

# Office of Consumer Health Insurance 2002 Annual Report

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## PREFACE

The [Managed Care Reform and Patient Rights Act](#) (the "Act") became law on August 19, 1999. Section 90 of the Act (215 ILCS 134/90), effective January 1, 2000, required the establishment of the Office of Consumer Health Insurance (OCHI) within the Department of Insurance and requires OCHI to file an annual report with the Governor, the Director of Insurance, and the General Assembly. The Act also spells out consumer rights under a health care plan; prohibits "gag clauses"; establishes procedures for transitional services, standing referrals to specialists, requirements for external independent reviews, and reporting complaints; and establishes a registration process for all persons conducting utilization review programs in the state of Illinois.

The Act required the Director of Insurance to establish the Office of Consumer Health Insurance within the Department of Insurance to provide assistance and information to all health care consumers within the state. Within the appropriation allocated, OCHI provides information and assistance to all health care consumers by:

1. Assisting consumers in understanding health insurance marketing materials and the coverage provisions of individual plans.
2. Educating enrollees about their rights within individual plans.
3. Assisting enrollees with the process of filing formal grievances and appeals.
4. Establishing and operating a toll-free telephone number to handle consumer inquiries.
5. Making related information available in languages other than English, if that language is spoken as a primary language by a significant portion of the state's population, as determined by the Department.
6. Analyzing, commenting on, monitoring, and making publicly available reports on the development and implementation of federal, state, and local laws, regulations, and other governmental policies and actions that pertain to the adequacy of health care plans, facilities, and services in the state.
7. Filing an annual report with the Governor, the Director, and the General Assembly, which contains recommendations for improvement of the regulation of health insurance plans, including recommendations on improving health care consumer assistance and patterns, abuses, and progress that have been identified through its interactions with health care consumers.
8. Performing all duties assigned to the office by the Director.

The [Uninsured Ombudsman Program \(P.A. 92-331\)](#) became law on January 1, 2002, establishing an ombudsman program for uninsured individuals to provide assistance and education regarding health insurance benefits, options, and rights under state and federal law.

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## **EXECUTIVE SUMMARY**

The Office of Consumer Health Insurance (OCHI) was established in January 2000 by the Managed Care Reform and Patient Rights Act (P.A. 91-617). In its third year of operation, OCHI received 18,191 calls and provided information on a wide array of issues. Members of the OCHI staff performed a number of outreach activities during the year by staffing a booth at the State Fair, attending speaking engagements, and making contact with county and local health departments, hospitals, and township supervisors throughout the state.

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

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

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

[Section 4](#) describes activities of the Uninsured Ombudsman Program and describes various methods used and steps taken to assist uninsured consumers in their efforts to find insurance or local services at community sponsored health centers, as well as the availability of state and federal programs for those who qualify.

[Section 5](#) contains information about:

- Trends in the health insurance marketplace.
- Changes to the Illinois Comprehensive Health Insurance Plan.
- Synopsis of the State Planning Grant.
- Effects of large employer bankruptcies.
- Increase in Multiple Employer Welfare Arrangements (MEWAs).
- Proliferation of discount plans.
- Problems relating to physician networks.
- Supreme Court decision in the case of Rush Prudential HMO v. Moran.
- State and federal legislation.
- Recommendations for improvement of the health insurance marketplace.

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

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

The [Office of Consumer Health Insurance \(OCHI\)](#) answered a wide array of questions from consumers during calendar year 2002. Calls came from a variety of groups including consumers, employers, agents, associations, attorneys, health care providers and advocacy groups.

Terminologies that are insurance specific were explained in terms that the average layperson could understand. The differences between individual and group insurance and the rights stemming from the Health Insurance Portability and Accountability Act (HIPAA) were explained. Consumers were given specific information applicable to their plan. Information was also provided for those who needed help understanding their options regarding continuation of coverage once a HIPAA "qualifying event" had occurred or was about to occur. OCHI also directed consumers to the Department's Internet site ([insurance.illinois.gov](http://insurance.illinois.gov)) enabling them to gain further knowledge of a particular topic and access of printed "fact sheets" developed by the Department.

OCHI also received calls from individuals who experienced problems with their specific health plan. Problems included: getting a particular procedure approved by the plan, understanding and filing an appeal with the plan, having a claim for a pre-approved procedure denied by the plan, and filing a request for an external independent review with HMO plans. OCHI explained a covered person's rights, the procedure for filing appeals and grievances with the plan, and the option for filing a complaint with the Department of Insurance. OCHI guided HMO enrollees through the external independent review process and explained how to file the request, the required time periods involved, and the role played by the primary care physician in the process.

The Managed Care Reform and Patient Rights Act requires HMOs to track all complaints they received, regardless of the source, and to report the data to the Department of Insurance. [Exhibit 5, HMO Company Complaint Record - General Summary 2001](#), shows the general summary of HMO complaints for 2001. [Exhibit 6, HMO Company Complaint Record - Classification Summary 2001](#), shows the classification breakdown of the HMO complaints. [Exhibit 7, HMO External Independent Review Summary 2001](#), is derived from Exhibits 5 and 6 and provides specific information relating to external independent reviews. This information is provided by the plans and is not independently verifiable by the Department. These exhibits may be accessed through the Department's Internet site ().

As presented in [Exhibit 5](#), during calendar year 2001, HMOs reported a total of 12,470 complaints (of these 1,329 (11%) were also filed with the Department of Insurance). The "Disposition of ALL Complaints" section indicates that of the total complaints: 6,444 (52%) were granted relief; 455 (4%) were granted partial relief; 1,695 (14%) received additional information; and 3,876 (31%) received no relief.

[Exhibit 7](#) shows that HMO enrollees requested 116 external independent reviews that were completed by HMOs in the state of Illinois in 2001. Of these, 41 (35%) were granted relief, 4 (3%) were granted partial relief, 2 (2%) received further information, and 69 (59%) had no change in status. The reporting date for complaint data is March 2 for the previous year. Complaint data for 2002 will be addressed in the 2003 report.

The Department of Insurance office in Chicago also handles many calls and assists consumers who walk into the office requesting information. From January 1, 2002, through December 31, 2002, the Chicago office handled 2,835 calls relating to health insurance complaints; 2,154 calls regarding general health insurance questions; 178 English-speaking walk-ins with health insurance questions; 141 calls and 23 walk-ins requiring the services of a translator.

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

In calendar year 2002, a number of large manufacturing companies went bankrupt, generating many calls regarding COBRA benefits. By processing information from other areas of the Department, OCHI passed the

most up-to-date information on to callers. Many of the displaced workers were referred to the [Illinois Comprehensive Health Insurance Plan \(CHIP\)](#) to determine their eligibility under Illinois' HIPAA alternative mechanism for individual health insurance coverage. Retired workers questioned how they could maintain coverage to coordinate with Medicare and were given information on guaranteed issue Medicare supplement coverage through standard insurers. Medicare supplement inquiries were referred to the Department's Senior Health Insurance Plan (SHIP).

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

Upon request, we have given several presentations regarding OCHI. We have spoken with consumer organizations, community development organizations, employer organizations, and public health organizations, and are open to other opportunities to reach interested parties. Presentations by our staff can be arranged by contacting the Office of Consumer Health Insurance at 877-527-9431.

A very small number of calls to OCHI have required the services of a translator. The OCHI office can generally provide a translator for consumers who need this service. The brochure "Your Rights Under the Managed Care (HMO) Reform and Patient Rights Act" was printed in Spanish and the initial 5,000 copies were distributed, requiring a reorder for an additional 5,000 copies.

### **3. Expanding public knowledge of OCHI and available services**

OCHI continued to explore other methods of reaching additional consumer groups, new avenues of assistance for those seeking information on the toll-free line, and contacted additional organizations to find more specific resources available in localized areas. In addition, we targeted hospitals in Chicago metro areas with high density Hispanic populations for mailing information printed in Spanish. We had a number of requests for additional brochures from many of these hospitals.

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

Letters were mailed to the various health departments in the state and to all of the township supervisors, informing them of our services, and advising them of our availability to attend health fairs and other functions they may have for the general public. We accommodated specific requests to speak before interested parties. We have also requested from the local health departments a listing of all "help" agencies in their operating area,

including addresses and phone numbers. We are attempting to identify all agencies that provide emergency services and help relating to health care issues in order to get this information to Illinois residents.

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

### **Status report of OCHI toll-free telephone number**

OCHI received a total of 18,191 calls on its toll-free telephone line (877-527-9431) for calendar year 2002. This represents an increase of 3,919 calls over the 14,272 received during the year 2001. OCHI received calls from 1,083 of the estimated 1,500 zip codes in the state.

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

- Setting benchmarks for desired levels of service:

1. To answer 80% of incoming calls prior to the call going to voice mail.

RESULT: The final year-end numbers tell us that 77% of our calls were answered before going into the voice mail system. Call volume has increased tremendously with calls being handled by three analysts. Inquiries have become more complex and demand more time to answer.

2. To return all voice mail messages within one hour from receipt.

RESULT: The year-end average for time to return calls was 14 minutes. Only 56 calls (1.57%) were not returned within one hour from the time they were received.

3. To have no unanswered calls at the end of the day, regardless of when the call came in.

RESULT: There were 10 (less than 1%) calls not returned the same day they were received.

4. To be able to:

- A. Directly answer the consumer's question while on the phone; or
- B. Research the issue of concern and respond to the consumer within 24 hours; or
- C. Transfer the caller to a Department analyst who has more expertise on the subject matter in question.

RESULT: Virtually all calls were handled in the above manner.

- OCHI benchmarks will be reassessed during 2003.

#### **4. Uninsured Ombudsman Program**

With the passage of [P.A. 92-331](#), the Uninsured Ombudsman Program, OCHI saw expanded responsibilities. As of January 1, 2002, the Uninsured Ombudsman Program (Program) became effective and operational within OCHI using the same facilities, phones and personnel, but with no additional funding from the Department's budget.

Preparation for the Program began several months prior to the effective date. All of the county and local health departments were notified of the Program and requested to provide OCHI with information regarding medical services or any other type of help agencies in their respective areas. This information was filed and later used to guide callers who were in need of medical or other types of service that insurance would normally cover. In addition, a library of related Web sites has been compiled in order to direct callers who have Internet access, or to assist in finding more specific information to those who have no computer access.

OCHI, in cooperation with other DOI personnel, is compiling a database of all the information, clinics, Web sites, help agencies, and drug programs that are available throughout the state of Illinois. This information will be compiled by county for quicker reference.

In addition, we obtained a listing of all township supervisors throughout the state from the Township Officials of Illinois. Letters were mailed to the supervisors introducing them to the Program by explaining its purpose and scope. The letter invited inquiries from the supervisors regarding the type of uninsureds seeking assistance from their offices. Many calls came into our office following the mailing.

The Program has provided assistance to over 400 uninsured consumers informing them of the various programs available through federal, state, local and other resources.

#### **5. Market status, government actions and recommendations for improvements to health insurance regulation**

##### **A. MARKET STATUS**

##### **I. Health Insurance Marketplace**

The most significant market trend for 2002 continued to be the loss of insurers in the small employer, large employer, and individual health insurance market. During 2002, 2 companies filed with the Illinois Department of Insurance their intent to withdraw products from the small group market; 2 companies filed their intent to withdraw products from the large group market; and 6 companies filed their intent to withdraw products from the individual major medical market. While Illinois' overall marketplace remains viable and competitive, if this trend

continues, access to health insurance in this state could become problematic. The small group market still had in excess of 20 carriers as of year-end 2002.

The [Medicare + Choice](#) market continued to be a concern for senior citizens in the northern part of Illinois. Currently, only one HMO offers this coverage in Cook County and that plan continues to collapse its coverage areas due to cost. The Department's Consumer Division and [Senior Health Insurance Plan \(SHIP\)](#) worked together to provide information on other options available to affected individuals.

Medicare + Choice was an affordable option for some Medicare disabled persons; however, this option becomes less available each year due to Medicare + Choice plans exiting the market. Medicare beneficiaries who are under age 65 and on Medicare because of a disability currently do not have guaranteed issue private Medicare supplement policies available in Illinois. [CHIP](#) does provide secondary insurance to this group of beneficiaries; however, this secondary insurance is not comparable to the standardized Medicare supplement A-J plans mandated by the federal government. The Department's [Senior Health Insurance Plan](#) talks to many of the Medicare disabled who would like to have the ability to purchase a private [Medicare supplement](#) (one of the A-J plans), but because of their health conditions and the fact that these policies are underwritten, many are turned down for this insurance. (SEE ITEM C-6 UNDER "RECOMMENDATIONS FOR IMPROVEMENTS TO HEALTH INSURANCE REGULATION.")

## II. Illinois Comprehensive Health Insurance Plan

The Illinois [Comprehensive Health Insurance Plan \(CHIP\) \(215 ILCS 105\)](#) has two pools. Both pools charge enrollees a premium, which can be a maximum of 150% of the cost of a standard individual insurance policy.

The traditional pool (Section 7) is designed for individuals who are otherwise unable to purchase insurance due to a health condition. This pool is partially funded through annual state appropriations. This pool imposes a six-month pre-existing condition limitation on enrollees.

HIPAA-CHIP (Section 15), conversely, is the state's mechanism to protect the portability rights of individuals who have satisfied the requirements of HIPAA including prior creditable coverage in a group health plan. HIPAA-CHIP, by statute, cannot impose pre-existing condition requirements. This pool is partially funded by insurance industry assessments.

Due to the economic downturn experienced in Illinois during 2001 and 2002, several large downstate Illinois employers either filed for bankruptcy or closed their doors, which resulted in additional demand for access to the CHIP program. In response to this increased need, CHIP staff partnered with other state and local agencies by conducting outreach seminars to provide information about the program to displaced workers and retirees.



On December 31, 2002, enrollment included 5,899 persons in traditional CHIP (Section 7) and 8,292 persons in HIPAA-CHIP (Section 15). Persons seeking coverage under Section 7 were being placed on a waiting list for approximately two to four weeks before coverage could be offered.

### III. Synopsis of State Planning Grant

In September 2000, the State of Illinois received a \$1.2 million State Planning Grant from the Health Research and Services Administration of the U.S. Department of Health and Human Services. The Illinois Department of Insurance is the state's lead agency for this grant. The purpose of the grant is to develop a plan to assure access to health insurance for all Illinoisans. The grant funded two components of this planning: research on the characteristics of the uninsured in Illinois and development of plans to reduce the number of uninsured individuals in Illinois. The Illinois Assembly on the Uninsured, a participatory process established to take advantage of the views and talents of employers, insurers, health care providers, and other community representatives from both the public and private sectors from around the state, was used to help focus and prioritize these plans.

The grant gave Illinois the opportunity to gather state-specific data which had not been available before. Several types of research were conducted, including a random digit dial survey, focus groups and key informant interviews, and an expansion of the Behavioral Risk Factor Surveillance System (BRFSS). Also, funds from the grant were used to create a page on the Department's Internet site ([insurance.illinois.gov/spg/](http://insurance.illinois.gov/spg/)), gather information on a variety of potential strategies which have been used in other states, undertake a literature review, and develop a large bibliography. The new data, as well as existing national data, served as a bridge between researchers and stakeholders during the participatory process of developing strategies to provide coverage to all uninsured persons in the state. Data indicates that between 9.8% and 13.4% of Illinoisans have no health coverage. The research and participatory process results were included in a Report to the Secretary of the U.S. Department of Health and Human Services in October 2001.

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

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

Progress has been made in implementing these options. Illinois has received approval to implement the Family Care Program within the Illinois Department of Public Aid. The current focus of the planning grant is on developing ways for small employers (25 or less employees) to

be able to provide coverage to their employees. We have been working with an actuary and small employers to design coverage mechanisms. The draft product designs were reviewed in a series of statewide meetings with both employers and brokers. The next step is to award an RFP to develop a pilot project that can be used to test these ideas when funds become available.

#### IV. Trends

##### a. Loss of Employer Coverage

During 2002, several large, self-insured employers declared bankruptcy. Each time this happened, the employees who remained active in their jobs were left with many questions about their health coverage. How would their claims be paid when the company was self-insured and bankrupt at the same time? Would COBRA apply? When would the COBRA extension start? In the case of those former employees who have been laid off and have elected their COBRA extension of benefits, they are paying the premium as it becomes due, but their claims are not being paid. They are told by the employer that there is no money to pay claims as the company is bankrupt, and that includes money for claim payments. If the employee pays the COBRA premium, the money is not going to be used to pay claims. If they do not elect COBRA continuation, they have no coverage and are not allowed to transfer into the HIPAA CHIP (Section 15) plan to avoid a waiting period or pre-existing condition period because they have not exhausted their COBRA benefits.

The retired employees in this situation have a similar problem. Those under the age of 65 on COBRA have difficulty getting answers from the employer as to when their benefits will end. Those who are healthy can purchase an individual health policy on the open market. Those with any serious health problems can enroll in the CHIP plan. However, unless they have reached the end of their extension of coverage, they may not qualify for HIPAA CHIP (Section 15).

Additionally, if the retiree did not take Medicare Part B when they turned 65, when they attempt to apply for Part B coverage from Social Security, they are not allowed to enroll until the next general enrollment period, which is each January through March. Their Part B coverage will not be in effect until July 1 of the year they enroll. Further, they are assessed a penalty on their Part B premium of 10% for every year they delay enrollment into Part B. This penalty is payable for the retiree's lifetime. Without Part B coverage, a Medicare supplement insurer cannot sell them a Medicare supplement policy, even if they meet the law's guaranteed issue provisions, since it is a requirement in Illinois that the insured have both Medicare Part A and B to purchase a Medicare supplement policy.

Retirees age 65 and older are guaranteed to be able to transfer their coverage into a Medicare supplement plan. The problem for those over 65 (besides having to pay the premium themselves provided they have Medicare Part B) is that the Medicare

supplement plans to which they are guaranteed access have no prescription drug coverage. The majority of the population over age 65 require at least some prescription drugs in order to maintain their health.

For several of these bankruptcies, public meetings were held to advise employees and ex-employees of their rights. The Department's Consumer Division and SHIP program, as well as CHIP, were well represented at these public venues to address concerns on insurance issues.

b. MEWAs

The overall increases in cost of health care and health insurance have resulted in a number of purported health insurance plans being presented as viable alternatives to provide insurance to employers in the small group marketplace. Generally, these arrangements, often called MEWAs (Multiple Employer Welfare Arrangements) are in violation of the Illinois Insurance Code, as they are unauthorized insurers presenting products that they claim qualify for ERISA preemption or as state-approved health insurance. Often these arrangements are fly-by-night scams designed to bilk as much money as possible in the shortest amount of time while providing little, if any, actual payment for health claims. The Department's Financial Division and the financial divisions of departments across the United States have been actively working to ensure the prompt shutdown of these types of plans. Unfortunately, because these are not legitimately licensed insurance plans, when they are closed down they do not fall under the State's Guaranty Association, and individuals covered under these plans are generally left without coverage for their health care costs. For additional information, see the Department's Illinois Insurance Newsletter, April 2002 #2, "Producers - Just Say No." ([http://insurance.illinois.gov/newsLetter/NL02/NewsLetter\\_0402.pdf](http://insurance.illinois.gov/newsLetter/NL02/NewsLetter_0402.pdf))

c. Discount Plans

With the increasing pressure health care costs and the weakened economy are bringing to bear on the delivery of health insurance, many plans and other entities in the marketplace are attempting to develop programs which do not fit neatly into the regulatory structure envisioned by the Insurance Code. In particular, the Department is witnessing an explosion of health, dental and prescription discount plans. While the majority of these plans may be legitimate, some plans are presented to persons as innovative products that would provide health coverage for minimal costs, but in reality provide minimal coverage at a great profit margin for the sponsors of these programs.

This is not to say that there are not legitimate and viable discount programs, which should be recognized in the marketplace. Because discount plans in Illinois are generally required to register as preferred provider organizations, the majority of them do in fact establish networks to provide incentives to enrollees to visit various providers. Illinois

appears to be one of the few states that regulate these discount plans. Unfortunately, because of this lack of oversight of discount plans in other states, many plans are not aware they have to register or believe they do not have to register under the Illinois law. To gain a handle on all of these programs, the Department has tried to work actively to either register these plans or to work with the Department's financial unit to force them to cease and desist as an unauthorized entity.

d. Physician Network Conflicts with HMOs

In 2002, the Department saw several trends relating to physician networks (usually referred to as Independent Practice Associations (IPAs) or Physician Hospital Organizations (PHOs)) that resulted in an increase in complaints to the Department. These complaints generally took two forms. The first resulted from situations in which an IPA/PHO could not reach agreement with an HMO to continue a contract for the delivery of health care services. This in essence meant that doctors once available to enrollees were no longer available through the HMO and enrollees were forced to switch plans, if another plan with their doctor was available, or to switch doctors. Unfortunately, while there are provisions in the HMO Act and the Managed Care Reform and Patient Rights Act to deal with availability and accessibility of providers and for an enrollee's right to continuation of care when their doctor is no longer a participating provider of the HMO, there are no requirements regarding how HMOs provide required services. The provision of services under an HMO plan is determined by the contractual relationship between the HMO and the various providers freely entered into by both parties. As such either party may decide not to renew such contracts. In these instances there is little the Department can do to ensure provider participation when the contract is no longer in force.

The second trend in complaints the Department witnessed in 2002 related to the financial impairment of IPAs and PHOs. The Department does not regulate these entities for financial solvency. Thus, when one of these networks becomes financially impaired, it is often unable to make payments to its participating physicians for services already rendered even though the HMO has capitated the provider for those services. Physicians who provided the care in these instances are often left with two options: try to bill the HMO for money it already paid or try to bill the patient for the cost of care. A physician's options are often limited by language contained in their agreement with the IPA/PHO or the HMO. Such language, often called a "hold harmless" clause, contractually prohibits the provider from billing the enrollee. Even without this language, an enrollee should not be liable for these costs as they were promised coverage for such costs under the enrollee's agreement with the HMO. Both providers and enrollees have the right to file complaints with the Department to attempt to alleviate these payment problems.

- e. Supreme Court Decision in the Case of Rush Prudential HMO v. Moran  
In 2002 the Supreme Court found in favor of an enrollee of Rush Prudential HMO to exercise her right to a state law providing for the external independent review of a denial of care by the HMO. The 5 to 4 decision should have the effect of ensuring Illinois HMO enrollees have the right granted them in the Managed Care Reform and Patient Rights Act to request an independent external appeal when reimbursement for care is denied by the plan.

## B. GOVERNMENT ACTIONS

- I. The Mental Health Parity Act  
The Mental Health Parity Act was to sunset September 30, 2001, but was extended until December 31, 2002. The U.S. Congress then passed an extension for the Act and now has a sunset date of December 31, 2003.
- II. [P.A. 92-0135](#) - HMO Point-of-Service  
House Bill 1040 amended the HMO Act (215 ILCS 125) to allow HMOs to offer limited point-of-service products. It changes the capital and reinsurance requirements for these point-of-service products and allows HMOs to set out-of-pocket limits and lifetime maximum benefits for out-of-plan benefits. This Act became effective January 1, 2002.
- III. [P.A. 92-0579](#) - Non-Participating Provider Disclosure  
House Bill 5842 amends the Illinois Insurance Code and the Health Maintenance Organization Act to require insurance companies to provide prominent disclosure in the policy and certificate stating that when a consumer utilizes a non-participating provider for a non-emergent covered service, the insurer will reduce their benefit payment increasing the out-of-pocket cost to the enrollee. The amendment became effective January 1, 2003.
- IV. [P.A. 92-0630](#) - Comprehensive Health Insurance Plan Break in Coverage  
House Bill 5606 amends the Illinois Comprehensive Health Insurance Plan Act (CHIP) to extend to 90 days, rather than 63, the requirement for an individual to apply for coverage following the involuntary termination of individual health insurance coverage due to the insolvency of the insurance carrier. The amendment became effective July 11, 2002.
- V. [P.A. 92-0745](#) - Prompt Pay  
Senate Bill 2245 amended the prompt pay law by deleting the phase-in provisions applicable only to IPAs and PHOs. This amendment became effective January 1, 2003.
- VI. [P.A. 92-0764](#) - Anesthesia/Hospital Coverage for Dental Treatment  
House Bill 1889 requires policies of individual and group insurance to provide coverage for charges incurred for hospital care and anesthetics provided in conjunction with dental care in a hospital or ambulatory surgical treatment center and that care must be provided by a certified anesthesiologist. Coverage is limited to: children under 6, individuals with a medical condition

that requires hospitalization or general anesthesia for dental care, or disabled individuals. The amendment became effective January 1, 2003.

VII. [P.A. 92-0770](#) - Attending Physician

House Bill 4220 amends the Managed Care Reform and Patient Rights Act to prohibit health care plans from requiring enrollees in both individual and group plans to utilize the services of a physician other than their attending physician with agreement of the enrollee's participating primary care physician. The amendment became effective January 1, 2003.

VIII. [P.A. 92-0556](#) - Privacy Provisions of Gramm-Leach-Bliley Act (GLBA)

House Bill 4989 amends Article XL (Insurance Information and Privacy Act) to authorize the Director to enforce the privacy provisions of GLBA. The law grants the Director the right to make reasonable rules and regulations as may be necessary to permit the enforcement of the privacy provisions of GLBA. The amendment became effective June 24, 2002.

C. RECOMMENDATIONS FOR IMPROVEMENTS TO HEALTH INSURANCE REGULATION

I. Women's Health and Cancer Rights Act

The Department previously initiated, the General Assembly passed, and the Governor enacted changes to revise Illinois statutes dealing with the federal Women's Health and Cancer Rights Act [Senate Bill 866 (Peterson/Mulligan) [P.A. 92-0048](#)]. Since enactment of Senate Bill 866, the federal regulating entity, CMS (Centers for Medicare and Medicaid Services), has determined that Illinois' statute is not in compliance with the federal act. The Department passed a rule to insure federal compliance. There still exists possible confusion between the state and federal laws.

POSSIBLE REMEDY: Amend the Illinois Insurance Code and the HMO Act to incorporate specific requirements of the federal Women's Health and Cancer Rights Act of 1998 to insure that state law mirrors federal law.

II. Coverage for Experimental/Investigational Treatment

Currently, there are no standards for companies to follow in utilizing exclusionary language for experimental/investigational procedures/treatments. Current law dealing with organ transplants incorrectly cites a federal agency to provide guidance. The federal agency cited does not provide the information that present state statute references.

POSSIBLE REMEDY: Amend 215 ILCS 5/356K of the Illinois Insurance Code to require that no individual or group policy of accident and health insurance shall deny reimbursement for any drug, device, medical treatment or procedure, including organ transplantation, solely on the basis that it is deemed experimental or investigational unless: there has not been approval for marketing by the United States Food and Drug Administration; reliable evidence shows it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of

treatment or diagnosis; or reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy compared with the standard means of treatment or diagnosis. This proposal should also delete 215 ILCS 5/367(13) of the Illinois Insurance Code due to the fact that the proposed changes would make it obsolete.

### III. Insurer External Independent Review

Insurance companies, unlike HMOs, are not required to have an appeals mechanism or an external independent review process. This often leaves insureds without a recourse to appeal insurer denials of care or treatment.

**POSSIBLE REMEDY:** Establish a mechanism for insureds and covered individuals to appeal denials and give them access to an external independent reviewer that would render a fair, unbiased decision by adding a new section to the Illinois Insurance Code (215 ILCS 5/356z.2) to require group and individual accident and health and disability policies to include an appeals procedure and an external independent review procedure for procedures, services or treatments that have been denied as not medically necessary. This provision should be similar to the requirements currently in place for HMOs under the Managed Care Reform and Patient Rights Act.

### IV. Insurer Recovery of Overpayments to Providers

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

**POSSIBLE REMEDY:** Create a new section 215 ILCS 5/356z.3 in the Illinois Insurance Code that limits the right of an insurance company to recover overpayments for health claims to a two-year period following the date the claim was paid. In the event an insurer requests reimbursement of an overpayment within the two-year period, written notice with specific information should be provided and the claim must have been clearly overpaid under the policy provisions.

### V. Proof of Loss

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

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

VI. Medicare Supplement Insurance for Under 65 Disabled

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

POSSIBLE REMEDY: Amend 215 ILCS 5/363 to mandate availability of coverage for those insureds who are covered under the federal Medicare program due to disability and are under age 65. This change will require companies writing Medicare supplement business to make available to persons eligible for Medicare by reason of disability each type of Medicare supplement policy that an issuer makes available to persons eligible for Medicare by reason of age and shall not charge those eligible disabled under-65 persons premium rates for any medical supplemental insurance benefit plan offered by the issuer that exceeds the issuer's premium rates charged for such plan to individuals who are age 65. The change should also allow for those persons under 65 years of age who become eligible for Medicare by reason of disability to make application and receive a Medicare supplement policy within 6 months of the first day on which the person enrolls for benefits under Medicare Part B, or within 6 months of receiving notification of retroactive eligibility from the Social Security Administration. Any amendment should also provide guaranteed issue rights to those under 65, disabled persons who apply for a Medicare supplement policy during the 6 month period beginning with the first day of the month in which the applicant enrolls for benefits under Medicare Part B.

VII. Emergency Care Reimbursement

Currently, when insureds use out-of-network emergency room services, insurers are required to provide the same benefit level as if the insured were in network. Unfortunately, an in-network benefit may be based on a discounted fee schedule. Applied to out-of-network providers, this may be below the provider's charge, leaving the insured with a larger out-of-pocket expense than had they stayed in network.

POSSIBLE REMEDY: Amend Chapter 215 ILCS 5/370o of the Illinois Insurance Code to indicate that in the case of emergency care an insured would have the same out-of-pocket expenses as if they went to a preferred provider. Current law provides that an insured will receive the same benefit level as if they had received emergency services from a preferred provider.



## 6. Action taken on past recommendations

Of the six recommendations in last year's report, the following action has been taken on one of the issues. The remaining five items continue to warrant attention. A list of items from past reports can be accessed on the Department's Internet site ([insurance.illinois.gov/OCHI/office\\_consumer\\_health\\_ins.htm](http://insurance.illinois.gov/OCHI/office_consumer_health_ins.htm)).

1. During 2001, a number of insurers withdrew products from the market. Unlike the group market, policyholders losing individual health coverage have limited HIPAA portability protections. If the person is generally healthy, they may be able to find another individual policy from another insurer. If the person has health problems, they often must accept a policy with riders, exclusions, or even in some instances be denied insurance. The only option open is applying for the traditional CHIP plan (Section 7).

Although these people have had coverage in the past, and have endured a pre-existing condition clause in the previous policy, applicants to traditional CHIP (Section 7) are faced with a new pre-existing condition clause. They may also be faced with a waiting period. We have had calls from people in this situation who are seriously ill and need coverage or face extensive medical bills in the very near future. Usually they are self-employed people with no availability of group coverage. More often than not they are in an income level that is above the amounts allowed to receive assistance from any of the governmental or private agencies.

ACTION TAKEN: [Public Act 92-0630](#) amended the Illinois Comprehensive Health Insurance Plan Act (CHIP) to extend to 90 days, rather than 63, the requirement for an individual to apply for coverage following the involuntary termination of individual health insurance coverage due to the insolvency of the insurance carrier. The amendment became effective July 11, 2002.

### Exhibits:

- 1 - [Zip Code Listing](#)
- 2 - [Top Ten Subject Categories of Phone Calls](#)
- 3 - [Top Ten Informational Items Requested](#)
- 4 - [Number of Calls Per Month](#)
- 5 - [HMO Company Complaint Record -- General Summary 2001](#)
- 6 - [HMO Company Complaint Record -- Classification Summary 2001](#)
- 7 - [HMO External Independent Review Summary 2001](#)