Office of Consumer Health Insurance 2007 Annual Report

Table of Contents

PREFACE

Established on January 1, 2000, by the Managed Care Reform and Patient Rights Act (the Act), the Office of Consumer Health Insurance (OCHI) operating within the Illinois Department of Financial and Professional Regulation, Department of Insurance (IDFPR) continued to serve Illinois residents in 2007 by responding to their health related inquiries.

The responsibilities of OCHI, as set forth by the Act, have not changed since its inception. Its two main functions are to assist consumers in relation to their health insurance needs and to report annually on the state of the health insurance marketplace. OCHI provides assistance to Illinois consumers through the toll-free, consumer inquiry telephone line mandated by the Act and through other outreach mechanisms including speaking engagements, health fairs, radio and television interviews, and the distribution of insurance fact sheets. Through these media, OCHI helps consumers understand the terms and meanings of their insurance

coverage, advises persons of their rights under insurance policies, assists insureds in filing appeals and complaints and provides appropriate resources to Illinois residents who need assistance.

In assessing the overall state of the health insurance marketplace in Illinois, OCHI reviews state and federal legislation and regulations, monitors significant trends affecting health coverage for Illinois citizens, identifies specific problems faced by health insurance consumers, and sets forth recommendations for possible resolutions to some of the problems identified.

In 2002, the Illinois Department of Insurance expanded OCHI to include the administration of the Uninsured Ombudsman Program established by Public Act 92-0331 (20 ILCS 1405/1405-25). The Ombudsman is responsible for providing assistance and education to individuals regarding health insurance benefit options and rights under state and federal laws. The Ombudsman Program also counsels uninsured individuals on finding and shopping for insurance, evaluating insurance products, comparing options when buying health insurance coverage and providing information on non-insurance resources that are available throughout the state.

EXECUTIVE SUMMARY

The Managed Care Reform and Patient Rights Act (P.A. 91-0617) established the Office of Consumer Health Insurance (OCHI) in January 2000. In 2007, OCHI's eighth year of operation, the office received 14,204 calls (increased from13,696 calls in 2006) and provided consumers with a broad range of health information. Members of the OCHI staff performed a number of outreach activities during the year, assisted health insurance consumers at the State Fair and provided information on various radio and television talk programs.

Section 1 of this report describes the type of calls received and the methods used for assisting callers.

Section 2 describes the various activities of the OCHI staff, steps taken to educate consumers about their health plans, and lists advisory information available on the Division's Internet site.

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

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

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

The Office of Consumer Health Insurance (OCHI) responded to a wide array of questions from consumers during calendar year 2007. Calls came from a variety of groups including consumers, employers, agents, associations, attorneys, health care providers and advocacy groups.

OCHI provides information and education on insurance-specific terminologies that the average consumer may not understand. Members of the OCHI staff also explain the differences between benefits available in individual, small group and large group insurance products, and the rights associated with each stemming from the Health Insurance Portability and Accountability Act (HIPAA). Consumers were provided specific information applicable to their plans and their rights relating to continuation of coverage options. OCHI also directed consumers to the Insurance Division's link on the Department of Financial and Professional Regulation's Internet site (www.idfpr.com) enabling them to gain further knowledge of a particular topic through access to "fact sheets" developed by the Division.

In 2007, OCHI received calls requesting information on many topics, including:

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

OCHI guided HMO enrollees through the external independent review process, mandated by the Managed Care Reform and Patient Rights Act, by explaining the information needed by the independent reviewer, the required time periods involved and the role played by the patient's primary care physician in the process.

The Managed Care Reform and Patient Rights Act requires HMOs to track all complaints received, regardless of the source, and to report the data to the Department of Insurance. Exhibit 5(HMO Company Complaint Record – General Summary 2006) shows the general summary of HMO complaints for 2006. Exhibit 6(HMO Company Complaint Record – Classification Summary 2006) shows the classification breakdown of the HMO complaints. Exhibit 7(HMO External Independent Review Summary 2006) is derived fromExhibits 5 and 6and provides specific information relating to external independent reviews. This information is provided by the plans and is not independently verified by the Division. These exhibits may also be accessed through the Division's Internet site at
http://insurance.illinois.gov/Complaints/healthttp://insurance.illinois.gov/Complaints/healthCarePlan_complaints/CompanyComplaint2006.pdf

and

http://insurance.illinois.gov/Complaints/healthCarePlan_complaints/ExternalReview2006.pdf

As presented in Exhibit 5, during calendar year 2004, during calendar year 2006, HMOs reported a total of 5,893 complaints, of which 458 (7.8%) were also filed with the Department of Insurance. According to the data submitted by the companies, the "Disposition of ALL Complaints" section indicates that of the total complaints:

- 2,285(39%) complaints were granted relief;
- 653 (11%) were granted partial relief;
- 534 (9%) received additional information; and
- 2,421 (41%) received no relief.
- 2,339 (35%) received no relief.

The reporting date for complaint data is March 1 for the previous year. Complaint data for 2007 will be addressed in the 2008 report.

The Department of Insurance office in Chicago also handles many telephone calls and visitors requesting information. From January 1, 2007, through December 31, 2007, the Chicago office handled 1,202 calls relating to health insurance complaints; 350 calls regarding general health insurance questions; 67 English-speaking visitors with health insurance questions; and 243 calls and 21 visitors requiring the services of a translator.

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2. Educating enrollees about their health plan rights

As in previous years, several large and small employers declared bankruptcy in 2007, generating many calls to OCHI regarding COBRA and Illinois continuation benefits. Upon receiving information from other areas of the

Division, OCHI communicated the most up-to-date information to consumers. Many of the displaced workers were referred to the Illinois Comprehensive Health Insurance Plan (CHIP) to determine their eligibility under Illinois' HIPAA alternative mechanism for individual health insurance coverage.

When applicable, workers losing their insurance were also informed of the federal Trade Adjustment Assistance Reform Act of 2002, which offers a tax credit for certain workers and retirees who lose their sponsored health coverage due to international dislocation or increased imports.

Retired workers questioned how they could maintain coverage to coordinate with Medicare and were given information on guaranteed issue Medicare supplement coverage through standard insurers. Medicare supplement inquiries were referred to the Division's Senior Health Insurance Plan (SHIP).

The Division continues to create and provide "fact sheets" in response to questions received from Illinois consumers in an effort to simplify complex insurance issues that are important to consumers. These "fact sheets" are available on the Division's website (http://insurance.illinois.gov/Main/Consumer_Facts.asp). For callers unable to access this information via internet, requested materials were mailed.

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

Occasionally, calls to OCHI have required the services of a translator. The OCHI office can generally provide a translator for consumers who need this service. The fact sheets entitled, *Your Rights Under the Managed Care (HMO) Reform and Patient Rights Act* and the *Ombudsman Brochure for the Uninsured* are available in Spanish.

Following is a list of consumer fact sheets and other information currently available on the Division's Internet site. Fact sheets revised or created during 2007 are shown in bold letters.

Acronyms for Life, Accident & Health Insurance and Managed Care
Beware of Fraudulent Insurance Companies
Birth Control Is Now Covered
Cancer
Contact the Proper Agency – Where to File Medicare, Medicaid and Other Health Plan Complaints
Coordination of Benefits
Finding a Reputable Insurance Company – Using Financial Rating Agencies
Getting off to a Good Start with Medicare
Health Insurance Continuation Rights – COBRA
Health Insurance Continuation Rights – Dependent Children
Health Insurance Continuation Rights – Illinois Spousal Law

Health Insurance Continuation Rights – Illinois Law
Health Insurance Continuation Rights – Municipal Employees
Health Insurance for Small Employers
Health Maintenance Organizations (HMOs)
Insurance Guaranty Associations
Illinois Mandated Benefits, Offers, and Coverages for Accident & Health Insurance and HMOs
Insurance for College Students
Insurance Coverage for Diabetes
Insurance Coverage for Infertility Treatment
Insurance Coverage for Newborn Children
Maternity Benefits in Illinois
Medical Necessity
Mental Health Coverage - New 2006
Pre-Existing Conditions – HIPAA
Prompt Pay Law
Self-Insured Health Plans - New 2006
Senior Health Insurance Program
Shopping for Individual Disability Income Insurance
Small Employer Health Insurance Rating Act
Travel Insurance
Understanding the Consumer Complaint Process
Uninsured Ombudsman Program
Usual and Customary Fees in Health Insurance Claims
Women's Health Care Issues
Workers' Compensation Insurance

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3. Expanding public knowledge of OCHI and available services

OCHI continues to explore new avenues for reaching consumers and consumer groups and continues to perform valuable research in an effort to assist consumers seeking information.
Participation on radio talk-shows, participation at Rapid Response Meetings for dislocated workers who have lost insurance coverage, interaction with local agencies that provide services to Illinois residents, increased coverage by newspapers, and increased interaction with government officials, insurance agents and companies have all been helpful in raising consumer awareness about OCHI and the toll free telephone number. OCHI staff increased its availability as a regular guest on scheduled talk-radio programs around the state.
OCHI received calls from consumers regarding specific diseases or conditions and the financial burden that

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

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

Status report of OCHI toll, free telephone number

OCHI received a total of 14,204 calls on its toll-free telephone line (877-527-9431) for calendar year 2007. Since its inception in 2000, OCHI has received approximately 122,804 phone calls.

Other duties as assigned by the Director

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

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

The OCHI staff's broad base of health insurance knowledge, combined with the database of information compiled by the Ombudsman Program, allowed the handling of approximately 1,257 written inquiries in 2007. The handling of inquiries by OCHI allows the Division's Consumer Service staff to focus on more complex consumer complaints.

OCHI also assists in responding to inquiries to the Director's email. This email address director@ins.state.il.us, is posted on the Department of Insurance website for consumers to write with any questions regarding insurance. OCHI staff replied to 341 (increased from 175 in 2006) Director email inquiries in 2007.

In 2005, Medicare Part D became available to Medicare eligible individuals throughout the United States. Consumer calls to the Divisions' Senior Health Insurance Plan (SHIP) rose dramatically and continued to be high during 2006 and 2007. OCHI staff assisted SHIP by returning calls and assisting consumers by answering questions and providing information about Medicare Part D options. The OCHI staff responded to 95 Medicare Part D calls in 2007.

4. Uninsured Ombudsman Program

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

Since its inception, the Program has continued to gather information about local resources that may provide medical services to those who are uninsured and compiled that information into a database that is easily accessible to all staff. Information in the database includes resources for medical, dental, mental health, prescription drugs, vision and other health care needs and can be accessed by county and city. Information was gathered from the local and county Public Health Departments, as well as from various websites on the Internet. New resources are added to the database as information is gathered from the internet, health fairs, and Rapid Responses Meetings.

For Calendar year 2007, the Program handled 1,135 calls (increased from 925 calls in 2006). As in previous years, calls came from a variety of sources including other state agencies, legislators, agents, family and friends, radio stations and others who were assisting the uninsured. Continued efforts to increase the awareness of the Program included regularly participating as a guest on radio talk shows and participating at Pre-Layoff Workshops for dislocated workers. The Ombudsman also participated at the Green County Health Fair, the Lincoln Community Health Fair and the Eureka Grand Chapter Health Fair. In addition, the Ombudsman served as a guest speaker for Stephen Decatur Jr. High School, the Farm Resource Center Conference and Lincoln Land Community College.

As in previous years, the Ombudsman has participated as a member of the Rapid Response Team for Dislocated Workers. At these meetings, individuals from different agencies provided information about local resources and services to dislocated workers.

More importantly, the Ombudsman was able to provide 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 which allow enrollment on the spouse's employer group health plan, and how the Department of Insurance can be of further assistance. COBRA continuation is a major topic of discussion if the employer group health plan remains in existence. Information is provided regarding the ability to enroll qualified beneficiaries separately on COBRA. This information is valuable at a time when financial hardship is involved and the employee may have one dependent that has a health condition and is not insurable on the open market.

Goals for 2007 include continuing to increase the awareness level about the Program, establishing a network with local organizations and providing assistance to the uninsured.

Details of the Rapid Response Meetings and Media Outreach Activities follows:

Rapid Response Meetings

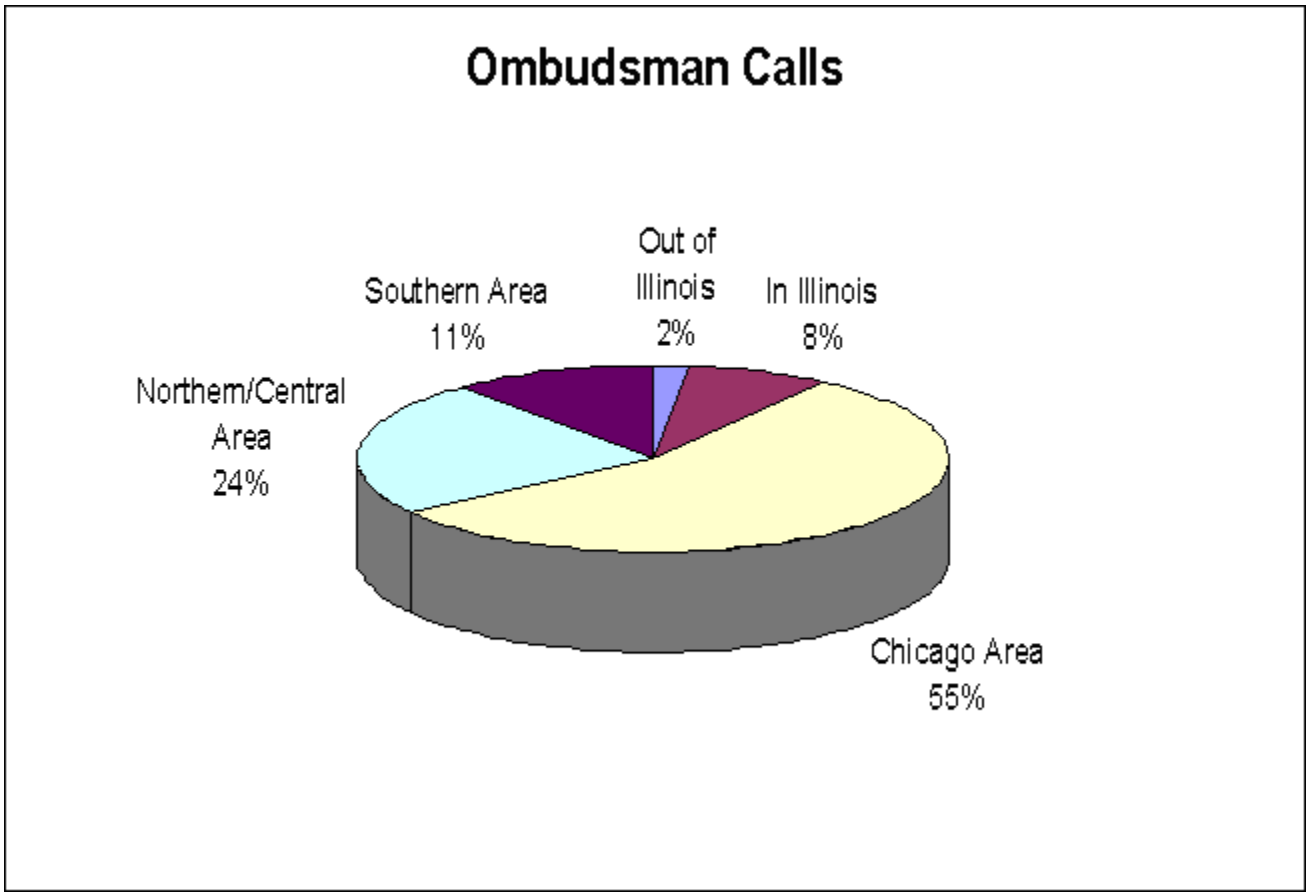
Company	**Location**	**Number of employees impacted**
ADM	Decatur	27

American Steel	Granite City	115
Carhartt	Galesburg	33
Cerro Flow Products, Inc	Saget	36
Collins & Aikman	Rantoul	970
Crown II Mine	Virden	241
Dawn Food Products	St. Peter	60
Dyno Nobel	Wolf Lake	105
Jewel	Dixon	75
K's Merchandise	Decatur	148
Kraft Foods	Rochelle	58
Loparex	Dixon	140
MAI	Taylorville	108
Monterey Coal	Gillespie	374
Philips Brothers Printing	Springfield	50
Technicolor Universal	Pinckneyville	441
Wabash Mine Holding	Keensburg	277

Media Outreach

City	Station	Number of Visits	Estimated Listening Audience
Alton	WBGZ	6	25,000
Canton	WBYS	1	10,000
Carlinville	WSMI	1	5,000
Centralia	WILY	4	10,000
Champaign	WBCP	1	5,000
Champaign	WDWS	1	25,000
Danville	WDAN	5	20,000
Dixon	WIXN	3	5,000
Galesburg	WGIL	3	13,000
Jacksonville	WLDS	1	10,000
Kewanee	WKEI	1	15,000
Oglesby	WLPO	1	20,000
Princeton	WZOE	3	10,000
Quincy	WTAD	2	25,000
Sparta	WHCO	2	15,000
Vandalia	WPMB	2	10,000
Watseka	WGFA	1	10,000

The following page contains a pie chart illustrating a break-down of the regions that called the Uninsured Ombudsman in 2007.



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5. Market Status, Government Actions and Recommendations For Improvements To Health Insurance Regulation

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 desiring to discontinue selling all health insurance products in the individual, small employer, and large employer markets must provide proper notification to the Illinois Department of Insurance ("Division") and the insureds. Between 1997 and 2004, the trend by health insurers to terminate business continued to rise. In 2005 and 2006, there was little activity in this area. In 2007, four insurers exited the individual/small employer/large employer market. The exit of these carriers did not appear to significantly impact the availability and affordability of coverage offered in the individual/small employer/large employer market.

Whenever a health insurance company withdraws from the market, the Division and OCHI receive numerous calls from individuals whose health care coverage is disrupted. The Division explains how these transactions work and the applicable consumer protections. For individuals losing coverage, the Division identifies available options to ensure continued health coverage. Effective August 8, 2005, 215 ILCS 97/40(a)(iii) requires insurers leaving the individual health market to notify each affected individual of the individual's option to purchase all other individual health benefit plans offered by any affiliate of the carrier. This notification must take place at least 180 days prior to the date of expiration of coverage. Often, 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 Section 2C of this report.

Persons losing individual coverage enjoy few rights under HIPAA. For individuals who cannot obtain coverage on the open market due to past or present health conditions, the options are limited to:

- applying for standard CHIP coverage, which entails re-imposition of pre-existing condition limitations;
- going without health coverage; or
- securing employment with an employer that offers group health insurance as a benefit.

2. Health Insurance Availability

a. Uninsured

The most disturbing trend in the health insurance marketplace continues to be the large number of uninsured both nationwide and in Illinois. In August 2006, the U.S. Census Bureau released 2005 year-end statistics for the uninsured. According to the report, entitled *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, the percentage of people without health insurance coverage increased from 15.3% in 2005 to 15.8% in 2006. The state's average percentage of uninsured from 2004 through 2006 was estimated at 13.6%. This statistic is reflected in the 1,135 calls to the Uninsured Ombudsman in 2007. There are no indications that this trend will be altered in 2008 or beyond.

b. Underinsured

Another disturbing but often overlooked 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. In its September 2007 survey titled "Are You Really Covered," Consumer Reports used this definition and found: 1) 29% of Americans with health insurance were underinsured; and 2) 56% of the underinsured population postponed needed medical care.

The growth of the underinsured has been especially rapid in Illinois. A December 2007 Families USA study reports that while underinsured rates have risen in every state since 2000, the growth in the Illinois underinsured population outpaced the growth found in two-thirds of country. The study, titled "Too Great a Burden:

America's Families at Risk," estimates that in 2008, 21.9% of the Illinois population under 65 (2.5 million people, 2.06 million of whom have health insurance) will be in families that spend over 10% of their pre-tax income on health care. About 5.9% of the population under 65 (662,000 people, 508,000 of whom have health insurance), the study reports, will be in families that spend over 25% of their pre-tax income on health care. There are no indications that this trend will be altered in 2008 or beyond.

b.Employees Losing Group Health Coverage

In 2007, OCHI continued to receive calls from employees losing their health insurance coverage and asking about continuation options. In 2007, OCHI received 1,974 calls regarding continuation of group health coverage. Employees lose their health insurance coverage for a variety of reasons, including layoffs, business closings, or employer bankruptcy. A complete list of employer closing notifications by month can be viewed at the Department of Commerce and Economic Opportunity (DCEO) website

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

As reported in previous years, many employers no longer offer retiree health insurance coverage and have terminated coverage for current retirees. This trend continued in 2007.

In response, the State created a Rapid Response Team which informs and educates the dislocated workers and retirees about services available to ease their transition. In 2007, the Rapid Response Team continued its work on this front. Section 4 of this Report details the Uninsured's Ombudsman participation.

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 increased imports or trade-related relocations.

c. Illinois Comprehensive Health Insurance Plan

The Illinois Comprehensive Health Insurance Plan (CHIP) (215 ILCS 105/1 *et seq*.) operates two pools. The Traditional CHIP (Section 7) 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 (Section 15) 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 TAA-CHIP program. It became a qualified health plan pursuant to the Trade Act of 2002 for eligible persons, allowing participants to claim the Health Coverage Tax Credit (HCTC) equal to 65% of paid premium. HIPAA-CHIP by statute cannot impose pre-existing condition

limitations. This pool is funded partially by health insurance industry assessments and partially by premiums. In 2007, CHIP for the first time entered directly into a separate contract with a pharmacy benefit manager, Walgreens Health Initiatives, for prescription services. The contract became effective January 1, 2007, as did CHIP's contract with its plan administrator, Blue Cross and Blue Shield of Illinois. CHIP continues to partner with other state and federal agencies on outreach activities in response to situations where employee health plans are affected by business changes.
On December 31, 2007, enrollment included 5,704 persons in Traditional CHIP (Section 7) and 10,706 in HIPAA-CHIP (Section 15). Enrollment in the new TAA-CHIP plans constituted 303 of the HIPAA-CHIP total.

d. Synopsis of State Planning Grant
In September 2000, Illinois received a $1.2 million State Planning Grant (SPG) from the Health Research and Services Administration (HRSA) of the U.S. Department of Health and Human Services. The Division was the state's lead agency for this grant. The SPG expired in 2007. The Final Report to the Secretary of the U.S. Department of Health and Human Services and the Health Resources and Services Administration may be viewed at http://insurance.illinois.gov/spg.

The purpose of the grant was to develop a plan to increase access to health insurance for all Illinoisans. The SPG funded two components of this planning: research on the characteristics of the uninsured in Illinois and development of plans to reduce the number of uninsured individuals in Illinois. The Illinois Assembly on the Uninsured, a multi-stakeholder group comprised of employers, insurers, health care providers, and other public sector and private sector community representatives, helped develop the plans.
The SPG gave Illinois the opportunity to gather important and unique state-specific data. Several types of research were conducted, including a random digit dial survey, focus groups and key informant interviews. The SPG provided for the expansion of the Behavioral Risk Factor Surveillance System (BRFSS). Also, funds from the SPG were used to create a page on the Division's Internet site (insurance.illinois.gov/spg), gather information on other states' strategies, and undertake a literature review.
The participatory process produced three priorities for specific strategy development:

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

COVERAGE OPTION B. Incentives for Small Employers: Provide financial incentives to small employers who often cannot afford coverage or predict coverage cost increases.

COVERAGE OPTION C. Education and Marketing of Insurance Programs and Products: Enhancement of education, marketing and enrollment processes and procedures for both public and private insurance programs.
Progress has been made in implementing all three of these options. Illinois implemented FamilyCare, expanding its SCHIP program. The Governor expanded eligibility for All Kids (formally KidCare, now All Kids): the income threshold was raised from 185% to 200% of the FPL.
In November 2005 Governor Blagojevich signed legislation establishing the All Kids program, a

comprehensive health coverage plan for every uninsured child in Illinois. The KidCare program is now part of the All Kids program.

Illinois worked with several communities to help them develop the three-share pilot project, which is intended to provide small employer-based coverage options. St. Clair County and the tri-county region that includes Jackson, Franklin and Williamson counties were successful in developing a coverage program. Both areas designed a benefits package and developed eligibility requirements for their programs. We anticipate that pilot projects for small employers will be implemented once a dedicated funding mechanism is approved.

In 2007, Governor Blagojevich introduced Illinois Covered, a bold and comprehensive health care reform proposal designed to provide all Illinoisans with access to affordable health coverage. Illinois Covered includes a reinsurance component, which is designed to lower premiums for individuals and small businesses by covering catastrophic health care costs.

The Ombudsman for the Uninsured Office continues to provide education and assistance to uninsured individuals with understanding available options for public and private programs.

Status of the Pilot Project

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

1. Develop and promote a consensus on new policy options for expanding health care coverage in Illinois, as outlined in the Health Care Justice Act (Public Act 93-0973).

The Health Care Justice Act (IL Public Act 93-0973) established the Illinois Adequate Health Care Task Force. The Task Force was charged with examining the state's health care system, including the state's health insurance markets, and developing recommendations for a statewide health care access plan. The Task Force submitted its report to the Governor and members of the Illinois General Assembly in January 2007. The Task Force recommended broad reforms with respect to both the Illinois health care system generally and Illinois health insurance markets.

2. Develop a measurement tool to evaluate the Illinois three-share model for providing health insurance coverage. Illinois contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota for the provision of technical assistance and support services, including an evaluation of an Illinois pilot project supported by previously awarded HRSA State Planning Grant funds.

SHADAC designed and assisted in developing an evaluation strategy for implementation of a three-share model for providing health insurance coverage. The SHADAC evaluation will add considerable value to the overall pilot program effort.

The three-share programs planned for St. Clair County and the Jackson, Franklin and Williamson tri-county area have not yet been implemented. Both programs are waiting for CMS to formally approve the financing

mechanism and the certified public expenditure. Once formal CMS approval has been secured both pilot program locations will be able to move ahead with implementation. After implementation, and after the first twelve months of operation, application of the SHADAC evaluation tool can begin.

3. Trends

a. 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 does allow the insured the flexibility to use non-participating providers; however, exercising this flexibility is increasingly very costly to consumers. Many PPOs now pay non-participating providers based upon the negotiated rate that would have been paid to a participating provider.

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

Another fee methodology being used by some insurers is payment for non-participating provider claims based on a percentage (*e.g.*, 200%) of the Medicare published rate for the same or similar service. Because Medicare claim reimbursement rates are relatively low rates established by the federal government, 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 Division 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.2) 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.

b. Discount Plans

Illinois currently has approximately 153 active Preferred Provider Administrator (PPA) licenses, covering in excess of 27 million lives. Approximately half of these entities continue to report offering health care services on a discounted basis. At the same time, the Division continues to witness an explosion of unlicensed discount plans. Illinois residents are being repeatedly exposed to fax blasting, multimedia presentations, and internet solicitations for enrollment into discount card plans, plans that offer a wide array of health care services and supplies. Routinely, these plans offer discounted rates for medical, surgical, hospital, dental, vision, prescription drug, emergency travel, mental health, and substance abuse care.

Many employers view discount health care programs as cost effective alternatives to offering supplemental insurance coverage to their employees. Individuals often see them as an alternative to costly private coverage. Many of these plans 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. In fact, in many instances, the "discounts" Illinois consumers pay for are not available because the purported contractual relationship between the plan and the providers does not exist. Consumers are left with the cost of the plan but are denied the benefit.

Although there are exceptions, Illinois law generally requires discount plans to be registered as preferred provider administrators under the Health Care Reimbursement Act (Article XX ½ of the Insurance Code, 215 ILCS 5/370 f). The Division continues to actively work to 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 is reinforced by existing state mandates that require discount programs to disclose on membership cards that discount programs are "not insurance." While it is true that preferred provider administrators are not insurance companies, they are still required to be registered with the Division.

The Division continues to address this issue, and encourages the consumer to verify that their discount program is authorized to conduct business in Illinois before purchasing the product. A listing of authorized preferred provider program networks has been placed on the Division's website

c. PPO Plans Accessing Inappropriate Provider Discounts

The Division continued to receive complaints in 2007 regarding PPO Plans that either accessed discounts to which they were not entitled or accessed discounts through networks other than those approved by the Director (all networks approved by the Director are published on the Division's PPO Provider Network website). In both cases, plans inappropriately accessed health care provider discounts. This plan behavior does not benefit consumers, whose health care dollars either pay for a delivery system that does not exist or are routed through a repricing scheme that benefits the payor, not the member. For the provider, a plan may access discounts through a contractual relationship with a third party, of which the provider is not given proper notice, nor provided contractual consent. The Division continues to address this issue and actively works with state agencies to protect consumers.

d. Non-Directed Provider Networks By Indemnity Plans

As the insurance industry struggles to contain certain kinds of 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 insurers 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. Insurers are now issuing indemnity contracts which do not contain these safeguards and do not disclose benefit differentials for using contracted versus non-contracted providers. The insurer will simply reprice claims to known discount levels when the insured uses a provider contracted with the insurer. In these cases, the consumer may or may not receive the benefit of such discounts.

This approach has also raised concerns within the provider community. Providers argue that insurers 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 of providers who believe that their fees have been unfairly and extra-contractually reduced.

e. 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 combined with a health care spending account such as a Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA).

The use of HSAs appears to be increasing in the Illinois marketplace. 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 the account beneficiary who is 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 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. See Section XX of this report for more information about the underinsured.

f. Mail-Order Programs for Prescription Drugs

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

g. Retiree Benefits

In an effort to help control the rising cost of employer-sponsored health coverage, many employers are reducing or eliminating retiree health coverage benefits. According to a 2006 Kaiser/Hewitt Retiree Health Benefits Survey, large employers are taking a number of steps to increase what retirees pay for health benefits. In 2006, premiums and cost-sharing requirements increased for retirees under and over age 65. Large employers also anticipated making a number of changes that would result in retirees paying more in 2007, including: increasing retiree premium contributions; increasing cost-sharing requirements; and raising drug co-payments and out-of-pocket limits. Between 2005 and 2006, the survey reported, 11% of large employers eliminated benefits for a group of future early retirees. Nine percent of the employers did the same for a group of future Medicare-eligible retirees. As noted earlier in this report, The Ombudsman for the Uninsured, in partnership with the Illinois Rapid Response Team, conducts meetings for retirees of employers who have terminated retiree health benefits or significantly increased cost-sharing. Information regarding the survey may be found at: http://kff.org/health-costs/report/2006-kaiserhewitt-retiree-health-benefits-survey/.

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. Costs of health care coverage are being 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) limiting prescription drug benefits.

B. GOVERNMENT ACTIONS

1. Federal

a. Medicare Modernization Act

Medicare Prescription Drug Coverage, or Medicare Part D, was created by Medicare Modernization Act of 2003. Medicare Part D provides coverage of outpatient drugs for the Medicare population.

The annual coordinated election period for people with Medicare begins November 15 and runs through December 31. Medicare prescription drug plans are offered by insurance companies and other private companies approved by Medicare. The many Medicare prescription drug plans can be placed in one of two categories:

- Stand-alone Prescription Drug Plans, or PDPs, which provide only prescription drug coverage; and
- Medicare Advantage Prescription Drug Plans, or MA-PDs, in which prescription drug coverage is only part of a larger health benefits package. Examples of Medicare Advantage Plans which may provide drug coverage are Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Private Fee-for-Service plans (PFFS).

Medicare prescription drug plans may vary, but each must meet the minimal coverage available in the standard or basic plan. In the basic plan, enrollees pay:

- A monthly premium (varies depending upon the plan);
- An annual deductible which cannot exceed $275 in 2008. After meeting any applicable deductible, enrollees pay:

1. 25% of annual drug costs up to $2,510, with the plan paying the remaining 75% (initial coverage phase);
2. 100% of an additional $3,216.25 in drug costs (coverage gap or doughnut hole); and
3. 5% (or a small co-payment) of any additional drug costs for the remainder of the calendar year (catastrophic coverage phase). To qualify for the catastrophic coverage, a beneficiary must have incurred $4,050.00 in True Out-of-Pocket (TrOOP) expenses in a calendar year. The plan will then pay the balance of the drug costs – the remaining 95% -- for the year.

People with limited income and resources may qualify for the Extra Help program or the Low-Income Subsidy through Social Security, both of which help pay for Medicare drug plan costs. Additionally, the through Illinois Cares Rx plan, Illinois assists low-income individuals who do not qualify for the federal Extra Help program.

Individuals who do not enroll in Medicare Part D when first eligible, and later choose to do so, pay a penalty of 1% per month for every month they went without drug coverage. This penalty is based upon the national average Part D premium at the time of enrollment and is recalculated every year. People with proof of credible coverage, such as employer or union coverage, do NOT pay this penalty.

b. Mental Health Parity Reauthorization Act

The original Mental Health Parity Act was set to expire on September 30, 2001. Each year Congress has passed legislation to extend the sunset date. Most recently, the Act was extended until December 31, 2007. The Act has not yet been extended beyond that date. However, Congress is expected to extend the law again, this time with retroactive application.

2. State - Public Acts

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

a. P.A. 95-0189 Breast Exam

HB 147 amends the State Employees Group Insurance Act, the Counties Code, the Illinois Municipal Code, the School Code, the Public Aid Code, the Insurance Code, the HMO Act and the Voluntary Health Services Plans Act to require individual and group policies of insurance to provide a complete and thorough physical examination of the breast at least every 3 years for women at least 20 years of age but less than 40 years of age; and annually for women 40 years of age or older. The bill specifies who may conduct such exams and indicates that public and private plans must provide coverage for breast exams on a separate and distinct basis when a nationally recognized exam code is approved.

The law does not designate a benefit level for the examinations in relation to other office visits under the policy.

The bill also amends the Department of Public Health's Powers and Duties Law under the Civil Administrative Code (20 ILCS 2310/2310-345). The amendment requires the Department's standardized summary for breast exams to include information contained in this new mandate. The law became effective August 15, 2007.

b. P.A. 95-0200 Long-Term Care Partnership

HB 0517 creates the Illinois Long-Term Care Partnership Act and repeals the existing Partnership for Long-Term Care Act (320 ILCS 35/1 *et seq.*). The bill establishes that the Act is to be administered by the Department of Healthcare and Family Services (DHFS) in conjunction with the Department of Financial and Professional Regulation (DFPR).

The bill requires DHFS to apply to the federal Department of Health and Human Services (DHHS) for a State plan amendment. The amendment would establish asset guidelines for an individual who is a beneficiary of a long-term care partnership program certified policy: the total assets an individual owns and may retain under Medicaid and still qualify for benefits under Medicaid at the time the individual applies for Medicaid long-term care benefits are increased by $1 for each $1 of benefit paid out under the individual's long-term care partnership program certified insurance policy.

DHFS is also to provide DFPR with information and technical assistance in assuring LTC Partnership policies are sold by properly trained insurance producers.

DFPR, in establishing Partnership policies that meet the federal requirements of Title VI, Section 6021, of the federal Deficit Reduction Act of 2005 (DRA), is prohibited from imposing any requirements affecting the terms and benefits of qualified policies unless such requirements are imposed on all long-term care

policies. Insurance companies that issue Partnership policies would be required to regularly report to DHHS in accordance with federal requirements.

DHFS and DFPR possess rulemaking authority to implement the Act in compliance with the DRA. The granted rulemaking authority includes, but is not limited to, data reporting and establishing reciprocity with other Partnership states. The law Long-Term Care Partnership Act became effective August 16, 2007.

c. P.A. 95-0230 Emergency/Under the Influence

SB 0021 amends the Insurance Code to provide that group and individual policies of major medical insurance and managed care plans shall not exclude coverage for any emergency or other medical, hospital, or surgical expenses incurred by an insured as a result of and related to an injury acquired while the insured is intoxicated or under the influence of any narcotic solely on the basis of the insured being intoxicated or under the influence of a narcotic regardless of whether the intoxicant or narcotic is administered on the advice of a health care practitioner.

The bill also deletes Section 357.25 of the Insurance Code which allowed insurers to avoid liability for losses resulting from an insured's use of intoxicants or narcotics when the insured was covered by an individual policy of accident and heath insurance. This law became effective January 1, 2008.

d. P.A. 95-0436 Medicare Under 65

SB 0873 amends the Insurance Code to prohibit insurers from denying Medicare supplement coverage to persons under 65 who meet certain criteria. The bill also sets limits on certain Medicare supplement rates and requires that all policies available to persons over 65 be made available to persons who become eligible for Medicare by reason of a disability. Finally, the bill provides that rates charged to the under 65 disabled enrollees may not exceed the highest rate currently filed with the Department for plans offered to the over-65 population. This law becomes effective on June 1, 2008.

NOTE: This has been an OCHI recommendation for several years. The Division is pleased to report that this legislation has finally been enacted.

e. P.A. 95-0520 Amino-Acid Based Elemental Formulas

Senate Bill 0935 amends the State Employees Group Insurance Act, the Counties Code, the Illinois Municipal Code, the School Code, the Public Aid Code, the Insurance Code, the HMO Act, the Limited Health Service Organization Act, and the Voluntary Health Services Plan Act, by adding a new mandate to group and individual policies to cover non-prescription and specialized amino acid-based elemental formulas administered either by feeding tube or orally when prescribed by a physician as being medically necessary.

The law does not designate a benefit level for the mandate. The law became effective August 28, 2007.

f. P.A. 95-0422 HPV Vaccine

SB 0937 amends the State Employees Group Insurance Act, the Counties Code, the Illinois Municipal Code, the School Code, the Public Aid Code, the Insurance Code, the HMO Act, and the Voluntary Health Services Plan Act to require that entities licensed under those Acts provide coverage in all individual and group policies and plans for the vaccine for human papillomavirus.

The law does not designate a benefit level for the mandate. The law became effective August 24, 2007.

g. P.A. 95-0431 Breast Ultrasound Screening

HB 1365 amends the Illinois Insurance Code (215 ILCS 5/356g) and the HMO Act (215 ILCS 125/4-6.1) to expand coverage for mammograms to include women who have had a prior personal history of breast cancer or who have a positive genetic test for breast cancer. The bill also adds coverage for a comprehensive ultrasound screening when a mammogram demonstrates heterogeneous or dense breast tissue and when found to be medically necessary by a physician.

The benefits shall be at least as favorable as for other radiological examinations and subject to the same dollar limits, deductibles, and co-insurance factors. This law became effective August 24, 2007.

3. Other State Actions - Division Regulations

a. 50 IAC 2020 Reimbursement and Subrogation Provisions Contained in Individual and Group Accident and Health Policies

This Rule applies to individual and group accident and health policies that contain a reimbursement provision. If an insurer includes a reimbursement provision in its policy, that provision must comply with the language set forth in this regulation. It was amended in 2007 to more clearly describe the required language. The amendments became effective October 22, 2007.

b. 50 IAC 5425 Managed Care Dental Plans

This Rule sets forth the guidelines for the Dental Care Advisory Committee that was established by the Dental Care Patient Protection Act. The Rule further sets standards for filing and approval of summary descriptions and grievance procedures for managed care dental plans and it specifies point of service plan filing requirements. The Rule was amended to modify the terms of office (from 3 years to as necessary) and the frequency of meetings (from every 6 months to as needed) for the Dental Managed Care Advisory Committee. The Revised Rule became effective June 20, 2007.

4. Other State Actions – Company Bulletins

a. Company Bulletin #2007-04 – Ancillary Providers - Reimbursement

Issued by Director McRaith on November 13, 2007, Company Bulletin #2007-04 clarified the Preferred Provider Administrator Statute and Regulation with regard to payment of ancillary providers such as anesthesiologists, radiologists, pathologists and emergency room physicians. The Company Bulletin requires members to be held harmless when they seek services at a PPO facility as directed by a PPO physician but unknowingly receive ancillary services from a non-PPO provider. The member, in this instance, is to pay no more out of pocket than the member would have paid if services had been received from a PPO provider.

NOTE: This has been an OCHI recommendation for several years. The Division is pleased to report the Director's decision to issue this Company Bulletin.

C. RECOMMENDATIONS TO IMPROVE HEALTH INSURANCE REGULATION

1. Illinois Covered

Governor Blagojevich's "Illinois Covered" proposal, introduced as Amendment 1 to Senate Bill 5 on March 30, 2007, would bring needed change to health insurance regulation in Illinois. The regulatory improvements found in the Illinois Covered legislation include: 1) affordable and accessible coverage for individuals and small business through the Covered Choice and Covered Rebate programs; 2) creation within the Department of Insurance of an Office of Patient Protection, which will enforce health insurance consumer protection laws and help consumers understand the coverage for which they paid; 3) expanded coverage options for dependents covered under a group insurance policy or HMO contract; 4) a requirement that employers with more than 10 employees maintain a cafeteria plan that complies with Section 125 of the Internal Revenue Code; 5) additional transparency and legal rights for consumers challenging a claim denial through the internal or external independent review process, including expansion of the external independent review process to insurance companies and protections specific to those with denied mental health claims; 6) new health insurance application regulations that will bring more certainty and fairness to the application process.

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

2. 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 justify coverage denials is usually found by insurance companies in an individual's health insurance application and/or medical records. Current state law does not prohibit insurers 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 priced out of coverage because of a repaired birth defect with no present-day health effects; a 22-year-old woman can be rejected or priced out of coverage based on asthma ; a 28-year-old man can be rejected or priced out of coverage based on an allergy ; a

34-year old man can be rejected or priced out of coverage 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 priced out of coverage based on breast cancer that has been in remission for more than a decade; a 54-year old man can be rejected or priced out of coverage because his doctor noticed early signs of arthritis. The prospect of these coverage denials and expensive premium offers discourage people from receiving treatment, including preventive treatment, for fear of creating a medical record that could later be used to deny them or price them out of coverage.

State law does not require insurance companies to price or deny 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 at the expense of consumers. State law does, however, require that insurance companies meet minimum solvency requirements. These solvency requirements can, in the current regulatory environment, pressure insurance companies to price or deny coverage to individuals who in actuarial terms are more likely to incur high medical costs. Not all individuals who are denied or priced out of coverage have minor or long-ago resolved conditions – some people at the time of application do, in fact, suffer from or are likely to soon suffer from major illnesses which require very expensive treatment (*e.g.*, cancer, heart disease).

A hypothetical example demonstrates the solvency problem an insurer would face 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, potentially resulting in insurer insolvency (*i.e.*, the so-called "death spiral").

Individuals and families lucky enough to 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 premium increases on existing 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.

The fact that state law can help explain why some Illinoisans and their families cannot purchase or afford health coverage does not justify state law. State law cannot be justified as "natural" -- other states require insurance companies to "guarantee issue" coverage to all citizens, and restrict the use of age and health status to determine premiums. The current system cannot be described as the "free market" – state law, not the free market, determines who is denied coverage and who receives an affordable offer. The Insurance Code provides insurance companies nearly unfettered discretion to determine this market's winners and losers, a determination that has serious individual and public health consequences and a determination often made based on factors an individual has absolutely no control over, *e.g.*, age, predisposition to illness, or an unfortunate accident.

The state's high risk pool, also known as the state Comprehensive Health Insurance Plan ("CHIP"), 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. His monthly premium for a PPO product with a $500 annual deductible – $1,153. A 28-year-old woman purchasing the same coverage would pay less, but would still owe $453 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: Governor Blagojevich's "Illinois Covered" proposal, introduced as Amendment 1 to Senate Bill 5 on March 30, 2007, would guarantee individuals, families, and small businesses access to an affordable private market health insurance product. The product would be made more affordable by broadening the risk pool, controlling insurance company administrative costs, and providing state-supported reinsurance. Illinois Covered also proposes new health insurance application regulations that will bring more certainty and fairness to the health insurance application process. For more information about Illinois Covered, see Section (C)(1) of this report.

3. Affordability of Coverage in the Small Group Market

The 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, 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 of the employees. Assuming the insurance company is telling the truth and complying with specific restrictions found in the Small Employer Health Insurance Rating Act, the employer must either pay the premiums or lose the coverage.

State law does not require that insurance companies maximize shareholder or company profits at the expense of consumers. However, 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, potentially resulting in insurer insolvency (*i.e.*, the so-called "death spiral").

POSSIBLE REMEDY: Governor Blagojevich's "Illinois Covered" proposal, introduced as Amendment 1 to Senate Bill 5 on March 30, 2007, would guarantee individuals, families, and small businesses access to an affordable private market health insurance product. The product would be made more affordable by broadening the risk pool, controlling insurance company administrative costs, and providing state-supported reinsurance. Illinois Covered also proposes new health insurance application regulations that will bring more certainty and fairness to the health insurance application process. For more information about Illinois Covered, see Section (C)(1) of this report.

3. Health Insurance Company Premium, Loss, and Enrollment Data

Unlike many other states, Illinois does not require health insurance companies to report basic premium, loss, and enrollment data. Such data is needed for two main reasons. First, premium, loss, and enrollment data is needed so that consumers can evaluate the value provided by different health insurance products. Some companies may spend a higher percentage of premium dollars on administrative costs and others may deliver more premium dollars to shareholders – consumers need this information to make rational marketplace choices. Second, with this data policymakers will finally have access to meaningful facts about the overall health insurance marketplace. These facts will inform public debates about reforming state health insurance regulation.

POSSIBLE REMEDY: On July 12, 2007 and at the direction of Governor Blagojevich, the Division filed Emergency Part 937 and Regular Part 937, rules that would require health insurance companies and HMOs to provide basic premium, loss, and enrollment data. A legislative committee called the Joint Committee on Administrative Rules (JCAR) sought to suspend the emergency rule on September 18, 2007 and sought to prohibit the regular rule on November 13, 2007. The Division filed its refusal to withdraw the regular rule January 9, 2008.

2. External Independent Review

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

POSSIBLE REMEDY: Amend the Insurance Code to require group and individual accident and health and disability policies to include an appeals procedure and an external independent review procedure for any procedures, services or treatments that have been denied as not medically necessary. These requirements would be similar to the requirements currently in place for the HMOs under the Managed Care Reform and Patient Rights Act (215 ILCS 134/45).

Governor Blagojevich adopted this recommendation, along with other necessary and important changes to internal and external independent review processes, in his Illinois Covered proposal, which was introduced as Amendment 1 to Senate Bill 5 on March 30, 2007.

3. Emergency Care Reimbursement

Currently 215 ILCS 5/370(o) requires PPO policies to pay for emergency claims incurred at non-preferred providers at the same benefit level as it would have paid to a preferred provider. Many times the insured incurs a much larger out-of-pocket expense under the terms of the law because insurance companies pay emergency care claims based on usual and customary fee schedules (schedules that provide less generous provider reimbursements than in the past) and non-preferred providers "balance bill," *i.e.*, bill insureds for the difference between the actual charges and the usual and customary fees paid by the insurer.

POSSIBLE REMEDY: Amend the Insurance Code (215 ILCS 5/370o), add a new Section to the Insurance Code (215 ILCS 5/356z.7), and amend the Managed Care Reform and Patient Rights Act (215 ILCS 134/65) to require that out of pocket costs incurred by an insured or enrollee who receives emergency care from an out-of-network provider will be no greater than if treatment had been rendered by a preferred provider.

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. This Section 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 notice of Section 15 HIPAA-CHIP by employers and insurance companies when the employer terminates group coverage without replacement coverage and prior to exhaustion of benefits under COBRA or State Continuation.

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 eliminates the spouse's right under the Spousal Continuation law. COBRA has protections for such events whereas state continuation does not.

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

6. State Continuation Laws – Lack of Employer Cooperation

The state continuation laws require certain action 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. In some instances, the employer refuses to cooperate. The Department of Insurance does not have regulatory authority over the employer and, in some instances, the insurance company will not assist the Division or consumer, *i.e*. will not contact the employer to reaffirm the employer's responsibility to offer continuation, when this situation occurs. The problem is further exacerbated when an application is made to HIPAA-CHIP and coverage is denied because the employee, spouse, or dependent was unable to fulfill the continuation requirement, which requires exhaustion of continuation rights.

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

7. Insurer Audits of Paid Claims

In 2007, the Division received numerous complaints from providers and insureds regarding recovery practices by insurance companies and HMOs. Public Act 93-0261, effective January 1, 2004, provided guidelines for companies to recoup payments. Unfortunately, this law (215 ILCS 5/368d) did not stipulate any time frame within which the recoupment must be made. Many times companies request recoupment for claims that are over two years old. While the Division does not dispute the insurer's right to recover monies that have been paid in error, a reasonable time limit should be imposed. The Division has received complaints wherein the claims being recovered are so old that the provider no longer has current patient records and cannot locate the patient to recover the money.

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

8. 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 insurers to review the insured's individual membership file before pre-certifying benefits. In addition, insurers 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 Division has received an increasing number of calls and complaints from consumers who call insurers to pre-certify services and are not advised of important benefit limitations. Consumers are not told 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 plans 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 insurers 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

insurers 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.

9. Disclosure of products being sold to consumers.

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

Possible Remedy: Require that information be provided the agent or insurer about the Office of Consumer Health Insurance 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 the OCHI toll-free number and a statement encouraging the consumer to call OCHI with questions before or after purchasing any health insurance policy

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Exhibits:

1. Zip Code Listing
2. Top Ten Subject Categories of Phone Calls
3. Top Ten Informational Items Requested
4. Number of Phone Calls per Month
5. HMO Company Complaint Record -- General Summary 2006
6. HMO Company Complaint Record -- Classification Summary 2006
7. HMO Independant Review Summary 2006