and Accountability Act of 1996.

i. **P.A 95-1049 Habilitative Services**

[Public Act 95-1049](#) amends the State Employees Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Illinois Insurance Code, the HMO Act, and the Voluntary Health Services Act. The law requires coverage for habilitative services for children under 19 years of age with a congenital, genetic, or early acquired disorder so long as specified conditions are met. The law requires coverage for physical therapy, occupational therapy, speech therapy and other services, prescribed as part of a treatment plan to enhance a child's ability to function with his or her congenital, genetic or early acquired disorder. The services must be prescribed by a licensed physician and administered by a licensed speech-language pathologist, audiologist, occupational therapist, physical therapist, physician, nurse, optometrist, nutritionist, social worker or psychologist; and may subject to medical necessity requirements under the policy. Uniquely, the law provides for an external independent review for disputes regarding medical necessity. The law was effective January 1, 2010.

j. **P.A. 96-0857 External Independent Review, Uniform Health Applications and Health Expense Reporting (Illinois Fairness Act).**

[Public Act 96-0857](#) provides all Illinoisans with health insurance the right to an external independent review of insurance company denials or determinations regarding medical necessity. The Act makes it easier for individuals and small businesses to shop for health insurance, compare competing plans, and obtain the best insurance value. While individuals and small businesses seeking quotes from competing health insurance plans must now complete a separate application for each health insurer, the new law establishes a single health insurance application that will be used by all insurers and HMOs. In addition, the Act requires health insurance companies to report detailed information regarding premiums and expenses, including administrative costs and marketing expenses. The Department will publish this information on its website at [insurance.illinois.gov](http://insurance.illinois.gov).

**Independent External Review  
(available July 1, 2010)**

- Beginning July 1, 2010, all health insurers and HMOs will be required to provide an internal appeals process for denied claims, and must

notify covered individuals of the right to request an independent external review.

- Denied health insurance claims will be eligible for external review if:
  - The individual receiving or requesting the treatment was covered under the plan at the time of treatment;
  - The treatment in question is a covered benefit under the plan, but does not meet the insurer's or HMO's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
  - The individual has exhausted the internal appeals process (unless the timeframe for completion of a standard external review or expedited internal review would significantly increase the risk to a person's health or significantly reduce the treatment's effectiveness); and
  - In cases where the insurer or HMO determined that the treatment in question is experimental or investigational, the individual's health care provider has certified that the treatment in question is medically necessary.
- External reviews will be conducted by nationally-accredited Independent Review Organizations (IROs) approved by the Department every 2 years. When conducting external reviews, IROs must:
  - Assign qualified and impartial physicians or other health care professionals who are experts in the treatment of the person's condition, and who are knowledgeable about the treatment that is the subject of the review;
  - Maintain a system operating 24 hours a day, 7 days a week to accept and process information related to the review; and
  - Be independent, unbiased, and free of conflicts of interest with any of the individuals or entities involved in the review.
- Internal appeals:
  - Standard internal appeals must be completed within 15 business days after the insurer or HMO has received all required information.
  - Expedited internal appeals must be completed within 24 hours after the insurer or HMO has received all required information.
- External review:
  - Standard external reviews must be completed within 20 business days after the request for external review is first received.

- Expedited external reviews must be completed within 72-120 hours after the request for external review is first received (either orally or in writing).

**Standardized Health Insurance Applications  
(developed by July 1, 2010, and mandatory use by insurers  
begins January 1, 2011)**

- Prior to obtaining accurate premium rates for a given health insurance plan, individuals and small business owners must complete a detailed application for each insurer or HMO, including information about the health history of all persons to be covered – individuals, employees, and dependents.
- For small business owners especially – most of whom do not have access to a benefits consultant or human resources staff – this process can be difficult and time-consuming, and often prevents them from finding the most affordable and most appropriate plan for their employees.
- The Act establishes a committee within the Department to create a standardized health insurance application for use by all insurers and HMOs offering coverage in the individual and small group markets (2-50 employees).
- The committee will consist of consumers, small business owners, insurance agents and company representatives.
- Health insurers and HMOs will be required to use the standardized health insurance application beginning January 1, 2011.

**Insurer Expense Reporting  
(first reports published February, 2011)**

- Beginning in 2011, the Act will require insurers and HMOs to submit to the Department semi-annual statements with detailed information regarding premiums and expenditures for major medical health insurance plans.
- The information – which will be publicly available on the Department's website – will benefit individual consumers and small business owners seeking the best value for their hard-earned premium dollar. It

will also support the General Assembly and other policymakers in future health care reform efforts.

**k. P.A. 96-0833 Orthotic Device**

[Public Act 96-0833](#) amends the Illinois Insurance Code, Health Maintenance Organization Act, and Voluntary Health Services Plans Act to provide coverage for prosthetic and customized orthotic devices that are no less favorable than the terms and conditions applicable to substantially all medical and surgical benefits provided under the plan or coverage. The law allows a policy or plan to require prior authorization. Repairs and replacements of prosthetic and orthotic devices are also covered. A policy or plan may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to the Act shall be covered only if the prosthetic or orthotic devices are provided by a licensed provider employed by a provider service who contracts with or is designated by the carrier. The law is effective June 1, 2010 with a six-month delay until implementation.

**3. Other State Actions - Department Regulations**

**a. 50 Illinois Administrative Code 2008 Minimum Standards for Individual and Group Medicare Supplement Rule**

This rule was revised to comply with Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The changes to the rule must be in place in order for new 2010 Standardized Medicare Supplement policies to be sold after June 1, 2010. The rule incorporates the NAIC revised Medicare Supplement Insurance Minimum Standards Model Act. The rule established two new standardized Medicare Supplement policies (M/N) and eliminated four Medicare Supplement policies (E, H, I, and J) from consumer choices. The rule also establishes new hospice benefits to the Basic Core services and removes the Preventative Care Benefit and At-Home Recovery benefit from the standardized policies.

**b. 50 Illinois Administrative Code 2051 Preferred Provider Programs**

Illinois' framework for the regulation of Preferred Provider Program Administrators was last reviewed and modified in December of 1997. Since then, significant industry changes have occurred. At its September 15, 2009 meeting, the General Assembly's Joint Committee on Administrative Rules considered the Department of Insurance's revised rulemaking, intended to address these changes and govern, in a meaningful way, how managed care and provider networks interact with providers and with consumers within Illinois' current managed health care market.

Effective December 16, 2009, the Department's regulatory rewrite of Part 2051 does the following: 1) reorganizes the existing rule to give recognition to the roles and responsibilities of provider networks, discount plans and insurers; 2) strengthens standards for network adequacy and accessibility; 3) clarifies standards specific to the assignment of provider contracts; and 4) provides safeguards to those beneficiaries required to use the services of a non-contracted provider, including but not limited to ancillary providers (radiologists, anesthesiologists, pathologists and emergency room physicians).

**4. Other State Actions – Company Bulletins**

**a. Company Bulletin #2009-09**

[Company Bulletin #2009-09](#) issued by Director McRaith on December 21, 2009 advises insurers, HMOs and LHSOs that complete underwriting guidelines are required by the Department when investigating a consumer complaint related to rescission of a health policy.

## **Exhibits**

# Calls Received by Zip Code

From 1/1/2009 To 12/31/2009

<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>	<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>
61410	Abingdon	2	61411	Adair	1
62214	Addieville	3	60101	Addison	38
61230	Albany	4	62215	Albers	1
62806	Albion	5	60001	Alden	12
61231	Aledo	2	61412	Alexis	1
60102	Algonquin	54	62001	Alhambra	4
62807	Alma	1	62610	Alsey	1
60803	Alsip	28	62411	Altamont	1
62905	Alto Pass	1	62002	Alton	43
61310	Amboy	5	60666	Amf Ohare	3
61720	Anchor	1	61311	Ancona	1
61232	Andalusia	1	61233	Andover	1
62906	Anna	6	62413	Annapolis	1
61234	Annawan	1	60002	Antioch	40
61001	Apple River	3	61910	Arcola	5
62611	Arenzville	1	62501	Argenta	5
60004	Arlington Heights	110	60005	Arlington Heights	92
60006	Arlington Heights	14	61721	Armington	1
61812	Armstrong	1	60910	Aroma Park	1
61911	Arthur	2	60911	Ashkum	2
62612	Ashland	2	61912	Ashmore	1
61006	Ashton	6	62510	Assumption	4
61501	Astoria	2	62613	Athens	5
61723	Atlanta	3	62615	Auburn	7
60502	Aurora	37	60503	Aurora	9
60504	Aurora	32	60505	Aurora	26
60506	Aurora	69	60507	Aurora	2
60568	Aurora	1	60572	Aurora	4
60598	Aurora	1	62907	Ava	3
61415	Avon	1	61007	Baileyville	2
62809	Barnhill	1	60010	Barrington	117
60011	Barrington	12	61236	Barstow	1
62218	Bartelso	2	60103	Bartlett	55
60510	Batavia	40	62006	Batchtown	2
62314	Baylis	1	62618	Beardstown	11
62512	Beason	1	62219	Beckemeyer	3
60499	Bedford Park	3	60401	Beecher	12
62414	Beecher City	4	62220	Belleville	34
62221	Belleville	22	62222	Belleville	3
62223	Belleville	17	62226	Belleville	29
61724	Bellflower	1	60104	Bellwood	9

<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>	<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>
61008	Belvidere	27	61813	Bement	1
62009	Benld	2	60105	Bensenville	2
60106	Bensenville	26	61516	Benson	2
62812	Benton	7	60163	Berkeley	9
60402	Berwyn	40	62010	Bethalto	15
61914	Bethany	6	60511	Big Rock	2
61420	Blandinsville	1	60108	Bloomington	50
61701	Bloomington	39	61702	Bloomington	8
61704	Bloomington	36	60406	Blue Island	26
62513	Blue Mound	2	62621	Bluffs	3
60440	Bolingbrook	35	60490	Bolingbrook	26
62815	Bone Gap	1	60913	Bonfield	3
62816	Bonnie	1	60914	Bourbonnais	14
62316	Bowen	1	60407	Braceville	2
61421	Bradford	2	60915	Bradley	8
60408	Braidwood	8	62230	Breese	4
62417	Bridgeport	7	60455	Bridgeview	11
62012	Brighton	11	61517	Brimfield	2
60512	Bristol	1	60155	Broadview	9
60513	Brookfield	35	62910	Brookport	1
62418	Brownstown	3	62819	Buckner	1
61314	Buda	1	60089	Buffalo Grove	97
62912	Buncombe	1	60459	Burbank	14
60527	Burr Ridge	47	61422	Bushnell	1
62015	Butler	1	61010	Byron	17
60919	Cabery	2	62914	Cairo	2
61011	Caledonia	4	60409	Calumet City	29
61238	Cambridge	1	62319	Camden	1
62320	Camp Point	1	62916	Campbell Hill	1
60920	Campus	1	61520	Canton	20
62625	Cantrall	2	61012	Capron	1
61239	Carbon Cliff	2	62901	Carbondale	25
62902	Carbondale	1	62903	Carbondale	4
62626	Carlinville	18	61725	Carlock	3
62231	Carlyle	12	62821	Carmi	6
60116	Carol Stream	2	60128	Carol Stream	1
60132	Carol Stream	3	60188	Carol Stream	51
60197	Carol Stream	2	60199	Carol Stream	2
60110	Carpentersville	30	62917	Carrier Mills	1
62016	Carrollton	5	62918	Carterville	9
62321	Carthage	9	60013	Cary	34
62420	Casey	7	62232	Caseyville	9
61817	Catlin	3	62919	Cave In Rock	1
62801	Centralia	14	61818	Cerro Gordo	5
61820	Champaign	28	61821	Champaign	42

<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>	<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>
61822	Champaign	25	61824	Champaign	1
61826	Champaign	1	60410	Channahon	16
62628	Chapin	2	61920	Charleston	20
62629	Chatham	14	60922	Chebanse	2
61726	Chenoa	1	61317	Cherry	2
61016	Cherry Valley	3	62233	Chester	8
62630	Chesterfield	2	62518	Chestnut	1
60601	Chicago	75	60602	Chicago	52
60603	Chicago	46	60604	Chicago	19
60605	Chicago	35	60606	Chicago	93
60607	Chicago	33	60608	Chicago	31
60609	Chicago	27	60610	Chicago	56
60611	Chicago	59	60612	Chicago	41
60613	Chicago	63	60614	Chicago	106
60615	Chicago	30	60616	Chicago	42
60617	Chicago	42	60618	Chicago	66
60619	Chicago	41	60620	Chicago	43
60621	Chicago	13	60622	Chicago	54
60623	Chicago	18	60624	Chicago	11
60625	Chicago	69	60626	Chicago	44
60628	Chicago	28	60629	Chicago	49
60630	Chicago	41	60631	Chicago	31
60632	Chicago	22	60633	Chicago	10
60634	Chicago	46	60636	Chicago	16
60637	Chicago	39	60638	Chicago	52
60639	Chicago	33	60640	Chicago	66
60641	Chicago	43	60643	Chicago	55
60644	Chicago	19	60645	Chicago	38
60646	Chicago	29	60647	Chicago	57
60649	Chicago	25	60651	Chicago	26
60652	Chicago	30	60653	Chicago	15
60654	Chicago	49	60655	Chicago	19
60656	Chicago	34	60657	Chicago	98
60658	Chicago	1	60659	Chicago	32
60660	Chicago	40	60661	Chicago	25
60668	Chicago	1	60669	Chicago	1
60673	Chicago	1	60674	Chicago	1
60675	Chicago	1	60677	Chicago	2
60679	Chicago	1	60680	Chicago	2
60681	Chicago	1	60684	Chicago	1
60685	Chicago	1	60688	Chicago	1
60689	Chicago	1	60693	Chicago	2
60411	Chicago Heights	50	60412	Chicago Heights	4
60415	Chicago Ridge	8	61523	Chillicothe	12
62822	Christopher	3	60804	Cicero	15

<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>	<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>
62823	Cisne	1	60924	Cissna Park	1
62421	Claremont	2	60514	Clarendon Hills	16
62324	Clayton	1	60927	Clifton	3
61727	Clinton	15	60416	Coal City	6
61240	Coal Valley	2	62325	Coatsburg	1
62920	Cobden	3	62017	Coffeen	1
62234	Collinsville	35	61241	Colona	5
62236	Columbia	12	62631	Concord	1
61730	Cooksville	1	60112	Cortland	2
62018	Cottage Hills	2	62237	Coulterville	4
60478	Country Club Hills	12	62422	Cowden	15
62922	Creal Springs	2	60403	Crest Hill	17
60417	Crete	10	61610	Creve Coeur	7
62827	Crossville	3	60012	Crystal Lake	40
60014	Crystal Lake	94	60039	Crystal Lake	4
61427	Cuba	1	60929	Cullom	1
62238	Cutler	2	61428	Dahinda	6
62828	Dahlgren	3	62829	Dale	2
62330	Dallas City	1	61925	Dalton City	1
60930	Danforth	1	61732	Danvers	1
61832	Danville	24	61834	Danville	4
60561	Darien	22	61019	Davis	1
61020	Davis Junction	2	62520	Dawson	2
60115	De Kalb	23	61839	De Land	1
62521	Decatur	59	62522	Decatur	23
62523	Decatur	2	62525	Decatur	4
62526	Decatur	51	61243	Deer Grove	1
60015	Deerfield	105	61734	Delavan	1
62423	Dennison	1	61322	Depue	2
60016	Des Plaines	57	60017	Des Plaines	2
60018	Des Plaines	50	60019	Des Plaines	2
61735	Dewitt	1	62530	Divernon	2
62830	Dix	2	61021	Dixon	23
60419	Dolton	17	62926	Dongola	3
62019	Donnellson	1	62021	Dorsey	3
61323	Dover	1	60515	Downers Grove	48
60516	Downers Grove	31	61736	Downs	2
62832	Du Quoin	8	60118	Dundee	20
61525	Dunlap	5	62239	Dupo	3
61024	Durand	2	60420	Dwight	5
62023	Eagarville	2	60518	Earlville	3
62024	East Alton	18	62240	East Carondelet	1
61025	East Dubuque	3	61430	East Galesburg	1
60932	East Lynn	1	61244	East Moline	13
61611	East Peoria	28	62201	East Saint Louis	5

<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>	<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>
62202	East Saint Louis	2	62203	East Saint Louis	7
62204	East Saint Louis	7	62205	East Saint Louis	10
62206	East Saint Louis	11	62207	East Saint Louis	6
62928	Eddyville	1	62426	Edgewood	4
62531	Edinburg	3	61528	Edwards	7
62025	Edwardsville	29	62026	Edwardsville	1
62401	Effingham	38	61738	El Paso	2
60119	Elburn	11	61324	Eldena	1
62930	Eldorado	8	60120	Elgin	27
60121	Elgin	5	60123	Elgin	59
60124	Elgin	23	61028	Elizabeth	1
60007	Elk Grove Village	85	60009	Elk Grove Village	7
62634	Elkhart	1	62932	Elkville	2
62833	Ellery	1	62241	Ellis Grove	2
61431	Ellisville	2	61737	Ellsworth	1
60126	Elmhurst	60	61529	Elmwood	11
60707	Elmwood Park	37	62028	Elsah	1
62334	Elvaston	1	60421	Elwood	3
60934	Emington	1	62835	Enfield	4
61250	Erie	2	60935	Essex	1
61530	Eureka	10	60201	Evanston	54
60202	Evanston	32	60203	Evanston	10
60204	Evanston	2	60209	Evanston	2
62242	Evansville	5	60805	Evergreen Park	22
62836	Ewing	1	61739	Fairbury	2
62837	Fairfield	8	61841	Fairmount	1
62208	Fairview Heights	7	62838	Farina	1
62533	Farmersville	1	61531	Farmington	2
61251	Fenton	1	62032	Fillmore	2
61844	Fithian	2	62839	Flora	5
60422	Flossmoor	17	61532	Forest City	1
60130	Forest Park	20	62535	Forsyth	8
60020	Fox Lake	17	60021	Fox River Grove	3
60423	Frankfort	30	62638	Franklin	2
61031	Franklin Grove	2	60131	Franklin Park	26
62243	Freeburg	7	61032	Freeport	31
61252	Fulton	7	62244	Fults	2
62935	Galatia	4	61036	Galena	6
61401	Galesburg	55	61402	Galesburg	1
61434	Galva	4	61254	Geneseo	11
60134	Geneva	64	60135	Genoa	7
61846	Georgetown	1	61435	Gerlaw	1
62245	Germantown	4	60936	Gibson City	5
60136	Gilberts	4	62033	Gillespie	3
60938	Gilman	3	62640	Girard	6

<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>	<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>
61437	Gladstone	1	62034	Glen Carbon	12
60137	Glen Ellyn	58	60138	Glen Ellyn	1
62536	Glenarm	1	60022	Glencoe	20
60139	Glendale Heights	29	60025	Glenview	51
60026	Glenview Nas	18	60425	Glenwood	5
62035	Godfrey	14	62938	Golconda	2
62339	Golden	3	61742	Goodfield	2
62939	Goreville	3	62940	Gorham	2
62037	Grafton	1	61325	Grand Ridge	1
62942	Grand Tower	1	62040	Granite City	50
60940	Grant Park	2	61326	Granville	1
60030	Grayslake	55	62844	Grayville	4
60088	Great Lakes	1	61534	Green Valley	1
62044	Greenfield	2	62428	Greenup	2
62642	Greenview	4	62246	Greenville	7
60036	Greys Lake	1	61744	Gridley	1
62340	Griggsville	2	61535	Groveland	3
60031	Gurnee	57	62045	Hamburg	1
62341	Hamilton	3	60140	Hampshire	12
61256	Hampton	1	61536	Hanna City	3
61041	Hanover	1	60133	Hanover Park	43
62047	Hardin	5	62946	Harrisburg	9
60033	Harvard	10	62538	Harvel	1
60426	Harvey	14	62644	Havana	3
60429	Hazel Crest	19	60034	Hebron	3
62248	Hecker	1	61327	Hennepin	4
62947	Herod	1	62431	Herrick	1
62948	Herrin	9	60941	Herscher	2
62649	Hettick	1	61745	Heyworth	1
60457	Hickory Hills	9	62432	Hidalgo	1
62249	Highland	16	60035	Highland Park	77
60040	Highwood	6	62049	Hillsboro	4
61257	Hillsdale	2	60162	Hillside	10
62050	Hillview	1	60520	Hinckley	2
60141	Hines	3	60521	Hinsdale	36
60522	Hinsdale	3	60570	Hinsdale	4
62250	Hoffman	2	60169	Hoffman Estates	40
61849	Homer	2	60491	Homer Glen	36
60456	Hometown	3	60430	Homewood	28
60942	Hoopeston	1	61258	Hooppole	1
61747	Hopedale	3	60944	Hopkins Park	1
62803	Hoyleton	4	62343	Hull	2
60142	Huntley	30	62344	Huntsville	1
62949	Hurst	2	62433	Hutsonville	2
62539	Illioplis	2	99999	In Illinois	3933

<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>	<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>
62846	Ina	1	61850	Indianola	1
60041	Ingleside	18	61441	Ipava	3
60042	Island Lake	12	60143	Itasca	41
62849	Iuka	2	61851	Ivesdale	2
62650	Jacksonville	25	62651	Jacksonville	1
62052	Jerseyville	11	62951	Johnston City	4
60431	Joliet	33	60432	Joliet	17
60433	Joliet	15	60434	Joliet	3
60435	Joliet	49	60436	Joliet	14
62952	Jonesboro	2	60458	Justice	11
60901	Kankakee	33	61933	Kansas	3
61328	Kasbeer	1	62852	Keensburg	2
60043	Kenilworth	1	61749	Kenney	1
61443	Kewanee	14	62540	Kincaid	1
60145	Kingston	8	61539	Kingston Mines	1
62854	Kinmundy	1	60437	Kinsman	1
60146	Kirkland	4	61448	Knoxville	3
61449	La Fayette	1	60525	La Grange	32
60526	La Grange Park	18	61330	La Moille	3
61541	La Rose	1	61301	La Salle	26
61540	Lacon	1	61329	Ladd	1
60044	Lake Bluff	28	60045	Lake Forest	29
60156	Lake in the Hills	32	60046	Lake Villa	42
60047	Lake Zurich	74	60438	Lansing	26
62439	Lawrenceville	7	61752	Le Roy	2
62254	Lebanon	4	60530	Lee	7
60531	Leland	2	60439	Lemont	30
61048	Lena	5	62255	Lenzburg	1
61332	Leonore	6	62440	Lerna	2
61542	Lewistown	4	61753	Lexington	3
62347	Liberty	4	60048	Libertyville	48
60092	Libertyville	1	62656	Lincoln	24
60069	Lincolnshire	18	60712	Lincolnwood	14
60532	Lisle	58	62056	Litchfield	19
62660	Literberry	1	61452	Littleton	1
62058	Livingston	3	62661	Loami	1
60441	Lockport	41	61454	Lomax	1
60148	Lombard	77	61333	Long Point	2
61852	Longview	3	62349	Lorraine	2
62858	Louisville	13	61111	Loves Park	42
61937	Lovington	2	61545	Lowpoint	1
61262	Lynn Center	2	60534	Lyons	12
61115	Machesney Park	32	61755	Mackinaw	10
61455	Macomb	11	62060	Madison	3
62256	Maestown	1	61853	Mahomet	12

<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>	<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>
60150	Malta	3	60442	Manhattan	8
61546	Manito	4	61338	Manlius	2
60950	Manteno	6	60151	Maple Park	6
61547	Mapleton	2	60152	Marengo	10
62959	Marion	35	62257	Marissa	4
61340	Mark	1	60428	Markham	10
61756	Maroa	2	61341	Marseilles	12
62441	Marshall	6	62442	Martinsville	1
60951	Martinton	1	62062	Maryville	6
62224	Mascoutah	1	62258	Mascoutah	5
62664	Mason City	4	61263	Matherville	1
60443	Matteson	22	61938	Mattoon	29
60153	Maywood	7	60444	Mazon	1
60050	Mc Henry	46	60051	Mc Henry	33
61754	Mc Lean	1	62859	Mc Leansboro	4
62545	Mechanicsburg	1	60157	Medinah	7
62063	Medora	3	60160	Melrose Park	16
60161	Melrose Park	3	60164	Melrose Park	11
62351	Mendon	1	61342	Mendota	11
62665	Meredosia	1	61548	Metamora	7
62960	Metropolis	10	62666	Middletown	1
60445	Midlothian	21	61264	Milan	11
60953	Milford	2	60536	Millbrook	3
61051	Milledgeville	1	60537	Millington	1
62260	Millstadt	7	61760	Minonk	1
60447	Minooka	8	62444	Mode	1
62261	Modoc	1	60448	Mokena	31
61265	Moline	30	60954	Momence	5
60449	Monee	13	61462	Monmouth	8
61052	Monroe Center	1	60538	Montgomery	25
61856	Monticello	12	62445	Montrose	1
60539	Mooseheart	7	62067	Moro	2
60450	Morris	29	61270	Morrison	6
62546	Morrisonville	1	61550	Morton	20
60053	Morton Grove	39	62963	Mound City	1
62863	Mount Carmel	9	61053	Mount Carroll	4
62446	Mount Erie	1	61054	Mount Morris	3
62069	Mount Olive	8	60056	Mount Prospect	65
62548	Mount Pulaski	2	62353	Mount Sterling	7
62864	Mount Vernon	30	62550	Moweaqua	3
62070	Mozier	1	62549	Mt Zion	7
62262	Mulberry Grove	1	62865	Mulkeytown	1
60060	Mundelein	47	62966	Murphysboro	13
62668	Murrayville	2	60540	Naperville	87
60563	Naperville	59	60564	Naperville	54

<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>	<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>
60565	Naperville	61	60566	Naperville	1
60567	Naperville	2	62263	Nashville	1
62354	Nauvoo	3	62355	Nebo	1
62447	Neoga	2	61345	Neponset	3
62264	New Athens	3	62265	New Baden	4
61272	New Boston	1	62074	New Douglas	3
60451	New Lenox	43	62266	New Memphis	1
60541	Newark	5	61942	Newman	1
62448	Newton	4	62551	Niantic	2
60714	Niles	53	62868	Noble	3
62075	Nokomis	2	61761	Normal	25
62869	Norris City	1	60542	North Aurora	23
60064	North Chicago	6	60062	Northbrook	116
60065	Northbrook	1	62269	O Fallon	23
60523	Oak Brook	47	60452	Oak Forest	24
60453	Oak Lawn	60	60454	Oak Lawn	2
60301	Oak Park	3	60302	Oak Park	59
60303	Oak Park	1	60304	Oak Park	21
62673	Oakford	2	61858	Oakwood	1
62449	Oblong	5	62553	Oconee	1
60460	Odell	1	61859	Ogden	2
61348	Oglesby	4	61349	Ohio	1
62076	Ohlman	1	62271	Okawville	3
62969	Olive Branch	1	62970	Olmsted	1
62450	Olney	4	60461	Olympia Fields	12
60955	Onarga	1	61467	Oneida	1
61469	Oquawka	2	61061	Oregon	5
61273	Orion	2	60462	Orland Park	52
60467	Orland Park	37	60543	Oswego	42
61350	Ottawa	12	88888	Out of Illinois	2384
62972	Ozark	5	60038	Palatine	1
60067	Palatine	51	60074	Palatine	47
62451	Palestine	2	62674	Palmyra	1
60463	Palos Heights	16	60465	Palos Hills	15
60464	Palos Park	9	62557	Pana	10
61944	Paris	11	60466	Park Forest	26
60068	Park Ridge	65	62875	Patoka	2
62078	Patterson	1	61353	Paw Paw	2
62558	Pawnee	5	60957	Paxton	7
62361	Pearl	1	61062	Pearl City	2
61063	Pecatonica	6	61554	Pekin	41
55555	Pending HMO Complaints	3	61601	Peoria	1
61602	Peoria	13	61603	Peoria	17
61604	Peoria	19	61605	Peoria	13
61606	Peoria	8	61607	Peoria	19

<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>	<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>
61612	Peoria	2	61614	Peoria	44
61615	Peoria	27	61625	Peoria	2
61629	Peoria	1	61630	Peoria	1
61635	Peoria	1	61637	Peoria	1
61616	Peoria Heights	6	60468	Peotone	7
62272	Percy	1	62362	Perry	1
61354	Peru	14	61863	Pesotum	4
62675	Petersburg	6	62079	Piasa	1
62273	Pierron	1	62274	Pinckneyville	5
60959	Piper City	2	62974	Pittsburg	1
62363	Pittsfield	3	60544	Plainfield	30
60585	Plainfield	22	60586	Plainfield	41
60545	Plano	16	60170	Plato Center	2
62366	Pleasant Hill	2	62677	Pleasant Plains	3
62367	Plymouth	1	62275	Pocahontas	14
62975	Pomona	1	61764	Pontiac	20
61065	Poplar Grove	8	61275	Port Byron	3
60469	Posen	3	61356	Princeton	20
61559	Princeville	3	61277	Prophetstown	1
60070	Prospect Heights	10	61560	Putnam	2
62301	Quincy	46	62305	Quincy	19
62306	Quincy	1	62080	Ramsey	3
60470	Ransom	1	61866	Rantoul	8
62560	Raymond	2	62278	Red Bud	12
62279	Renault	3	60071	Richmond	2
60471	Richton Park	4	62877	Richview	1
62979	Ridgway	2	61067	Ridott	1
62878	Rinard	1	60072	Ringwood	3
61472	Rio	1	60305	River Forest	23
60171	River Grove	10	60627	Riverdale	1
60827	Riverdale	14	60546	Riverside	11
62561	Riverton	8	60472	Robbins	3
62454	Robinson	10	61068	Rochelle	13
62563	Rochester	12	61070	Rock City	1
61071	Rock Falls	8	61201	Rock Island	26
61204	Rock Island	1	61101	Rockford	19
61102	Rockford	21	61103	Rockford	39
61104	Rockford	12	61105	Rockford	1
61107	Rockford	52	61108	Rockford	49
61109	Rockford	34	61110	Rockford	1
61114	Rockford	21	61132	Rockford	1
61072	Rockton	17	60008	Rolling Meadows	61
60446	Romeoville	34	62082	Roodhouse	1
62083	Rosamond	1	61073	Roscoe	22
60172	Roselle	47	60706	Rosemont	31

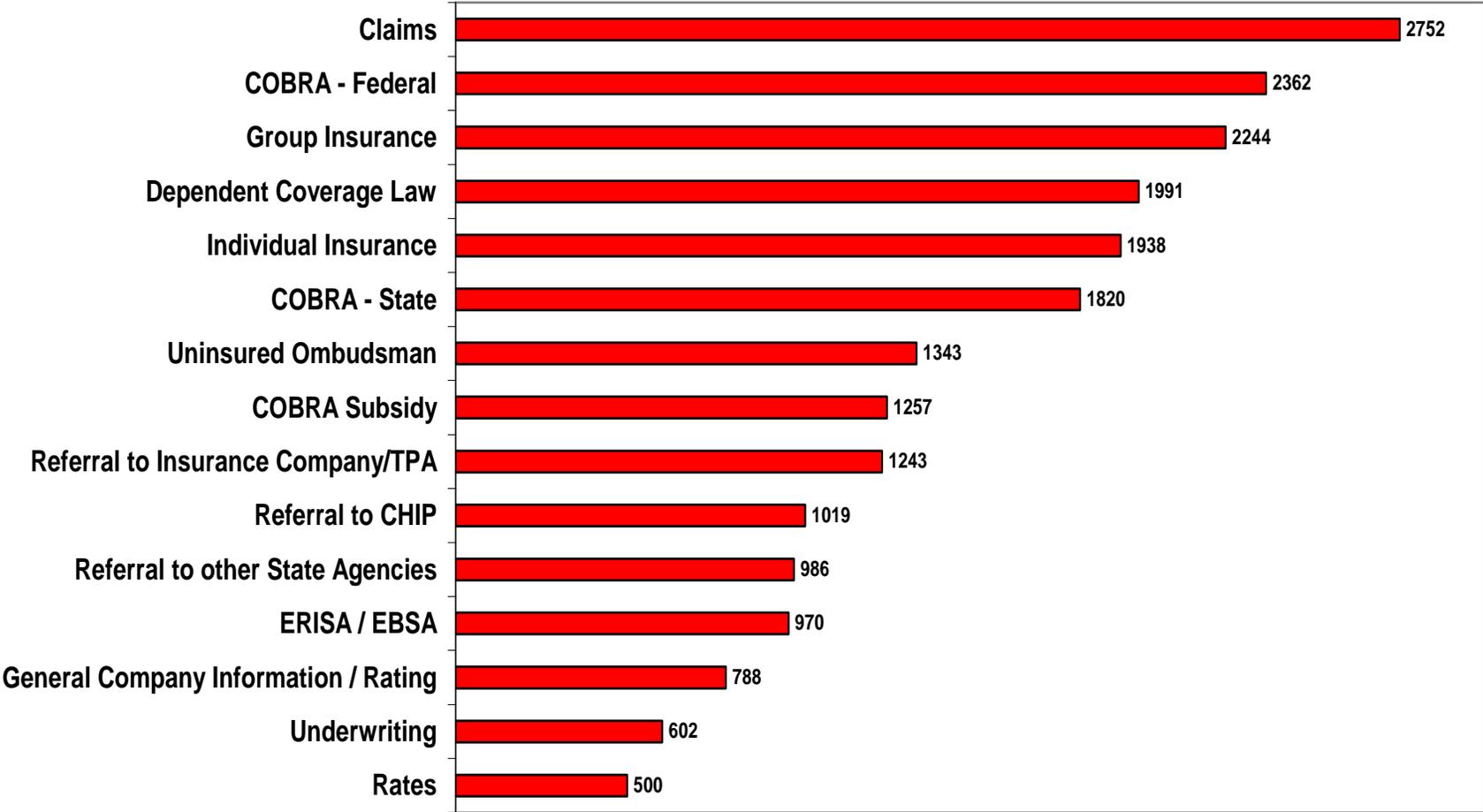
<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>	<b>Zip Code</b>	<b>Post Office Name</b>	<b>Calls</b>
62982	Rosiclare	1	60963	Rossville	3
60073	Round Lake	56	62084	Roxana	1
61871	Royal	1	62983	Royalton	1
62681	Rushville	4	60075	Russell	1
61872	Sadorus	1	62879	Sailor Springs	1
60964	Saint Anne	4	60174	Saint Charles	66
60175	Saint Charles	41	62460	Saint Francisville	1
62281	Saint Jacob	7	61873	Saint Joseph	4
62881	Salem	15	62882	Sandoval	1
60548	Sandwich	22	61769	Saunemin	2
61074	Savanna	6	61874	Savoy	5
62085	Sawyerterville	1	60173	Schaumburg	44
60192	Schaumburg	22	60193	Schaumburg	58
60194	Schaumburg	23	60195	Schaumburg	6
60196	Schaumburg	3	60176	Schiller Park	13
61475	Sciota	1	62225	Scott Air Force Base	4
61359	Seatonville	1	61771	Secor	1
61360	Seneca	4	60549	Serena	1
62884	Sesser	1	61875	Seymour	1
60550	Shabbona	1	62984	Shawneetown	1
61361	Sheffield	2	62565	Shelbyville	11
60966	Sheldon	1	60551	Sheridan	4
62684	Sherman	2	61281	Sherrard	1
62685	Shipman	6	60404	Shorewood	31
62461	Shumway	1	61773	Sibley	1
61877	Sidney	1	61282	Silvis	3
62985	Simpson	1	60076	Skokie	54
60077	Skokie	37	62284	Smithboro	3
61477	Smithfield	2	62285	Smithton	4
60552	Somonauk	12	62086	Sorento	3
61080	South Beloit	8	60177	South Elgin	20
60473	South Holland	20	61564	South Pekin	1
62087	South Roxana	3	60474	South Wilmington	1
62286	Sparta	6	60081	Spring Grove	18
61362	Spring Valley	14	62701	Springfield	5
62702	Springfield	74	62703	Springfield	31
62704	Springfield	111	62705	Springfield	7
62706	Springfield	2	62707	Springfield	19
62708	Springfield	2	62711	Springfield	29
62712	Springfield	13	62713	Springfield	1
62715	Springfield	1	62746	Springfield	1
62761	Springfield	2	62762	Springfield	1
62763	Springfield	1	62767	Springfield	4
62769	Springfield	1	62791	Springfield	3
62794	Springfield	1	61774	Stanford	1

<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>	<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>
62088	Staunton	7	62288	Steeleville	5
60475	Steger	10	61081	Sterling	9
60553	Steward	1	62463	Stewardson	1
61084	Stillman Valley	2	61085	Stockton	3
60165	Stone Park	1	62987	Stonefort	1
62464	Stoy	2	60107	Streamwood	38
61364	Streator	21	61480	Stronghurst	1
60554	Sugar Grove	19	61951	Sullivan	5
62289	Summerfield	1	60501	Summit Argo	8
60178	Sycamore	29	62888	Tamaroa	2
62988	Tamms	1	61283	Tampico	1
61284	Taylor Ridge	1	62089	Taylor Springs	1
62568	Taylorville	22	62467	Teutopolis	7
62889	Texico	1	61285	Thomson	2
60476	Thornton	2	62292	Tilden	1
61833	Tilton	1	62375	Timewell	1
60477	Tinley Park	43	60487	Tinley Park	36
62468	Toledo	4	61880	Tolono	5
61369	Toluca	8	61370	Tonica	2
61483	Toulon	4	61776	Towanda	1
62571	Tower Hill	1	61568	Tremont	3
62293	Trenton	8	62294	Troy	13
61372	Troy Grove	2	62991	Tunnel Hill	3
61953	Tuscola	4	60180	Union	5
61801	Urbana	20	61802	Urbana	9
62376	Ursa	1	61373	Utica	3
62295	Valmeyer	4	62471	Vandalia	9
61375	Varna	1	62090	Venice	3
60061	Vernon Hills	42	62995	Vienna	2
61956	Villa Grove	1	60181	Villa Park	37
62996	Villa Ridge	1	62690	Virден	6
60182	Virgil	1	62691	Virginia	4
60083	Wadsworth	7	61376	Walnut	1
62893	Walnut Hill	3	62091	Walshville	1
62894	Waltonville	1	61777	Wapella	2
61087	Warren	3	62573	Warrensburg	1
60555	Warrenville	28	62379	Warsaw	3
61571	Washington	17	61488	Wataga	2
62298	Waterloo	22	60556	Waterman	4
60970	Watseka	8	60084	Wauconda	27
60085	Waukegan	29	60087	Waukegan	22
62692	Waverly	7	60184	Wayne	3
62895	Wayne City	1	60557	Wedron	2
61882	Weldon	1	60185	West Chicago	43
60186	West Chicago	3	62896	West Frankfort	16

<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>	<u>Zip Code</u>	<u>Post Office Name</u>	<u>Calls</u>
62476	West Salem	1	62477	West Union	1
60154	Westchester	40	60558	Western Springs	20
60559	Westmont	38	61883	Westville	3
60187	Wheaton	46	60189	Wheaton	58
62479	Wheeler	1	60090	Wheeling	43
62092	White Hall	1	61884	White Heath	4
61489	Williamsfield	4	62693	Williamsville	1
62480	Willow Hill	2	60480	Willow Springs	4
60091	Wilmette	55	60481	Wilmington	12
62093	Wilsonville	2	62694	Winchester	2
61957	Windsor	2	60190	Winfield	19
61088	Winnebago	7	60093	Winnetka	43
61089	Winslow	2	60096	Winthrop Harbor	3
60097	Wonder Lake	10	60191	Wood Dale	30
62095	Wood River	12	61490	Woodhull	3
62898	Woodlawn	2	60517	Woodridge	36
62695	Woodson	1	60098	Woodstock	44
62097	Worden	4	60482	Worth	13
61379	Wyandot	3	61491	Wyoming	1
62899	Xenia	2	60560	Yorkville	37
62999	Zeigler	2	60099	Zion	22

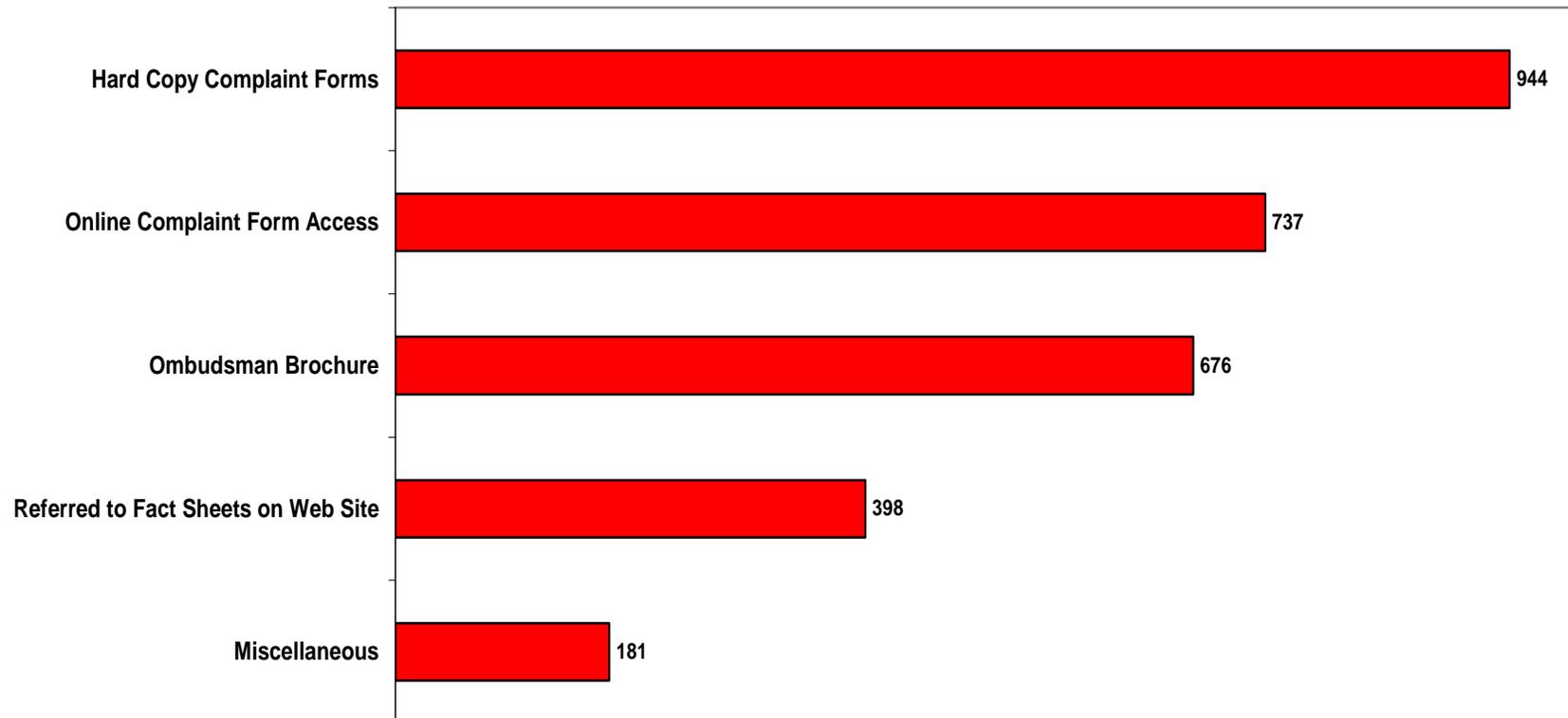
1114 Zip Codes Contacted by  
20785 Total Calls Received

**Calls received by OCHI (by Category)  
(Top 15)**



**EXHIBIT 2**

## Materials Sent to Consumers by OCHI (Top 5)



**EXHIBIT 3**

# Calls Received by OCHI Per Month

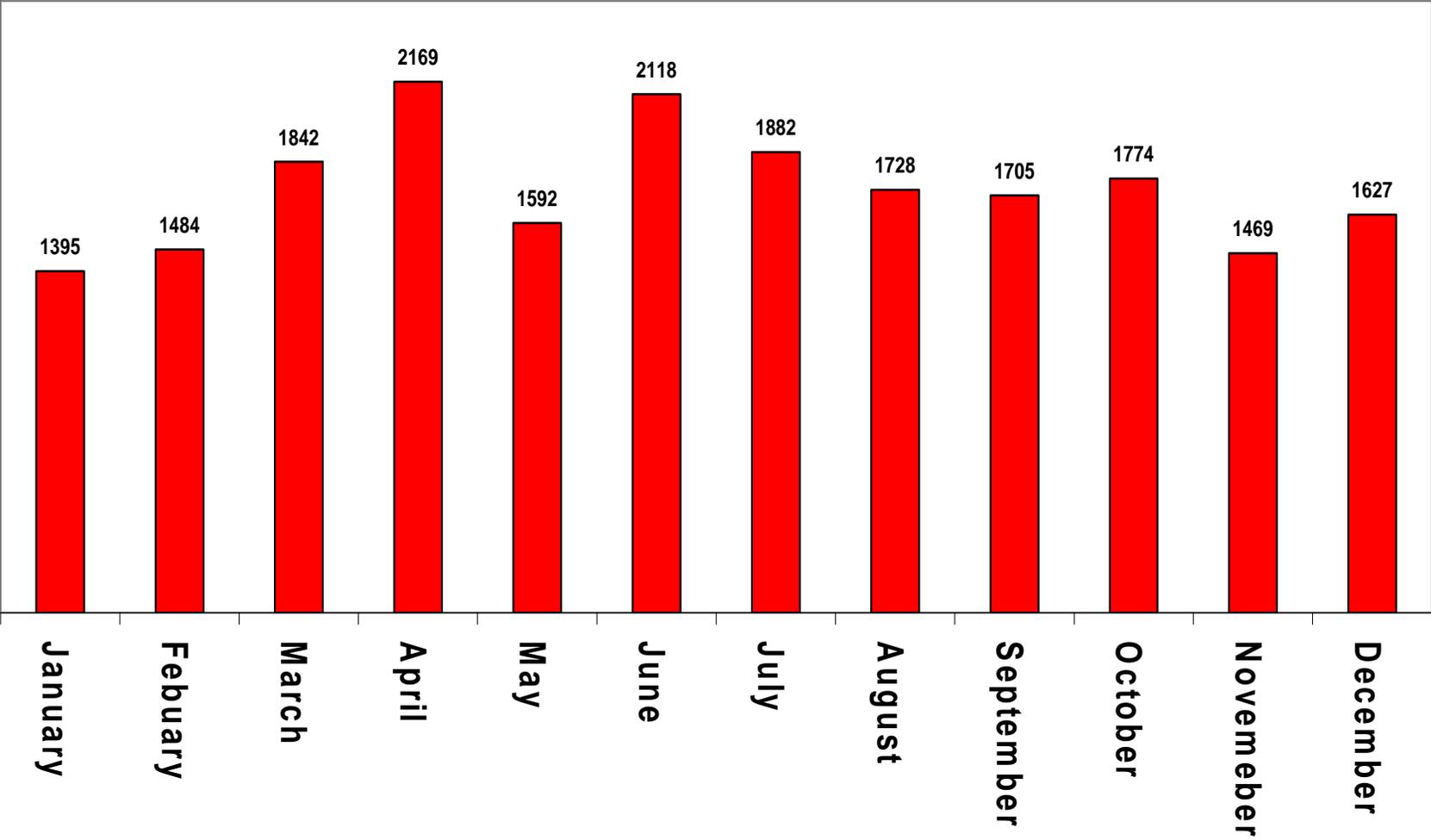


EXHIBIT 4

HMO Company Complaint Record -- General Summary 2008

Number of Complaints  
Originated by:

Disposition of  
Complaints

Company Name	HCP Enrollment	Total Complaints	Total DOJ Complaints	A) Consumer/Enrollee	B) Provider	C) Other Individual	Complaints with External Review	A) Relief Granted	B) Partial Relief	C) Information Furnished	D) No Relief Granted
AETNA HEALTH OF ILLINOIS	40,388	1,437	30	496	704	237	2	362	34	1,040	1
CIGNA HEALTHCARE OF ILLINOIS INC	944	207	4	159	43	5	0	120	2	73	12
CIGNA HEALTHCARE OF ST LOUIS INC	142	19	0	16	3	0	0	8	0	9	2
GROUP HEALTH PLAN INC	21,133	3	0	1	2	0	0	1	0	1	1
HEALTH ALLIANCE MEDICAL PLANS INC	134,169	581	29	318	253	10	15	76	4	15	486
HEALTH ALLIANCE MIDWEST INC	466	0	0	0	0	0	0	0	0	0	0
HEALTH CARE SERVICE CORP MUT LEG RES	661,860	480	194	337	122	21	0	216	113	34	117
HMO MISSOURI INC	0	26	0	19	6	1	0	12	1	1	12
HUMANA BENEFIT PLAN OF ILLINOIS	50,303	132	10	98	16	18	0	50	0	0	82
HUMANA HEALTH PLAN INC	86,340	506	33	450	48	8	2	288	30	4	184
MEDICAL ASSOCIATES HEALTH PLAN INC	3,177	18	1	6	12	0	0	5	0	1	12
MERCY HEALTH PLANS OF MISSOURI INC	723	59	0	14	41	4	0	15	1	2	41
NEVADACARE INC	18	0	0	0	0	0	0	0	0	0	0
PERSONALCARE INSURANCE OF ILLINOIS INC	45,041	713	29	491	214	8	50	334	10	11	358
UNICARE HEALTH PLANS OF THE MIDWEST IN	90,743	422	49	286	134	2	6	269	5	44	104
UNION HEALTH SERVICE INC	2,222	31	0	31	0	0	7	23	3	0	5
UNITED HEALTHCARE OF ILLINOIS INC	23,192	80	16	31	15	34	0	29	2	4	45
UNITED HEALTHCARE OF THE MIDWEST INC	8,980	11	0	7	3	1	0	4	0	0	7
UNITEDHEALTHCARE PLAN OF THE RIVERVAL	11,142	68	8	66	1	1	3	23	2	10	33
<b>TOTALS</b>	<b>1,180,98</b>	<b>4,793</b>	<b>403</b>	<b>2,826</b>	<b>1,617</b>	<b>350</b>	<b>85</b>	<b>1,835</b>	<b>207</b>	<b>1,249</b>	<b>1,502</b>

As of: December 31, 2008

Source: Illinois Department of Insurance

Published: Thursday, July 16, 2009

HMO Company Complaint Record -- Classification Summary 2008

Number of Complaints  
Classified As:

Company Name	HCP Enrollment	Total Complaints	Total DOJ Complaints	A) Denial of Care or Treatment	B) Denial of Diagnostic Procedure	C) Denial of Referral Request	D) Sufficient Choice & Accessibility of HCP	E) Underwriting	F) Marketing and Sales	G) Claims and Utilization Review	H) Member Services	I) Provider Relations - Quality of Care	J) Provider's Complaints - Prompt Pay	K) Miscellaneous
AETNA HEALTH OF ILLINOIS	40,388	1,437	30	7	10	4	1	1	1,297	33	41	42	0	
CIGNA HEALTHCARE OF ILLINOIS INC	944	207	4	29	0	0	9	0	43	106	1	5	14	
CIGNA HEALTHCARE OF ST LOUIS INC	142	19	0	0	0	2	0	0	2	14	0	0	1	
GROUP HEALTH PLAN INC	21,133	3	0	0	0	0	0	0	3	0	0	0	0	
HEALTH ALLIANCE MEDICAL PLANS INC	134,169	581	29	91	1	41	0	1	442	0	0	0	5	
HEALTH ALLIANCE MIDWEST INC	466	0	0	0	0	0	0	0	0	0	0	0	0	
HEALTH CARE SERVICE CORP MUT LEG RES CO	661,860	480	194	37	1	22	1	0	369	5	5	13	27	
HMO MISSOURI INC	0	26	0	14	0	2	0	0	9	0	0	0	1	
HUMANA BENEFIT PLAN OF ILLINOIS	50,303	132	10	60	5	10	0	0	49	0	0	0	8	
HUMANA HEALTH PLAN INC	86,340	506	33	98	5	10	2	0	360	29	2	0	0	
MEDICAL ASSOCIATES HEALTH PLAN INC	3,177	18	1	0	0	0	0	0	0	0	1	0	17	
MERCY HEALTH PLANS OF MISSOURI INC	723	59	0	5	0	5	9	0	5	0	0	0	35	
NEVADACARE INC	18	0	0	0	0	0	0	0	0	0	0	0	0	
PERSONALCARE INSURANCE OF ILLINOIS INC	45,041	713	29	199	64	10	0	0	428	1	5	6	0	
UNICARE HEALTH PLANS OF THE MIDWEST INC	90,743	422	49	116	2	2	0	0	286	4	11	0	1	
UNION HEALTH SERVICE INC	2,222	31	0	2	1	1	0	0	8	5	14	0	0	
UNITED HEALTHCARE OF ILLINOIS INC	23,192	80	16	0	0	0	1	0	77	0	0	0	2	
UNITED HEALTHCARE OF THE MIDWEST INC	8,980	11	0	0	0	0	0	0	7	1	2	0	1	
UNITEDHEALTHCARE PLAN OF THE RIVERVALLEY	11,142	68	8	7	0	6	0	0	48	0	0	0	7	
<b>TOTALS</b>	<b>1,180,98</b>	<b>4,793</b>	<b>403</b>	<b>665</b>	<b>89</b>	<b>115</b>	<b>23</b>	<b>2</b>	<b>3,433</b>	<b>198</b>	<b>82</b>	<b>66</b>	<b>119</b>	

As of: December 31, 2008

Source: Illinois Department of Insurance

Published: Thursday, July 16, 2009

HMO External Independent Review Summary 2008

Disposition of  
External Reviews

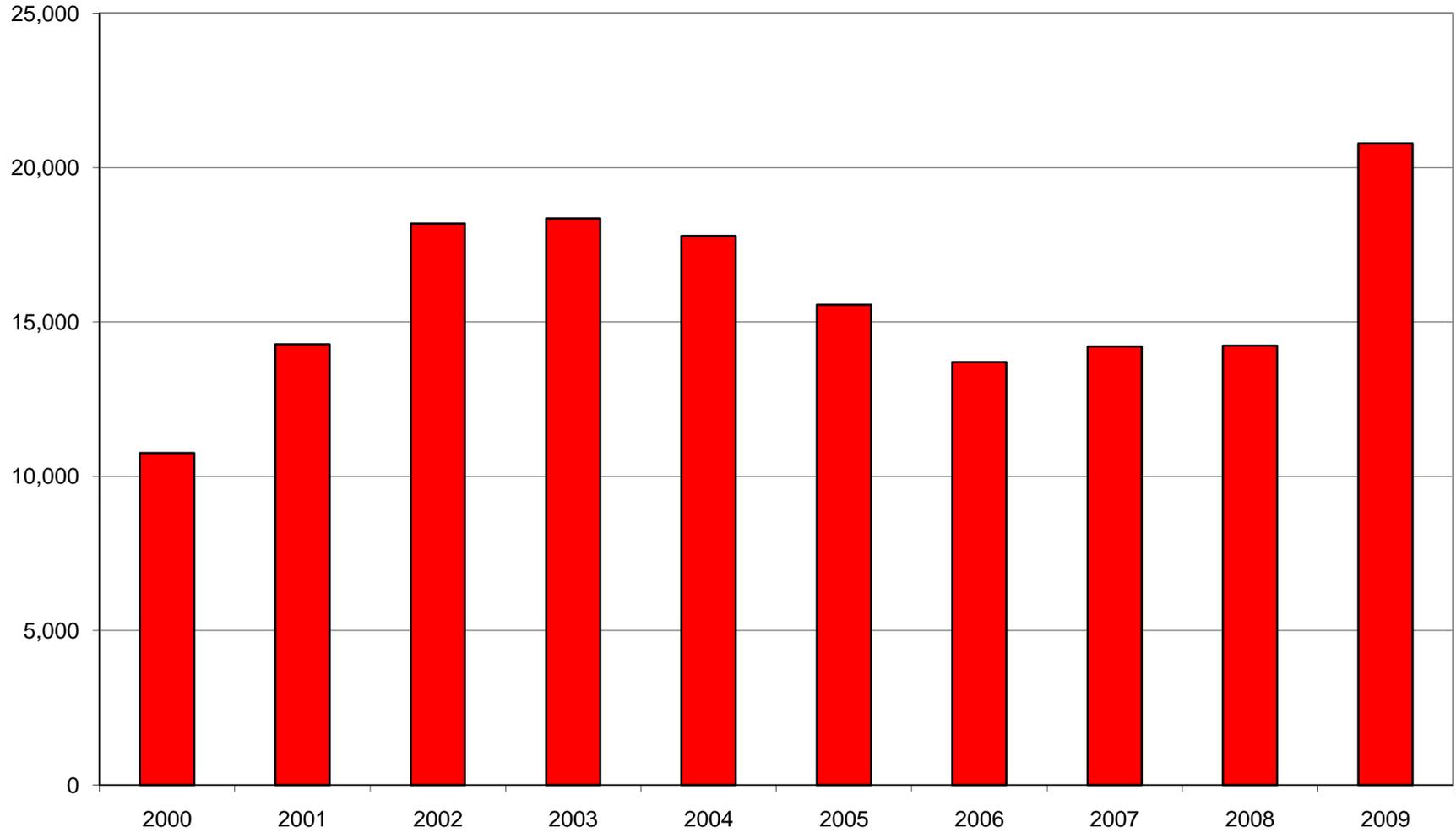
Company Name	HCP Enrollment	Total Complaints	Total DOJ Complaints	Complaints with External Review	A) Relief Granted	B) Partial Relief	C) Information Furnished	D) No Relief Granted
AETNA HEALTH OF ILLINOIS	40,388	1,437	30	2	1	0	0	1
CIGNA HEALTHCARE OF ILLINOIS INC	944	207	4	0	0	0	0	0
CIGNA HEALTHCARE OF ST LOUIS INC	142	19	0	0	0	0	0	0
GROUP HEALTH PLAN INC	21,133	3	0	0	0	0	0	0
HEALTH ALLIANCE MEDICAL PLANS INC	134,169	581	29	15	4	0	0	11
HEALTH ALLIANCE MIDWEST INC	466	0	0	0	0	0	0	0
HEALTH CARE SERVICE CORP MUT LEG RES	661,860	480	194	0	0	0	0	0
HMO MISSOURI INC	0	26	0	0	0	0	0	0
HUMANA BENEFIT PLAN OF ILLINOIS	50,303	132	10	0	0	0	0	0
HUMANA HEALTH PLAN INC	86,340	506	33	2	0	0	0	2
MEDICAL ASSOCIATES HEALTH PLAN INC	3,177	18	1	0	0	0	0	0
MERCY HEALTH PLANS OF MISSOURI INC	723	59	0	0	0	0	0	0
NEVADACARE INC	18	0	0	0	0	0	0	0
PERSONALCARE INSURANCE OF ILLINOIS INC	45,041	713	29	50	1	3	0	46
UNICARE HEALTH PLANS OF THE MIDWEST IN	90,743	422	49	6	1	0	0	5
UNION HEALTH SERVICE INC	2,222	31	0	7	4	0	0	3
UNITED HEALTHCARE OF ILLINOIS INC	23,192	80	16	0	0	0	0	0
UNITED HEALTHCARE OF THE MIDWEST INC	8,980	11	0	0	0	0	0	0
UNITEDHEALTHCARE PLAN OF THE RIVERVAL	11,142	68	8	3	0	0	0	3
<b>TOTALS</b>	<b>1,180,98</b>	<b>4,793</b>	<b>403</b>	<b>85</b>	<b>11</b>	<b>3</b>	<b>0</b>	<b>71</b>

As of: December 31, 2008

Source: Illinois Department of Insurance

Published: Thursday, July 16, 2009

## OCHI Calls By Year



**EXHIBIT 8**

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