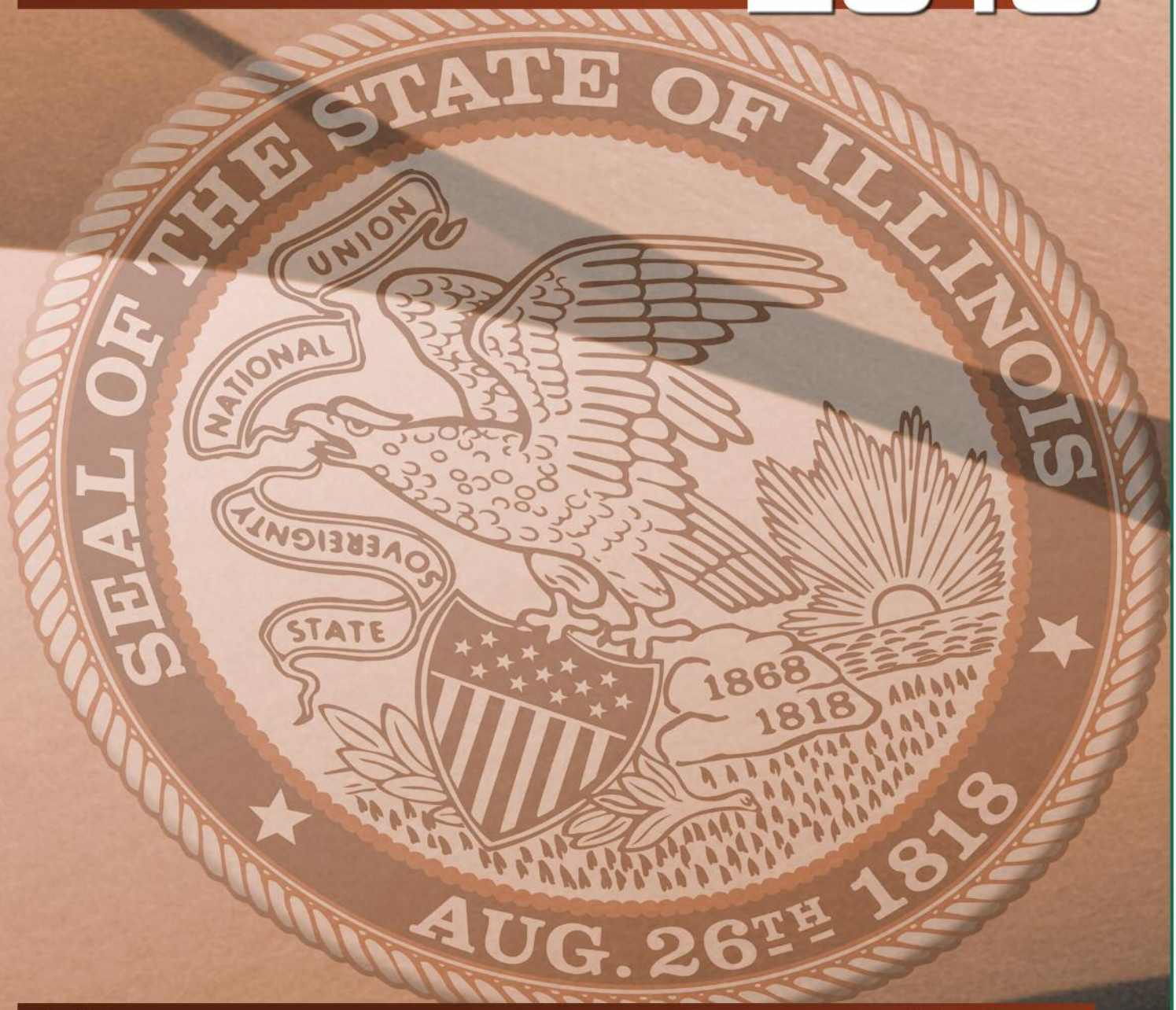
State of Illinois
Illinois Department of Insurance

DOI
Illinois Department of Insurance
Office of Consumer Health Insurance

Report 2013



Pat Quinn
Governor

Andrew Boron
Director of Insurance

Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

January 31, 2014

To: Pat Quinn, Governor
Andrew Boron, Director of Insurance
Honorable Members of the General Assembly

From: The Office of Consumer Health Insurance/Uninsured Ombudsman

Re: The Office of Consumer Health Insurance 2013 Annual Report

The Office of Consumer Health Insurance (OCHI) is pleased to submit its 2013 Annual Report as required by the Managed Care Reform and Patient Rights Act (215 ILCS 134/90).

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

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

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Exhibits:

Preface

Established on January 1, 2000, by the Managed Care Reform and Patient Rights Act, the Office of Consumer Health Insurance (OCHI) operating within the Illinois Department of Insurance (Department) continued to serve Illinois residents in 2013 by responding to their health-related inquiries. In 2013, three analysts were added to the OCHI staff making a total of eight full-time analysts including a Licensed Practical Nurse (LPN). In addition, a Registered Nurse (RN) was hired under a one-year personal services contract to handle External Independent Review requests. As in past years, one analyst spends a portion of the time traveling and representing OCHI and the Uninsured Ombudsman to the public.

The responsibilities of OCHI, as set forth by the Managed Care Reform and Patient Rights Act, have not changed since its inception. That said, activities have intensified, in light of enactment of several provisions of the Affordable Care Act, the state of the economy and the large number of uninsured residents. Its two main functions are to assist consumers with their health insurance needs and to report annually on the state of the Health Insurance Marketplace. OCHI provides assistance to Illinois consumers through a toll-free, consumer inquiry telephone number and through other outreach mechanisms including speaking engagements, health fairs, and the development and distribution of consumer-friendly fact sheets. Through these media, OCHI helps consumers understand their insurance coverage, advises consumers of their rights under insurance policies, assists the insureds in filing appeals and complaints, and provides appropriate resources to Illinois residents who need assistance.

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

In 2012, the Department of Insurance was awarded a Consumer Assistance Grant (CAP) to improve the assistance provided to Illinois consumers who are looking for health insurance or have questions, concerns or complaints regarding their health insurance. Under the CAP grant, many improvements and initiatives have been made which have enabled OCHI staff to assist consumers during a very exciting and confusing period. More information regarding the CAP grant is included later in the report.

In 2013, Health Insurance Marketplaces were established across the country. For 2014, Illinois is participating in a partnership with the federal government. Some responsibilities, such as plan management and in-person consumer assistance functions are being handled by the state and other functions are being handled by the federal government. Through the Marketplace (GetCoveredIllinois.gov and healthcare.gov), Illinois residents and small employers are able to compare health insurance options, apply tax credits directly, and receive enrollment support. As part of the implementation of the Affordable Care Act, Illinois expanded Medicaid to provide coverage for low-income adults ages 19-64. In 2013, Illinois launched a new on-line Medicaid application called the Application for Benefits Eligibility (ABE). The expanded Medicaid Program, coupled with the Health Insurance Marketplace, provides new options for Illinoisans.

Effective 2014, most individuals without health insurance will pay a shared responsibility fee with their federal tax income return. This is known as the Individual Shared Responsibility mandate. Most individuals must maintain Minimum Essential Coverage (MEC) for themselves and their dependents. The Marketplace offers coverage to consumers who previously were unable to obtain or afford coverage. It also provides a vehicle for consumers to purchase MEC in order to avoid the penalty.

Consumers began shopping the Marketplace for this new coverage with effective dates beginning January 1, 2014. OCHI began assisting consumers with questions and concerns regarding the Marketplace, Qualified Health Plans, Minimum Essential Coverage requirements, the Shared Responsibility mandate and many other topics related to the Affordable Care Act in 2014.

In assessing the overall state of the health insurance marketplace in Illinois, OCHI continually monitors state and federal legislation, regulations and bulletins; identifies significant trends and specific problems affecting health coverage for Illinois citizens; and sets forth specific recommendations to address those problems. These will be highlighted later in this report.

Executive Summary

The Managed Care Reform and Patient Rights Act (215 ILCS 134/1 et seq.) established the Office of Consumer Health Insurance (OCHI) in January 2000. Since its inception, OCHI has fielded 241,271 calls through toll-free number (877) 527-9431. (Exhibit 1)

In January of 2013, OCHI began receiving calls through the Voice-over Internet Protocol (VoIP) phone system. Calls came into OCHI through a world-wide toll-free telephone number, (877) 527-9431. The VoIP system was designed to provide accuracy when tracking, completing, and counting the calls received and made by OCHI analysts. The VoIP system includes the capability of capturing information such as complaint numbers, zip codes, and telephone numbers before being connected to the OCHI analyst which provides an opportunity to provide better customer service to the caller.

Effective June 1, 2013, the OCHI staff began tracking the topics which were the subject of calls via the Phone Inquiry and Response Tracking System (PIRT), a project funded under the Consumer Assistance Program (CAP) Grant. The staff received a total of 13,982 incoming calls through the PIRT System and returned a total of 3,208 calls for the time period of June 1, 2013 to December 31, 2013. On average, the call handling time was from 4 to 6 minutes.

Section 1 of this Report describes how OCHI educates consumers about their health insurance rights and options.

Section 2 describes how OCHI helps consumers navigate appeals, complaints and external reviews.

Section 3 describes other services provided by OCHI.

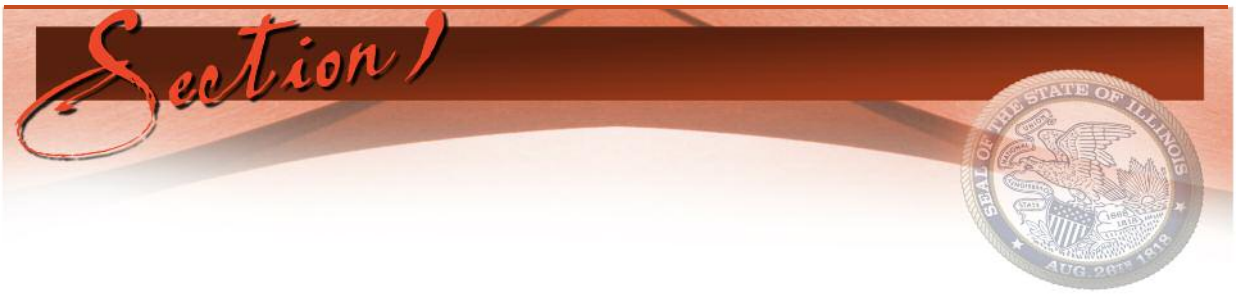
Section 4 documents efforts to expand public awareness of OCHI through various avenues, including media, brochures, fact sheets and outreach.

Section 5 provides information on the Uninsured Ombudsman Program.

Section 6 contains information about market status, trends, and recommendations.

Section 7 contains information about government actions during 2013.

Section 8 contains the exhibits.



Educating Consumers About Their Health Insurance Rights and Options

The OCHI staff fielded over 20,511 calls in 2013 which covered a vast array of topics. Since its inception OCHI has received 241,271 phone calls. (Exhibit 1)

Staff managed calls from a variety of individuals and groups, including consumers, employers, agents, associations, attorneys, health care providers, and advocates. Exhibit 2 contains a breakout of calls by the top twelve categories in 2013.

OCHI provides information and education that assists consumers in understanding their health coverage. OCHI staff often helps consumers define, in practical terms, the specific challenges they are experiencing. OCHI staff explains differences between rights and benefits available in individual, small group, and large group insurance products, and related rights guaranteed by the Health Insurance Portability and Accountability Act (HIPAA)(215 ILCS 97/1 et seq.) and the Patient Protection and Affordable Care Act (ACA) (Public Law 111-148). In addition to discussing issues with consumers by phone and in person, OCHI refers consumers to the Department's internet site (***http://www.insurance.illinois.gov***) and outside web sites (such as healthcare.gov, GetCoveredIllinois.gov and many others).

Health Insurance Marketplace

In 2013, OCHI responded to calls regarding the ACA, the Marketplace and related topics. These calls increased significantly with the beginning of the initial Open Enrollment Period on October 1, 2013. OCHI assisted consumers with Marketplace questions, concerns, and complaints regarding the following topics:

- How to access the Marketplace to shop for coverage;
- What are essential health benefits;
- Which plans are considered Qualified Health Plans in Illinois and where are they located;
- How to understand various options such as Medicaid eligibility, tax credits and cost sharing reductions and whether the caller may qualify for any of these assistance options;
- What are the advantages of shopping on the Marketplace vs. off the Marketplace;
- What plans are available in specific geographical areas;
- Differences between the types of plans being offered;
- What are the penalties for non-compliance with the health insurance mandate;
- How can a consumer address network discrepancies; and
- How to determine the status of the Marketplace application.

In anticipation of the initial Open Enrollment Period for the Health Insurance Marketplace, OCHI staff participated in numerous training sessions, including a training session reviewing the federal government navigator manual and a session reviewing the Illinois navigator manual. A Navigator is an individual or organization that is trained and able to help consumers, small businesses and their employees apply for health insurance through the Marketplace, including completing eligibility and enrollment forms. Navigators are certified by the federal and state government and registered with the Department of Insurance.

OCHI employees are not certified as navigators, nor do they assist with completing forms or actually enrolling consumers. However, this training has enabled them to answer questions and direct consumers to the appropriate place for assistance.

The Illinois Health Insurance Marketplace began initial open enrollment on October 1, 2013. OCHI fielded nearly 1,000 calls from Illinois residents who needed assistance or had questions regarding the Marketplace.

Questions included the following topics:

1) Enrollment and Eligibility

Consumers could apply for coverage on-line at ***www.healthcare.gov*** or ***www.GetCoveredIllinois.gov*** or by telephone at (866) 311-1119, or in person with a registered navigator, certified application counselor, or an in-person counselor. OCHI assisted callers by providing websites and phone numbers for the Marketplace. OCHI also provided names and telephone numbers of registered navigators, consumer assistance counselors and in-person counselors.

OCHI also assisted with eligibility related problems by referring consumers to the Marketplace, Medicaid or the carrier. When warranted, OCHI contacted the Marketplace or the carrier directly to connect a consumer who needed assistance with a specific issue.

2) Essential Health Benefits

Under the Affordable Care Act (ACA), beginning January 1, 2014, insurance coverage offered in the individual and small group markets (both inside and outside of the Marketplace) is required to provide coverage for essential health benefits. Essential Health Benefits (EHB) must include items and services within at least the following ten categories:

- Ambulatory Service
- Emergency Room Services
- Hospitalization
- Maternity/Newborn
- Mental Health and Substance Abuse

- Prescription Drugs
- Rehabilitative and Habilitative Services
- Laboratory
- Preventive Services
- Pediatric Services

Essential Health Benefits in Illinois are based on a benchmark plan (Blue Cross Blue Shield of Illinois Blue Advantage Plan) and include state mandates. Insurance policies must cover essential health benefits in order to be certified and offered in the Marketplace.

The ACA requires that pediatric dental services be a part of the Essential Benefit Coverage. The dental plans may be purchased as a part of a Qualified Health Plan or may be purchased as a stand-alone plan.

Adult dental coverage is not a requirement of the law and will not generally be provided with Qualified Health Plan coverage.

OCHI addressed questions regarding essential health benefits required by Illinois by accessing the checklists provided on the Department's website at ***http://insurance.illinois.gov/Main/industry.asp***.

3) Medicaid Expansion

In 2013, the State of Illinois expanded Medicaid coverage to low-income individuals between the ages of 19 and 64. Illinois residents were able to apply for coverage on the Marketplace (GetCoveredIllinois.gov) including answering questions about their household composition and income. Based on the answers to those questions and on information verified through the Data Services Hub, some or all members of the household may have been transferred to Illinois Medicaid within the Department of Healthcare and Family Services via the Application for Benefits Eligibility (ABE) for consideration. Under the Medicaid eligibility rules, it is possible that children in the household may be eligible for Medicaid while the adults were eligible for Marketplace coverage. OCHI fielded hundreds of questions regarding Medicaid eligibility, status of applications and incorrect initial determinations.

4) Premium Tax Credits and Cost Sharing Reductions

Premium tax credits and cost sharing reductions questions were answered by OCHI analysts in 2013. OCHI advised consumers that beginning January 2014 individuals who purchase Qualified Health Plans in the Marketplace may qualify for federal premium tax credits and cost sharing reductions that would help lower premiums for individuals with household incomes between 100 percent and 400 percent of the federal poverty level.

Premium tax credits help consumers afford health coverage purchased through the Marketplace by lowering their monthly premium costs. Advance payments of the tax credit can be used right away to

lower monthly premium costs or they may be refunded at the end of the year through federal income tax returns.

Income Level	Premium as a Percent of Income
Up to 133% FPL	2% of income
133 - 150% FPL	3 - 4% of income
150 - 200% FPL	4 - 6.3% of income
200 - 250% FPL	6.3 – 8.05% of income
250 - 300% FPL	8.05 – 9.5% of income
300 - 400% FPL	9.5% of income

Consumers who purchase coverage on the Marketplace beginning in 2014 may also be eligible to lower their out-of pocket costs by reducing the amount they have to pay through deductibles and co-pays. This generally includes deductibles, coinsurance, and copayments, or similar charges. It does not include premiums, balance billing amounts for out-of-network providers, or the cost of non-covered services.

5) Qualified Health Plans

Under the ACA, beginning in 2014, insurance plans that provide Essential Health Benefits (EHB) and follow the established limits on cost sharing (such as deductibles, copayments, and out of pocket amounts) along with other requirements are certified by the Federal Marketplace and Illinois Marketplace as Qualified Health Plans (QHP). Qualified Health Plans must be sold by an insurance company and must offer at least one Silver Metal and one Gold Metal plan.

There are eight companies offering Qualified Health Plans in Illinois. Aetna Life Insurance Company, Coventry Health and Life Insurance Company, Coventry Health Care of Illinois, Health Alliance Medical Plans, Humana Health Plan, Inc., Humana Insurance Company, Land of Lincoln Mutual Insurance Company and Blue Cross Blue Shield of Illinois offer Qualified Health Plans on the Marketplace.

The individual and small group market coverage for Essential Health Benefits (EHB) is determined by each state's Benchmark Plan – a health insurance plan offered in the state and identified by the state as including the required EHB. The Blue Advantage Entrepreneur Participating Provider Option plan is the Benchmark Plan for Illinois that sets the standards for the Marketplace plans.

OCHI answered a wide array of questions about Qualified Health Plans and eligibility requirements to enroll in a Qualified Health Plan, the Children's Health Insurance Program (CHIP), or Medicaid through the Marketplace or ABE. OCHI also answered questions relating to deductibles and out-of-pocket maximum costs for each plan (the total amount an individual or employee must pay out-of-pocket for Essential Health Benefits in 2014). The deductible amounts are limited to $6,350 for individual coverage and $12,700 for family coverage. The limits will increase in 2015 to $6,600 for individual coverage and $13,200 for family coverage. The maximum out-of-pocket limits apply to all markets including self-insured group plans.

Metal Levels (Exhibit 3) on the Marketplace are separated into four health plan categories based on the plan's Actuarial Value (AV). The AV is the proportion of medical expenses an insurance plan is expected to cover. For example, an AV of 60 percent means that on average across all services for all consumers the plan would pay 60% of medical expenses. Depending on the services obtained, some consumers will pay more than 40 percent of medical expenses and others will pay less.

Companies offer several plans under each level. (Exhibit 3) The AV for each plan is shown below:

- Bronze – 60% AV – the QHP issuer pays, on average, 60% of the cost of the EHB Coverage;
- Silver – 70% AV – the QHP issuer pays on average, 70% of the cost of the EHB coverage;
- Gold – 80% AV – the QHP issuer pays on average, 80% of the cost of the EHB coverage;
- Platinum – 90% AV – the QHP issuer pays on average, 90% of the EHB coverage.

In addition to the metal level plans, catastrophic plans are available for young adults under age 30 or for individuals for whom metal plans are unaffordable or have obtained a hardship waiver from the Marketplace. These plans have high-deductibles and lower premiums, include coverage for 3 primary care visits and preventive services with no out-of-pocket costs, and protect consumers from catastrophic expense.

Other Marketplace concerns included complaints about accessing the Marketplace website or being enrolled in the wrong plan. Callers also expressed concerns about being erroneously enrolled in the Medicaid program or conversely that their children who should have been enrolled in All Kids were not eligible for the program.

6) CO-OP

Beginning October 1, 2013, consumers and small businesses were given the option of choosing a Consumer Operated and Oriented Plan (CO-OP). Co-ops are private not-for-profit insurers governed by their members to provide consumer-friendly health insurance options. These plans use any profits to benefit members giving them more control over their coverage through actions to lower premiums, improve health benefits, improve the quality of their members' health care and contribute to the stability of coverage. The first federally approved co-op in Illinois is Land of Lincoln Mutual Insurance Company.

7) Individual Share Responsibility Provision

Beginning in 2014, individuals are required to:

- have health coverage (which provides minimum essential coverage) through an employer, directly from an insurance company, or through the Marketplace; or
- qualify for an exemption; or
- make a payment when filing their federal tax return.

In 2014, the shared responsibility fee is 1% of income (or $95 per adult, whichever is higher). The fee for children is half the adult amount.

There are statutory exemptions to this requirement for the following situations:

- Religious conscience;
- Members of a health care sharing ministry;
- Indian tribes;
- Income below the income tax return filing requirement;
- Short coverage gap;
- Affordability;
- Incarceration;
- Not lawfully present.

More specific information regarding the statutory exemptions may be found at ***http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision***.

8) Small Business Health Options Program (SHOP) and Small Business Tax Credits

OCHI received 59 calls regarding this topic. Callers were provided information regarding the availability of the SHOP Marketplace where small businesses with less than 50 employees could purchase coverage beginning January 1, 2014.

Small businesses with fewer than 25 full-time equivalent employees making an average of $50,000 or less per year may qualify for the small business health care tax credit worth up to 50% of the employer's contribution toward employee premium costs. This tax credit is available only if coverage is purchased through SHOP.

Health Related Issues – other than Marketplace

In addition to the ACA related calls, OCHI continued to receive calls requesting information on many other topics including the following:

- How to file for an independent review of a claim or service denied for medical necessity, pre-existing, or rescission;
- How to keep a grand-fathered or grand-mothered (transition) plan under the new law;
- How to contact an insurance company directly;
- Questions regarding the Affordable Care Act requirements;
- Questions regarding state health insurance laws and rules;
- Questions regarding rate increases; and
- How to continue coverage upon losing employment or having a change in family dynamic such as birth, death, divorce or legal separation.

OCHI continues to provide services to Illinois consumers who experience problems with insurance carriers, have questions about Illinois laws and the impact of the new federal law, have concerns regarding rate increases, and are unable to find coverage due to cost of access.

1) Claim Related Appeals

Claim related appeals continue to be the number one reason for calls coming in to OCHI. OCHI received 4,259 calls regarding this topic. Questions included claim denials, unsatisfactory claim payments, and contract exclusions. OCHI responded to callers by explaining the internal appeal process to them and determining if their insurance issues warranted filing a complaint for administrative appeals with the Department.

Some callers were advised that their claim denials might warrant filing an External Review with the Department. According to the Health Carrier External Review Act, consumers had the right to file an External Review for the denial of coverage on the basis of medical necessity, rescission of coverage, preexisting conditions and/or if the service or treatment is believed to be experimental and/or investigational. OCHI received 2,256 calls regarding this topic.

Some calls coming into OCHI do not fall under the jurisdiction of the Department of Insurance. For example, calls related to self-insured employer plans, and plans sponsored through school districts, municipalities, and church groups. Generally, self-insured plans are regulated by the United States Department of Labor (US DOL). When OCHI receives calls regarding self-insured plans, analysts refer consumers to the appeals procedures in their plan documents and also provide the toll-free number for the U.S. DOL.

2) Grandfathered plans

OCHI received numerous calls regarding grandfathered plans. A "grandfathered plan" is plan in existence prior to March 23, 2010 that has not made significant changes since that date. Grandfathered plans are exempt from many of the ACA's key provisions but are subject to certain other provisions. A grandfathered plan must disclose its grandfathered status in any plan materials describing the plan benefits.

3) Transition or Grand-mothered Plans

Individual policies or small group plans that did not meet the minimum essential coverage as required under the ACA were cancelled effective December 31, 2013. However, on November 14, 2013 the President announced that states could allow insurance companies (at their discretion) the option of renewing those plans effective January 1, 2014 through October 1, 2014 without the insureds being penalized. The only caveat was that an insurer may adjust premiums for the plans as permitted under Illinois law. Illinois opted to allow this option and several carriers decided to offer the transition policies to their insureds.

4) General Company Information

OCHI received 1,100 calls from consumers trying to reach their carrier or asking questions about the carrier. Many of the callers requested address and phone numbers for companies. OCHI also provided callers with the complaint history of specific carriers and rating information accessed at AM Best Rating Center which rates companies based on their financial status and ability to pay claims.

5) Questions regarding ACA Reforms:

a) IPXP/PCIP

OCHI received 140 calls regarding this topic. The federally funded temporary high risk pool implemented September 2010, consistent with the ACA, was known as the Illinois Preexisting Condition Insurance Plan (IPXP). IPXP was an insurance program for uninsured Illinois residents with preexisting conditions. The plan was designed to provide coverage until January 1, 2014 when denial of coverage based on preexisting conditions is prohibited. Eligibility requirements provided that an applicant must be a U.S. citizen, national or legal resident and be uninsured for six months.

Effective July 1, 2013, IPXP transitioned to the federally funded Pre-Existing Condition Insurance Plan (PCIP) to run through December of 2013; however, in January of 2014, PCIP announced it would extend the program through April 30, 2014 to allow members ample time to purchase other coverage.

b) Children Under age 19 Law

This law was effective for policies issued on or after September 23, 2010. The law prohibits new group health plans and health insurance issuers in the group and individual markets from imposing preexisting condition exclusions for children under age 19.

c) Preexisting Conditions

Beginning January 1, 2014, insurers on and off of the Marketplace are prohibited from using health status as a criteria when offering coverage. Plans can only be rated based on age, geographic areas, and tobacco use. This provision applies to all new individual and group plans. It does not apply to grandfathered plans in existence prior to March 23, 2010 or excepted benefits under the ACA such as short-term health policies.

d) Limits/Waivers

Starting in 2014, the ACA prohibits annual dollar limits. Until then annual limits were restricted under the Department of Health and Human Services regulations published in 2010.

For employers whose workers only had access to limited benefit plans with lower annual limits, the law and regulation issued allowed the Department of Health and Human Services to grant temporary waivers from this provision that phases out annual limits if compliance would result in a significant increase in premiums. The waivers were temporary and were not extended past January 2014. The waivers were granted to group plans only.

e) Preventive Services

Non-grandfathered plans issued on or after September 23, 2010 must offer preventive services that include screening, check-ups, and patient counseling to prevent illnesses, diseases, or other health problems at no cost sharing to the member (no copayments or deductibles).

Specific services for adult men and women include the following:

- Alcohol misuse and counseling
- Aspirin use to prevent cardiovascular disease
- Blood Pressure screening
- Cholesterol screening
- Colorectal Cancer screening
- Depression screening
- Diabetes (type 2) screening
- Diet counseling
- Hepatitis B screening
- HIV screening and counseling
- Immunization vaccines
- Obesity screening
- Sexually Transmitted Infections counseling
- Syphilis screening
- Tobacco Use screening and interventions

For a complete list of services which much be covered, please visit
http://www.uspreventiveservicestaskforce.org/adultrec.htm,
http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm,
http://www.uspreventiveservicestaskforce.org/tfchildcat.htm
http://www.hrsa.gov/womensguidelines/

6) Questions regarding state laws:

a) Autism

OCHI received a wide array of questions regarding the Illinois Autism Law which requires all individual and fully insured health policies and HMOs written in Illinois to provide coverage for the diagnosis of autism spectrum disorders.

b) Infertility

OCHI received 73 calls regarding the Illinois Infertility Law. The most common questions were regarding eligibility requirements and benefit clarification. Illinois law mandates insurance companies and HMOs to provide infertility coverage for fully insured employer groups written in Illinois with more than 25 employees. The law mandates that coverage for the diagnosis and treatment of infertility be the same as coverage for any other condition covered by the policy. Infertility coverage is an essential health benefit under the new Marketplace policies.

c) Civil Unions

Effective June 1, 2011, health insurance policies and HMO contracts issued in Illinois must offer coverage to two people of the same or opposite sex who share a domestic life that is identical to the coverage offered to married couples and their families. The law provides all of the same protections and legal rights to couples of Civil Unions that Illinois provides to married heterosexual couples.

d) HIPAA

OCHI staff handled 205 questions regarding enrollee rights under the federal and state Health Insurance Portability Act (HIPAA) which, among other things, allows individuals to move from one employer based group health plan to another plan without underwriting or the application of pre-existing waiting periods if done within a specific time period. During 2013, HIPAA rights continued to be an important aspect of health insurance and OCHI continued to assist with these questions.

e) Young Adult Dependent Coverage Age 26

Calls included questions regarding coverage of adult dependent children to age 26, coupled with the Illinois law (Public Act 95-0958) (effective June 1, 2009) that provided parents with insurance policies that cover dependents the right to elect coverage for qualifying dependents up to age 26 and up to age 30 who are military veterans. OCHI received 49 calls regarding this topic.

f) CHIP (All Kids)

The Children's Health Insurance Program (CHIP), also known as All Kids in Illinois, is an insurance program jointly funded by state and federal governments that provides low-cost coverage to children or families that earn too much money to qualify for Medicaid. CHIP routinely covers routine check-ups, immunizations, doctor visits, prescriptions, dental and vision care along with inpatient, outpatient and ancillary services. Well child visits may be covered at no cost to the member and cannot exceed more than 5% of the family's income.

7) Rates

In 2013, OCHI received a large number of calls relating to escalating insurance rates for health insurance coverage. OCHI staff handled 187 calls from consumers regarding rates, premium increases and premium billing.

The ACA requires the Secretary of the U.S. Department of Health and Human Services and the States to establish a premium reporting and review process that allows state insurance departments to review rate increases before insurance companies can apply them. It further requires all health insurance issuers to disclose and justify any unreasonable premium increase prior to the increase. In compliance with the ACA, the Department created the Department's rate review web page which includes the most recent information and offers consumers the opportunity to submit questions and comments. The Department's rate review web page may be reviewed at: ***http://insurance.illinois.gov/hiric/rate-filings.asp***.

8) Continuation

OCHI received 1,054 calls regarding continuation laws for individuals whose employer coverage ended.

a) Federal Law

Federal COBRA gives employees, spouses, and dependent children the right to continue their health coverage based on certain qualifying events such as termination of employment or reduction in work hours, Medicare entitlement, divorce, or death of employee. The individual who elects COBRA is required to pay the entire premium plus an administrative fee.

b) State Law

- Illinois Continuation gives employees, spouses, and dependent children the right to continue their employer sponsored health benefits when certain qualifying events occur such as termination of employment or reduction in work hours. This law applies to fully insured group plans issued in Illinois. Individuals electing Illinois Continuation are responsible for paying the entire premium.

- Illinois Spousal Law gives spouses and dependent children the right to continue their health coverage if lost due to divorce, due to the death of the employee, or due to the retirement of the employee. Spouses and covered dependents may stay on the employer health plan for up to two years, however, if the spouse is age 55 or older, the spouse and covered dependents may be covered until the spouse reaches age 65; however,the dependents may only be covered to the maximum age under the policy.

  Beginning two years after the coverage begins, the monthly premium will be computed according to the amount an employee would be charged, plus the amount of premium the

employer pays, plus an additional amount not to exceed 20% for costs and administration.

- Illinois Municipal Continuation requires that employees who participate in the Municipal Retirement Fund must be offered the right to continue their health coverage when they retire or become disabled. If the employee elects continuation coverage, he or she is responsible for the entire premium.

- Illinois Dependent Child Continuation must be offered to covered dependents of a deceased employee or to dependent children who attain the limiting age under the insurance policy who are not eligible to be covered under the Spousal Continuation Law.

9) Other topics explored by callers to OCHI during 2013 included:

a) Coordination of Benefits – having coverage under two employer group plans
b) Mental Health – Illinois mandates that serious mental health issues be covered to the same extent as other illnesses and diseases for employer groups over 50
c) Prompt Pay – requires capitation amounts and claims be paid within a specific time period
d) Long Term Care Coverage – policies that provide coverage for services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living.

Referrals

One of the primary functions of OCHI is to triage calls in order to determine if the information requested is related to a health insurance issue that can be handled by OCHI or if the caller needs to be directed elsewhere for assistance. In 2013, OCHI referred a wide array of individuals to other agencies or areas within the Department of insurance including the following:

1) **Marketplace** – OCHI referred over 1,400 calls regarding the Marketplace to Get Covered Illinois at the toll-free number (800) 318-2596 or the web site at getcoveredillinois.gov/ and to the federal Marketplace toll-free number (866) 311-1119 for help with signing up for the Marketplace coverage. Many of these calls were from consumers who encountered problems with the federal website (Healthcare.gov) which was riddled with technical difficulties in 2013 and continuing until early 2014. A number of calls were answered by OCHI regarding technical problems which prevented applicants from applying on-line or because applications were erroneously transferred to Medicaid. Many consumers complained that the on-line process erroneously placed children in the All Kids program while others complained that they were denied eligibility. Some were denied coverage, steered to the wrong plan, or charged too much for the coverage. Approximately 22,000 filed appeals with the Marketplace in an attempt to get these mistakes corrected. OCHI assisted these callers by helping them through the process as much as possible and referring them to the proper agency to assist with their problem.

2) **The Application for Benefits Eligibility (ABE)** is an on-line website application process for Medicaid in Illinois. In 2013, the State of Illinois partnered with the federal Marketplace to expand its Medicaid coverage (ABE) beginning January 1, 2014 to include very low-income people, pregnant women and adults with dependent children through family care and the All Kids program.

   Medicaid also expanded its coverage to individuals between the ages of 19 and 64 and to persons with disabilities who are U.S. citizens with annual incomes up to 138% of the Federal Poverty Level. OCHI referred callers with questions regarding their application and coverage to ABE for assistance at (800) 843-6154 or www.abe.illinois.gov.

3) **Carrier/TPA** – OCHI referred 1,928 callers directly to their insurance carriers. OCHI advised callers to contact the carrier first for assistance with questions or concerns, but were also provided information regarding how to file an internal appeal, how to file an external review, and how to file a complaint with the Department, depending on the situation.

4) **United States Department of Labor** – OCHI often receives calls regarding self-insured employer benefit or health and welfare plans. These plans are usually sponsored by large employers, municipalities, school districts, church groups or unions. Employers and unions who offer self-insured plans often contract for services such as enrollment, claims processing, and provider networks with a third party administrator (who may also be a licensed health carrier or HMO). Self-insured health plans are regulated by the US Department of Labor, Employee Benefits Security Administration under the federal Employment Retirement Income Security Act (ERISA). Although the Department of Insurance has no regulatory authority over self-insured plans, OCHI staff assists callers by explaining how to find appeal rights in plan documents and by referring them to the US Department of Labor for assistance. The telephone number for that agency is (866) 444-3272. In 2013, OCHI referred over 500 callers to the US Department of Labor.

5) **SHIP (Senior Health Insurance Program)** - OCHI works with SHIP located within the Department on Aging on a routine basis to provide answers to questions and resolve complaints regarding Medicare products. Callers shopping for products such as Medicare supplements and Medicare Advantage Plans or shopping for Medicare Prescription Drug Plans (Part D) were referred to SHIP's toll-free number at (800) 548-9034. Complaints about Medicare Supplement policies are handled by the Department of Insurance.

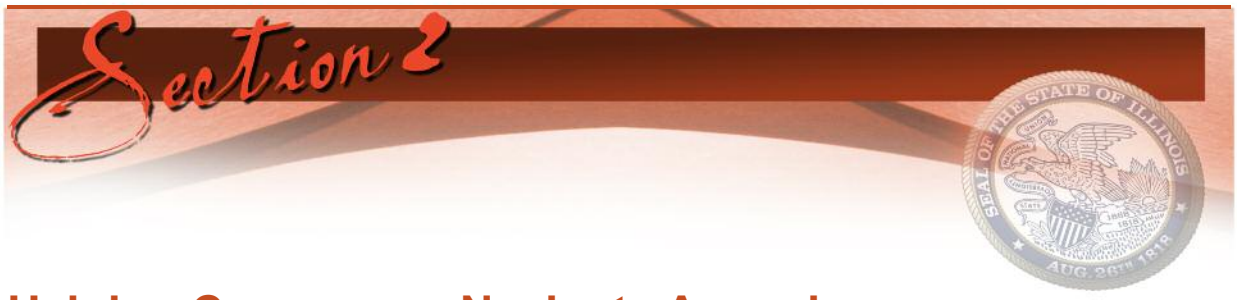
6) **Illinois Comprehensive Health Insurance Program (ICHIP)** – Federal and state HIPAA laws guarantee access to health coverage for individuals who lose their employer-sponsored group health coverage. The Illinois Comprehensive Health Insurance Plan (ICHIP) (215 ILCS 105/1 et seq.) was established as a state program that is intended to provide alternative coverage through two pools. The Traditional CHIP (215 ILCS 105/7) pool was designed for individuals who are denied health insurance coverage in the conventional market because of past or present medical conditions. The second pool, HIPAA-CHIP (215 ILCS 105/15) is the state's mechanism to protect the rights of individuals who have satisfied HIPAA requirements (e.g., prior creditable coverage in

a group health plan). HIPAA-CHIP is prohibited by statute from imposing pre-existing condition limitations.

a) OCHI analysts advised Illinois residents who lost their group health coverage of their possible eligibility for HIPAA-CHIP. OCHI advised the individual that he or she must exhaust all coverage available under federal COBRA or state continuation laws before becoming eligible for HIPAA-CHIP.
b) In circumstances where employer plans ended and COBRA was not offered, HIPAA CHIP was a possible option. However, because federal COBRA and state continuation coverage is unaffordable for many Illinoisans, the high cost of continuation coverage acted as a barrier to HIPAA-CHIP eligibility.
c) The TAA-CHIP program, which was effective June 23, 2003, ended December 31, 2013. Those members were provided information regarding Marketplace plans. If they did not enroll in Marketplace plans, members were moved to traditional CHIP.

Fact Sheets

OCHI, in conjunction with the Department, continues to create and provide fact sheets in response to questions received from Illinois consumers. These fact sheets, which effectively explain complex insurance issues, are available on the Department of Insurance website at ***http://insurance.illinois.gov/Main/Consumer_Facts.asp***.



Helping Consumers Navigate Appeals, Complaints and External Reviews

Appeal Rights

1) Marketplace

The Office of Consumer Health Insurance (OCHI) responded to many callers who were unhappy with Marketplace enrollment and eligibility determinations regarding their applications. Concerns from callers included:

a) Marketplace determined that some or all children of a household were potentially eligible for Public Aid and transferred file to ABE although parent's income was over the minimum threshold;
b) Callers concerned that they were denied advance tax credits and/or cost sharing reductions which they believed they should have qualified for;
c) People informed the tax credit was calculated incorrectly;
d) People denied coverage on the Marketplace due to other reasons;
e) People who qualified for Special Enrollment Periods but were unable to get coverage;
f) People who were unable to complete applications due to healthcare.gov technology glitches early on in the process;
g) Consumers unable to get through on the Marketplace, Public Aid or carrier consumer assistance lines;
h) Consumers who had coverage confirmed by the Marketplace but did not receive a premium notice from carrier;
i) Consumers who paid premium but had not received id cards and were not able to access treatment;
j) Consumers who signed up for networks which included doctors that were not contracted, resulting in a Special Enrollment for those consumers; and
k) Consumers who signed up for networks not realizing that their doctors were not part of the network and wished to change after enrolling.

OCHI assisted callers with all mentioned problems and many others. OCHI helped consumers file appeals of the Marketplace determinations. They also connected consumers with Marketplace and Public Aid staff that could assist depending on the situation. OCHI also assisted consumers with filing complaints with the Department when a carrier's action or inaction was in question. In circumstances where a person needed medicine or treatment, issues were expedited to the Marketplace, Public Aid and/or the carrier.

OCHI explained Special Enrollment Rights to consumers and explained how they could take advantage of those rights. They also explained to consumers how to change provider networks with the carrier

within the same metal level to get to a broader network during the Open Enrollment Period. As information was forwarded from the Marketplace explaining how to remedy different situations, OCHI was able to communicate that information to frustrated callers and help them with their situation.

Internal Appeals

Under Illinois law, there are two kinds of denials for health claims. An adverse determination relates to claims that involve medical judgment for which a carrier has found a service, supply, drug or procedure not medically necessary and thus not covered by the plan. An adverse determination includes claims, services, supplies, drugs or procedures denied as being experimental/investigational. All other types of denials, delays, unsatisfactory payments, referral issues, and contract disputes are considered administrative determinations.

Health carriers must have internal appeal procedures in place for both administrative and adverse determinations. Consumers, or their authorized representative, may file an internal appeal with the carrier within 180 days after receiving the EOB, denial or partial denial. There may be one or two levels of appeals; however, if there are two levels of appeals, both must be completed within the time frames set within the law. Depending on the type of appeal (pre-service, concurrent service or post service) the time frames for resolving the appeal vary. Additionally, if the medical condition of the patient is urgent, the time frames are expedited.

For administrative appeals, a consumer may file a complaint with the Department of Insurance at any time. OCHI explains the internal appeal process to the consumer and also explains the complaint process and provides access to the Department's complaint file.

For adverse determinations, a consumer may file an internal appeal, an expedited internal appeal if appropriate, and an expedited external review if appropriate. OCHI analysts talk with callers regarding the situation in order to advise the proper route to use in filing the appeal. OCHI staff includes an analyst who handles complaints which potentially involve adverse determinations so those consumers can be guided through the internal appeal process and then to the external review process without delay.

External Reviews

As indicated earlier, adverse determinations may be handled via the external review process. In addition to medical necessity and investigation/experimental adverse determinations, external review may also be requested when claims have been denied due to pre-existing conditions limitations and when a policy has been rescinded.

OCHI guided insurance consumers and HMO enrollees with adverse determinations through internal appeal procedures (mandated by the Managed Care Reform and Patient Rights Act) and the external independent review process (mandated by the Health Care External Review Act (P.A. 96-857)). The Health Care External Review Act, amended by P.A. 97-0574 effective August 26, 2011, provides that external review requests be filed with the Director of Insurance. Prior to that date, external review requests were filed with and assigned by the carrier. Under the amended law, the Department assigns a

registered independent review organization on a random basis.
In 2013, OCHI staff responded to 2,256 calls regarding external review. Among other issues, OCHI staff explained the information needed for the request, the relevant time periods, and the role played by the patient's health care provider. OCHI directed individuals to the on-line External Review Form.
OCHI responded to and closed a total of 1,275 External Review Requests in 2013. Some of the reviews did not qualify for external review under state law but qualified under federal law (15); information was provided to those requestors on how and where to file the request. Others (477) were not eligible for external review for a variety of reasons including not exhausting internal appeals and administrative denials which do not fit within the external review criteria. Of the 408 external independent reviews completed in 2013:

- 152 adverse determinations were overturned;
- 246 adverse determinations were upheld;
- 10 adverse determinations were partially overturned.

Until July 2013, an adverse IRO decision could be appealed to the Director of Insurance. The Department handled 71 appeals to the Director in 2013. Of those, 10 IRO decisions were found to be arbitrary and capricious and 61 reviews were found not to be arbitrary and capricious. Of the 10 that were found arbitrary and capricious, 4 were paid by the carrier without further review, and 6 were submitted to a second external independent review as requested by the carrier under the law. Of the 6 sent for a second review, 4 were upheld or partially upheld as arbitrary and capricious and 2 overturned the arbitrary and capricious determination.

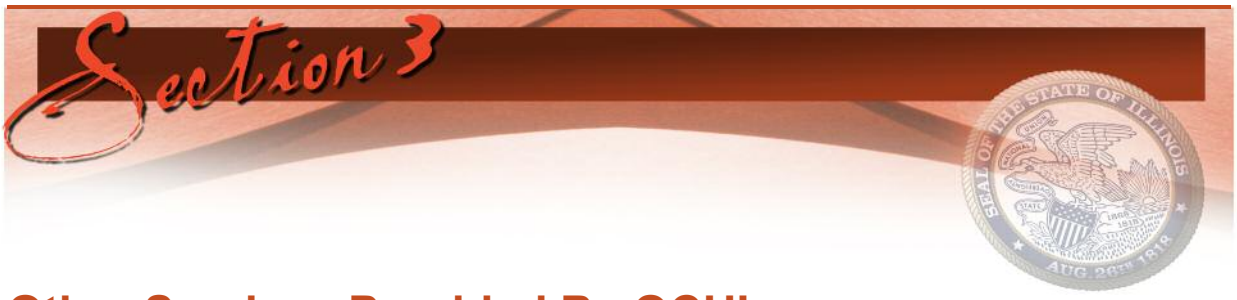
Complaints

The Department investigated 8,424 complaints in 2012. Of those, 2,572 (30.5%) were related to individual and group accident and health insurance and HMO products. Complaints regarding self-insured employer health plans totaled 773.These complaints are not included in the reconciled numbers reported below.

The following information provides summary statistics of reconciled accident and health and HMO complaints investigated by the Department for 2012, compared to 2011:

Coverage	Underwriting	Marketing/Sales	Claims	Service	Total
Individual A&H (2011)	246	7	388	55	696
Individual A&H (2012)	**251**	**29**	**311**	**49**	**64**
Group A&H (2011)	101	9	1,648	68	1,826
Group A&H (2012)	**86**	**11**	**1,541**	**63**	**1,701**
HMOs (2011)	19	3	312	9	343
HMOs (2012)	**7**	**0**	**215**	**9**	**231**

Complaint data for 2013 will be addressed in the 2014 report.



Other Services Provided By OCHI

During the early years of OCHI, benchmarks were established for staff to ensure prompt consumer assistance. For example, OCHI staff immediately responds to approximately 90% of incoming calls; OCHI returns more than 99% of all voicemail messages within one hour of receipt; OCHI strives to directly answer the consumer's questions while on the phone or researches the issue of concern and responds to the consumer within 24 hours. OCHI continues to meet all its consumer assistance benchmarks despite the increased volume and complexity of the calls.

In addition to meeting those benchmarks, OCHI staff has taken on additional duties over the past several years.

1) Correspondence Review

Complaints and inquiries are received via regular mail, fax, electronically, or via the Department's online complaint website at http://insurance.illinois.gov/Complaints/file_complaint.asp .

Two members of the OCHI staff have primary responsibility for reviewing all incoming correspondence and determining whether to handle as an inquiry or complaint. Those individuals identify the company involved, assign an analyst, determine the appropriate response to the inquiry, or provide instructions for the system to notify the carrier of the complaint and send an acknowledgement to the consumer.

2) Written Inquiries

If correspondence is determined to be an inquiry, a letter is sent back to the consumer explaining what information is needed, what action has been taken or answering the general question involved.

In 2013, OCHI staff continued to assist the Department's Consumer Services division in reviewing and responding to written inquiries from consumers. Written inquiries consist of correspondence that does not constitute a complaint based on one or more of the following reasons: (i) a letter from a consumer addressed to an insurer with a copy to the Department; (ii) a letter of complaint that does not contain enough information for the Department to begin a formal investigation; (iii) a general question about insurance or insurance law; or (iv) a letter requesting assistance on a matter that is not within the jurisdiction of the Department.

3) Complaints

In 2013, OCHI staff assisted the Life, Accident and Health Complaint Unit with written consumer complaints. OCHI staff, time permitting, assists with complaints that are straight forward and can be closed without delay or further investigation, such as complaints for self–insured plans or for out of state policies.

An OCHI analyst is responsible for written complaints that contain potential external review issues. These complaints must be handled in a timely manner to ensure the consumer does not lose external review rights which must be exercised within four months of the date of the adverse determination.

4) Writing Fact Sheets

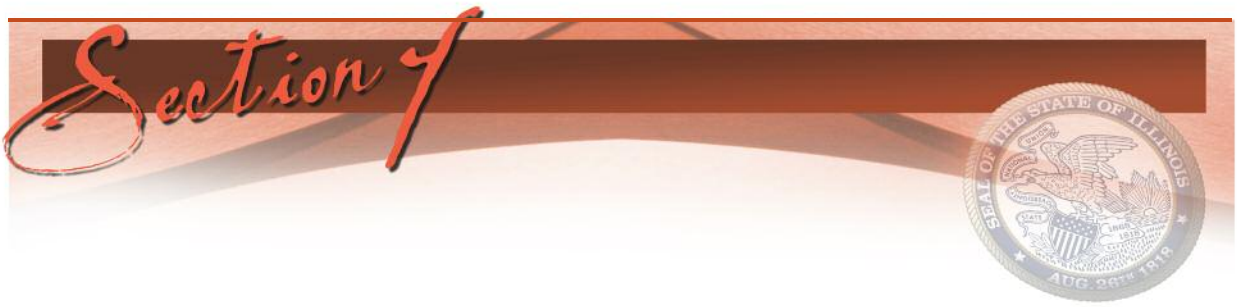
OCHI staff assisted with reviewing and re-writing the numerous Fact Sheets located on the Department's website. Many fact sheets needed revising in 2013 due to the impact of the ACA on health insurance and Illinois laws.

5) External Reviews

OCHI staff handles external review requests from consumers. At the end of 2013, three new OCHI analysts, including a Registered Nurse, were trained to handle those reviews. The Department is receiving an average of 100 external review requests a month. These requests are timely and must be handled immediately if the patient's condition is urgent or within one business day for all other requests. OCHI staff spends hours on the phone with consumers, authorized representatives, and health care providers navigating them through the process. OCHI staff members take turns handling external review requests which require work on the weekend. The staff is very proud of the work done in this area and reports a 30% overturn rate for completed reviews in 2013.

6) Emails

OCHI staff responds to inquiries sent to the email address of the Department of Insurance. This email address, DOI.InfoDesk@illinois.gov, is posted on the Department's website for consumers to send insurance questions. One OCHI analyst is assigned to provide responses to these emails. In 2013, OCHI staff replied to nearly 210 consumer inquiries sent to the email address.



Expanding Public Awareness of OCHI

During 2013, OCHI used various methods to expand public knowledge about the services provided to Illinois consumers.

1) Brochures

The Department of Insurance has developed the following brochures for consumers:

a) **We are Here for You** – Reflects the Department's mission and provides important health insurance telephone numbers and websites for state resources.
b) **Uninsured Ombudsman Brochure** - Provides information for uninsured Illinoisans including websites and telephone numbers for programs for provider services through various state and federal agencies. The brochure recently has been updated to reflect aspects of the Marketplace plans including tax credits, out-of-pocket costs and the availability of low cost or free health coverage through Medicaid.
c) **Premium Rate Review Brochures** – Provides information regarding premiums, medical loss ratios and the rate review process.

All three brochures are available in several languages, including Korean, Polishand Spanish.

2) Media Campaign

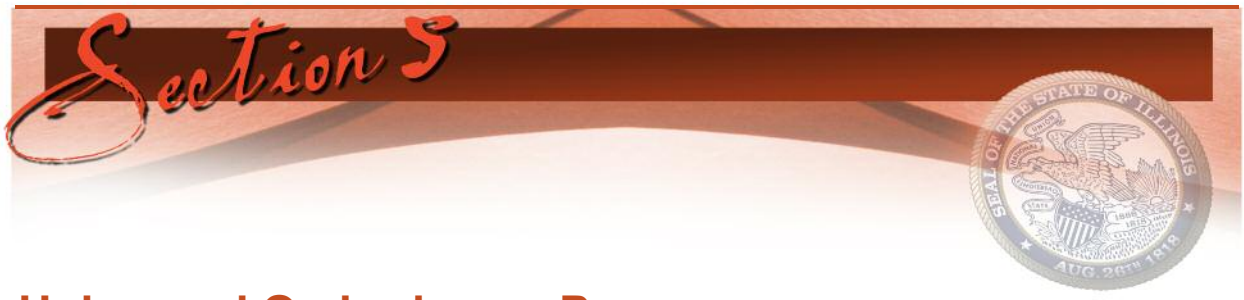
Another tool for educating the public about OCHI is through a media and outreach campaign funded by the Consumer Assistance Program Grant (CAP). The Department began working with the Illinois Office of Communication and Information (IOCI) in late 2013 to launch this campaign in early spring 2014. The main message of the campaign is to promote OCHI as a reliable source for information and assistance with health insurance issues. The target demographic is people under 64 years of age throughout Illinois. The campaign includes the use of radio, print, and bus and train lines as paid ad venues. Bus and train lines will include ads in English, Spanish, Polish and Korean. Print and radio ads throughout the state will complement each other and reinforce the overall message.

3) Fact Sheets

OCHI, in conjunction with the Department, continues to create and provide fact sheets in response to questions received from Illinois consumers. These fact sheets, which effectively explain complex insurance issues important to consumers, are available on the Department of Insurance website at the following web address: (***http://insurance.illinois.gov/Main/Consumer_Facts.asp***). For callers who are unable to access this information via the internet, requested materials were mailed.

4) Health Fairs for Dislocated Workers

An OCHI staff representative participated in several health fairs throughout the State on behalf of the Department's Uninsured Ombudsman Program. The purpose was to increase public awareness of the program, to provide the most current information about local resources and services for dislocated workers and to raise public awareness of the ongoing changes that are occurring with the implementation of the ACA and the Marketplace. The health fairs included the Crown III Health Fair for Dislocated Workers in Waggoner, the Lincoln County Community Health Fair in Lincoln, the Greene Annual Health Fair in Carrollton, the Richland Community College Expo for Dislocated Workers and the Community Event for Dislocated Workers in Decatur.



Uninsured Ombudsman Program

In January 2002, the Uninsured Ombudsman Program (Ombudsman) was established within OCHI to educate uninsured and underinsured Illinois residents about health insurance options and benefits, including an explanation of rights guaranteed by state and federal law. The Ombudsman also informs uninsured and underinsured consumers about available low-cost or subsidized medical services. For calendar year 2013, the Ombudsman staff fielded 2,111 Ombudsman calls, up from 1,455 telephone calls in 2012. As in previous years, calls came from the uninsured, concerned advocates, and from organizations providing assistance to the uninsured. These included other state agencies, legislators, insurance agents, and families.

Ombudsman Service Finder Database

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

In 2013, OCHI Staff continued to receive calls from consumers regarding the entire spectrum of health coverage issues, often concerning specific diseases or conditions and the related financial burdens faced by those who are uninsured or underinsured. To provide answers to consumer questions, OCHI staff is trained on the relevant sections of the Illinois Insurance Code and the Illinois Administrative Code. General familiarity with certain federal laws and regulations (e.g., the Employee Retirement Income Security Act (ERISA) and COBRA (federal health coverage continuation rights) is also a necessity. Given the unique coverage questions and challenges faced by consumers, particularly relating to disease specific mandates, OCHI staff utilized additional resources, including the Internet, as well as information from other state and local agencies (e.g., state and local public health departments), to provide clear and helpful answers. In many cases, OCHI directs uninsured and underinsured consumers to providers of low-cost or subsidized medical services

At the end of 2013, using funds from the CAP Grant, the Department's Internet Technology (IT) section began the process of updating and designing a new and more resourceful Service Finder Database. As new information is obtained, it is entered into the database as a potential resource for future callers. One advantage is the new database will check for out-dated links which can eventually be dropped from the site. The database is expected to be available for use in 2014. At that time, the OCHI Finder database will be moved to the PIRT database where the information will be verified and readily available to phone analysts.

2013 Rapid Response Workshops for Dislocated Workers

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

The response team passed out Ombudsman Brochures that reflected the aspects of the new Marketplace plans including information on tax credits, discounts on out-of-pocket costs, and the low cost or free health coverage through Medicaid. The brochures also provided a source for finding Navigators or Assisters and licensed agents who are reliable and available to explain health care options for purchasing coverage through the Marketplace. Websites and phone numbers for agencies and programs that provide services through various state and federal agencies have been included in the brochure as a tool for helping consumers find qualified health plans. The rapid response team attended the following workshop locations:

Companies	Location of Workshop(s)	Number of Impacted Employees
Amsted Rail	Alton	31
Amsted Rail	Granite City	150
Cast Metals Org.	Peoria	65
Caterpillar Mapleton & Caterpillar Inc.	Decatur	460
Crown III (Springfield Coal)	Springfield	20
Crown III (Tri-County Coal)	Waggoner	50
Eastern Illinois University	Bloomington/Rantoul	120
Electric Energy Inc.	Joppa	30
Hostess	Springfield	51
IDES	Springfield	61
Sears	Champaign	20
Sears	Champaign	30
Scott Air Force Base (4 firms)	Rantoul	150
Trace Laboratories Inc.	Carthage	30

Market Status and Trends/Recommendations

Market Status

1) Discontinued Products

The Illinois Health Insurance Portability and Accountability Act (HIPAA) of 1997 (P.A. 90-0030) requires that health insurance companies seeking to discontinue the sale of all health insurance products in the individual, small employer, and large employer markets must provide proper notification to the Department and their insureds.

In 2013, several companies offering health insurance in Illinois discontinued their coverage because it did not meet the essential benefit requirements as mandated under the ACA. These companies provided notice of discontinued sales or terminations within a market as noted in the table below.

Company	Action	Discontinuance	Notice
Sterling Life Insurance Company	Discontinuance from the Individual Long Term Care Market		03/26/2013
Washington National Insurance Company	Discontinuance from the Medicare Supplement Market – Maintaining Current Policies in Force	04/13/2013	09/14/2013
Humana Insurance Company	Uniform Termination of Coverage in the Small Group Market 1,230 Lives		09/18/2013
Humana Insurance Company	Uniform Termination of Coverage in the Small Group Market – 1 Covered Life		09/18/2013
Humana Insurance Company	Uniform Termination of Coverage, Group Health, Commercial Group Plans 5,353, 84,285 Members		04/09/2013
Humana Insurance Company	Uniform Termination of Coverage Group HMO Plans - 861 Groups; 26,589 Members		04/09/2013

Company	Action	Discontinuance	Notice
Guarantee Trust Life Insurance Company	Discontinuance from the Individual Long Term Care Market	04/15/2013	01/31/2013
United National Life Insurance Company	Discontinuance from the individual Long Term Care Market	04/15/2013	02/07/2013
New York Life Insurance Company	Discontinuance from the Association Group Health Market 1,699 Covered Lives	01/01/2014	02/15/2013
Physicians Benefits Trust Life Insurance Company	Discontinuance from the Individual and Small Group Health Market–774 Individual Covered Lives; 2,405 Small Group Covered Lives1 Covered Life	12/28/2013	03/29/2013
Madison National Life Insurance Company	Discontinuance from the Association Group Market 107 Covered Lives	12/12/2013	03/29/2013
Madison National Life Insurance Company	Uniform Termination of Coverage in the Small Group Market – 440 Covered Lives		09/27/2013
Independence American Insurance Company	Discontinuance from the Association Group Health Market – 45 Covered Lives	12/12/2013	03/29/2013
Standard Security Life Insurance Company-New York	Discontinuance of the Association Group Health Market – 208 Covered Lives	12/12/2013	03/29/2013
Standard Security Life Insurance Company-New York	Uniform Termination of the Small Group Health Market – 6 Covered Lives		09/27/2013
Trustmark Life Insurance Company	Discontinuance from the Large and Small Group Health Market – 12 Large Groups, 640 Total Covered Lives; 206 Small Groups 2063 Total Covered Lives	12/28/2013	06/04/2013
Chesapeake Life Insurance Company	Discontinuance from the Individual Health Market -136 Policies; 174 Covered Lives	12/28/2013	05/30/2013
Mega Life Insurance Company	Discontinuance from the Group Association Health Market – 42 Plans; 93 Covered		03/19/2013

Company	Action	Discontinuance	Notice
Mid-West National Life Insurance Company	Discontinuance from the Group Association Health Market 19 Plans; 23 Lives		03/19/2013
Physicians Mutual Insurance Company	Discontinuance from the Individual Health Market - 7 Policies	12/28/2013	02/08/2013
Aetna Life Insurance Company	Uniform Termination of Coverage in the Small Group Market 3,571 Plan Sponsors; 29,750 Covered Lives		06/30/2013
John Alden Life Insurance Company	Uniform Termination of Coverage in the Small Group Market – 6 Covered Lives		06/20/2013
Time Insurance Company	Uniform Termination of Coverage In the Small Group Market – 186 Groups; 1157 Covered Lives		06/17/2013
Time Insurance Company	Uniform Termination of Coverage in the Association Group Market 303 Covered Lives		06/20/2013
Coventry Health Care of Illinois	Uniform Termination of Coverage in the Individual Market – 4,189 Covered Lives		07/01/2013
Aetna Life Insurance Company	Uniform Termination of Coverage in the Small Group and HMO Market - 226 Plans; 1,867 Covered Lives		07/30/2013
Aetna Life Insurance Company	Uniform Termination of Coverage in the HMO Large Group Market – 29 Groups; 3,011 Covered Lives		08/29/2013
Aetna Health, Inc.	Uniform Termination of Coverage in the HMO Large Group Market 5 groups; 126 Covered Lives		08/29/2013
Coventry Health and Life Insurance Company	Uniform Termination of Coverage in the Individual Market 1,896 Covered Lives		07/01/2013
Health Care Service Corporation (BCBS)	Uniform Termination of Coverage In the Individual Market – 178,026 Covered Lives; Transition Policy Offered	12/31/2013	08/28/2013

Company	Action	Discontinuance	Notice
Health Care Service Corporation (BCBS)	Uniform Termination of Coverage Small Group, HMO Market – 48,659 Covered Lives; Transition Policy Offered	12/31/2013	09/26/2013
Health Care Service Corporation (BCBS)	Uniform Termination of Coverage In the Large Group Market – 52,782 Covered Lives	12/31/2013	08/28/2013
Health Care Service Corporation (BCBS)	Discontinuance from the Small Group Market – 226,985 Covered Lives; Transitional Policy Offered	12/31/2013	08/28/2013
United American Insurance Company	Discontinuance from the Individual Market 4 Covered Lives	12/31/2013	07/09/2013
Companion Life Insurance Company	Discontinuance of Coverage in the Individual Market – 65 Covered Lives	12/31/2013	09/26/2013
Royal Neighbors of America	Discontinuance from the Individual Market	12/31/2013	11/26/2013
Pekin Life Insurance Company	Discontinuance of Coverage from the Individual Market 37 Policies; 48 Lives	12/31/2013	02/19/2013
Celtic Insurance Company	Uniform Termination of Coverage in the Individual Market 3,425Policy-holders; 4,456		06/25/2013

2) Transitional Plans

The market discontinuations caused disruption to the health insurance market in the last quarter of 2013. OCHI received hundreds of calls from consumers who were upset and confused about losing their existing health coverage. They did not understand the options being presented to them and in many cases were looking at higher rates for the new plans. To complicate matters further, the federal website, ***www.healthcare.gov***, experienced numerous technical problems for the last three months of 2013, making it even more frustrating for consumers to obtain health coverage by January 1, 2014.

As mentioned earlier, President Obama announced on November 14, 2013 that the federal government would be using its regulatory discretion to allow a number of health plans in the individual and small group markets that did not meet the ACA requirements to renew in 2014. The Department, on November 25, 2013, announced that Illinois would allow transitional or "grandmothered" plans if carriers wanted to keep them. Several carriers opted to continue those policies for their customers. While

this was a relief to many consumers, further confusion resulted for those who had already chosen a Marketplace plan but wanted to return to their old plan. OCHI spoke to numerous consumers who needed help getting the correct policy, member ID cards, and in some cases, refunds of premium because money had been paid for two policies.

3) Qualified Health Plans on the Marketplace

All Marketplace coverage is provided by Qualified Health Plans (QHPs). To be a QHP, plans must meet a number of requirements, including offering Essential Health Benefits and meeting network adequacy requirements.

In 2013, eight companies submitted QHPs through the Illinois Marketplace:

- Aetna Life Insurance Company
- Coventry Health and Life Insurance Company
- Coventry Health Care of Illinois, Inc.
- Health Alliance Medical Plans, Inc.
- Health Care Service Corporation (Blue Cross Blue Shield of Illinois)
- Humana Health Plan, Inc.
- Humana Insurance Company
- Land of Lincoln Mutual Health Insurance Company

In Illinois, there is a choice of small group and individual plans in all counties, with at least 57 plans available in all counties. There are Gold, Silver, Bronze and Catastrophic plans available in all counties. Two individual PPO plans and three small group plans are available statewide.

4) Qualified Health Plans – Dental

Pediatric dental services are an Essential Health Benefit under the ACA and must be provided either as part of the health plan, or as a stand-alone dental plan.

Two carriers offer qualified health plans dental coverage only:

- Dentegra Insurance Company
- Delta Dental of Illinois

Many QHPs offer dental as part of the health plan, or as a stand-alone dental product. Illinois has 7 insurers with a total of 42 dental plans available statewide, with at least 20 high and 20 low coverage plans available in all counties. There are twenty seven small group and fifteen individual dental plans available statewide. Offerings available in all counties include child only and adult and child only plans.

5) Grandfathered Plans

Plans in existence on March 23, 2010 (effective date of the ACA) are referred to as grandfathered plans. These plans may remain in effect without meeting the minimal essential benefit requirements as long as there are no substantial changes to benefits, cost sharing, employer contributions or annual limits. Grandfathered plans are impacted by some portions of the ACA such as prohibition of lifetime limits; prohibition on rescission except for fraud; coverage of dependents until age 26; and appeal and external review rights. OCHI received many calls regarding grandfathered plans and questions regarding applicability of the various federal and state laws to those plans.

6) Large Employer Groups

Under the ACA, large employer groups (50 or more full-time employees) will be subject to the Employer Shared Responsibility provisions under section 4980H of the IRS Code as added by the ACA if they do not offer affordable health coverage that provides a minimum level of coverage to their full-time employees and their dependents, and if at least one of its full-time employees receives a premium tax credit for purchasing individual coverage on the Marketplace. No Employer Shared Responsibility payments will be assessed for 2014. Employer sponsored coverage remains the largest segment of the health insurance marketplace, with a large portion being self-insured. OCHI continues to assist consumers who have questions and problems with their employer-based coverage. Some of the ACA protections extend to this group including prohibition of limits on annual benefits, prohibition of lifetime benefits, prohibition on pre-existing conditions, coverage of dependents until age 26, coverage of preventive care, and appeal and external review rights. Various provisions apply to the groups depending on whether they are grandfathered or not.

7) Small Employer Groups

Small employer groups were eligible to purchase coverage on the Small Business Health Options Program (SHOP) Marketplace beginning October 1, 2013 for coverage beginning January 1, 2014. Due to problems experienced with healthcare.gov, small businesses were directed to agents and brokers for assistance with buying coverage on the Marketplace. Small employers, if they choose to purchase coverage for employees, must buy a plan that covers Essential Health Benefits. Small employers may be eligible for a tax credit if they provide coverage for employees.

8) Other Health Coverage

There are many other types of plans still being marketed, including Medicare Supplement Policies, Medicare Advantage Products, Medicare Part D products, disability income insurance, long-term care insurance, specified disease coverage such as cancer coverage, fixed indemnity policies, short-term health policies, accident only policies, and credit policies. Many of these plans are supplemental to other coverage and are not considered minimum essential coverage under the ACA. They are considered excepted benefits under the ACA. Others, such as disability coverage and long-term care coverage are policies that consumers buy to fit a different need in the market. These products are still prevalent on the market and have a niche. OCHI continues to assist consumers who have questions, concerns and complaints with these products.

Trends and Recommendations

1) Rate Increases

The Department of Insurance continues to receive calls regarding rate increases. In 2013, calls included but were not limited to complaints regarding significant increases for long term care policies. Many seniors have been forced to drop their coverage or to buy a more affordable policy with limited benefits.

Possible Remedy

As required by the Affordable Care Act, the Department of Insurance has implemented a Health Premium Rate Review program. This program is designed to provide access to premium rates that health care plans filed with the Director and to educate consumers on the medical and administrative costs driving rate increases.

While this process provides transparency and education regarding rates, the Department does not have rating authority. Rates cannot be disapproved. They are placed on file and published.

2) Disability Claims Denied

OCHI received a multitude of calls in 2013 regarding denied disability claims, many of which were the subject of complaints submitted to the Department of Insurance.

Under the terms of the policies, insurance companies are permitted to make decisions involving medical judgments that may result in a reduction or denial of benefits for disability claims. Since the Department of Insurance has limited authority over these decisions, our ability to assist is limited.

Possible Remedy

Legislation making disability claim denials based on medical judgment subject to independent external review.

3) Independent Reviewer Organization Pricing

In 2013, the Department received complaints from carriers regarding excessive charges by Independent Review Organizations (IROs). The law does not address this matter; therefore the Department of Insurance has no regulatory authority to require the IROs to reduce those charges.

Possible Remedy

Other states such as Washington, Maine, New Hampshire, Delaware, North Carolina, Arizona, Kentucky, Oklahoma, and Indiana have devised various ways of controlling this problem including

regulations and statutes that include restrictions or caps on fees charged for review. Illinois is considering legislation to correct this problem.

4) Provider Networks:

During open enrollment in 2013, there was considerable confusion in the Marketplace regarding provider networks associated with various plans. Some materials or provider networks included providers who were not actually contracted with or associated with the network. Some of the less costly products offered narrower networks which consumers did not understand when purchasing their coverage. Consumers did not understand that networks varied by product even if the carrier was the same. The provider networks associated with a particular product may not have been as clear as it could have been for consumers who were attempting to compare plans. Many consumers bought coverage from carriers they had used before with the misconception that their providers would be included in whichever plan they chose. This caused mass confusion for many consumers in Illinois and was exacerbated by the fact that the Marketplace did not allow consumers to cancel a plan and change to another during open enrollment. OCHI spent many hours assisting consumers change to plans with broader networks within the same metal level or explaining how they may qualify for a special enrollment period. Many complaints were filed regarding this issue.

Possible Remedy

The Department is taking an even closer look at QHP provider networks for the 2015 review process to ensure network adequacy. The Department is also requiring increased network transparency so that it is easier for consumers to determine on Healthcare.gov the network that applies to each product. The Department will also provide a fact sheet to consumers regarding provider networks, including narrow networks, to increase consumer awareness and education.

5) Customer Service Centers Overload

OCHI fielded hundreds of calls from consumers who could not make contact with the federal or state Marketplace, the Department of Healthcare and Family Services (Medicaid) and carriers who were selling products during open enrollment. The call centers were overloaded and some carriers experienced call waiting periods of several hours. Consumers were frustrated with the wait times and many times were told that they had called the wrong place for assistance.

Possible Remedy

The Department hopes to work more closely with the Marketplace call centers, Department of Healthcare and Family Services and carriers to assist callers in any way possible. It is hoped that the agencies and carriers may be able to develop a system to triage the calls coming in and get them to the proper agency without frustrating the consumer even more.

Government Actions

Federal

The Affordable Care Act (ACA) was passed by Congress and then signed into law by the President on March 23, 2010. The Initial Open Enrollment began on October 1, 2013. Illinois partnered with the federal government to provide coverage to Illinois residents on the Marketplace.

Numerous federal rules implementing the ACA were proposed or finalized during 2013. Those rules may be found at ***http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/index.html***.

1) Grants Under ACA

a) <u>Consumer Assistance Program Grant (CAP)</u>

The Consumer Assistance Program Grants (CAP Grants), awarded by the Department of Health and Human Services, provide resources to states to educate and provide accurate information to consumers who are making difficult health care decisions. Illinois received a grant award in the amount of $1,141,954.00. The activities funded in 2013 included:

i) Implementation and deployment of Public Inquiry and Response Tracking (PIRT), a mechanism to connect disparate information systems and enable data sharing between all areas of the Department, including OCHI, Life and Health (LAH) and Managed Care Units. The goal of PIRT is to combine technology and staff knowledge to improve the level of assistance DOI is able to provide to consumers and to streamline the processes currently employed. The system will track consumer contacts with the Department allowing us to meet our needs as an agency and to report data as required by the CAP Grant. Phase II of the system was developed in late 2013 which will streamline the process by which analysts can enter the information from calls, match resources to the topics discussed and send them to the caller in the most efficient manner.

ii) The Department was able to hire a Notes Developer in 2013 and began work on the on-line message center which allows consumers to securely submit inquiries, complaints and external review complaints on-line from personal computers, tablets and cell phones. The message center provides access to status for consumers at any time. The consumer message center, healthcare provider message will be deployed in 2014.

iii) The Notes Developer has also begun work on the CARE (Consumer Assistance Request Environment) system which is the electronic complaint system. Housekeeping changes were made in 2013 such as moving data from one server to another, and automating many processes which were previously manual and required constant monitoring. Many enhancements are planned for 2014.

iv) CAP Grant funds were used to train OCHI and Complaint staff during 2013. Staff was trained on a regular basis and included the Illinois Assister Training as well as the Federal Assister Training.

v) The VOIP system was procured and installed during 2013. This system allows monitoring of all calls, tracking of calls, etc.

vi) Media campaign planning began in late 2013. The campaign will take place all over the state and will include print, radio, bus and train ads. Several languages will be used for the campaign. The campaign is expected to launch in the first quarter of 2014.

Illinois

Beginning October 1, 2013, through March 31, 2014, consumers could purchase health plans through the Marketplace with effective dates of January 1, 2014 and after. These plans must cover Essential Health Benefits, pre-existing conditions and provide for preventive care with no cost sharing to the member.

Get Covered Illinois is the Illinois Marketplace where consumers could shop, compare, apply, and enroll for health insurance on line at ***www.GetCoveredIllinois.gov*** or by calling Get Covered Illinois directly at (866) 311-1119 for information on enrollment and eligibility.

1) Public Acts

a) HB 0991 INS CD-Rehab Domestic Ins. Co (Public Act 98-0136)

Amends the Illinois Insurance Code to set forth provisions concerning the rehabilitation or liquidation of a domestic company that is a covered financial company under the federal Dodd-Frank Wall Street Reform and Consumer Protection Act. Provides the grounds upon which the Director of Insurance may file a complaint for an order of rehabilitation or liquidation. Provides that after notice to the insurance company, a court may grant an order for rehabilitation or liquidation within 24 hours after the filing of a complaint and that if the court does not make a determination on a complaint within 24 hours after its filing, then the complaint shall be deemed granted by operation of law upon the expiration of the 24-hour period.

Sets forth provisions concerning the court order and the Director's powers and authority. Effective 8/2/13

b) HB 1388 Podiatric Physicians (Public Act 98-0214)

Amends various Acts by changing "podiatrist" to "podiatric physician." Also makes revisions to the Podiatric Medical Practice Act. Effective 8/9/13

c) SB 1758 INS CD-Limited License (Public Act 98-0159)

Amends the Illinois Insurance Code. Provides that a license as an insurance producer shall not be required of a person selling or soliciting lines of insurance that are exempt from the definition of insurance in the provision of the Code concerning financial institutions. Includes credit life and credit accident and health insurance and other credit insurance policies approved or permitted by the Director of Insurance among the classes of insurance for which a person may obtain a

limited lines producer license; makes a corresponding change concerning fees. Provides that a credit insurance company must conduct a training program in which an applicant shall receive basic instruction about the credit insurance products that they will be selling. Effective 08/2/13

d) HB 3300 Claim –related information; alternative means of communication – (Public Act 98-0189)

Amends the Illinois Insurance Code to require companies that issue, deliver, amend or renew an individual or group policy of accident and health insurance shall accommodate a reasonable request by a person covered by the policy to receive communications of claim-related information from the company by alternative means or at alternative locations if the person clearly states that disclosure of all or part of the information could endanger the person. Effective January 1, 2014.

2) Rules

There were no new rules adopted in 2013. The following amendments were proposed in 2013 to make the rules consistent with the Affordable Care Act for plans effective on or after January 1, 2014:

a) 50 Illinois Administrative Code 2005 – Preexisting Illness

This rule applies to individual and group accident and health insurance policies to the extent that they provide benefits and coverage that fall under "excepted benefits" plans and to all other individual and group Insurance policies defined in this section that are not subject to 50 Ill. Adm. Code 2001.5 or Ill. Adm. Code 2008." Benefits are not subject to these requirements if offered as independent non-coordinated benefits such as specified disease, illness policies, hospital indemnity, or other fixed indemnity insurance [215 ILCS 97/20] (26 USC 9832). (Effective January 2, 2014)

b) 50 Illinois Administrative Code 2007- Minimum Standards of Individual Accident and Health Insurance

Section 2007.60 of the Illinois Insurance Code amends the insurance code to include definitions for the "Patient Protection and Affordable Care Act (ACA)" (42 USC 18001 et seq.) and "Grandfathered Health Plans."

Section 2007.60 (H) prohibits preexisting condition exclusions for policies other than excepted benefits and grandfathered health plans. It also prohibits establishing a probationary or waiting period during which no coverage is provided under the policy with the exception that excepted benefit policies may specify a probationary or waiting period not to exceed six months for specified diseases or conditions and losses resulting from hernia, varicose veins, adenoids, appendix and tonsils; however, the permissible six month exception shall not be applicable when the specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain a probationary or waiting period. Benefits are not subject to requirements if offered separately. (Effective January 2, 2014)

c) 50 Illinois Administrative Code 2012 – Long Term Care

Section 2012.145 Long-Term Care Partnership Program was amended to mandate that an insurer shall offer within 12 months, on a one time basis, the option for enrollees to exchange their existing LTC coverage for coverage that is intended to qualify under the Illinois' Long-Term Care Partnership Program (LTCPP). This mandatory offer of exchange shall only apply to products issued by the insurer that are comparable to the type of policy form, such as group and individual policies, and on the policy series that the insurer has certified as partnership qualified. The rule allows for premiums to be adjusted based on the results of the underwriting process or the exchange may be denied by the insurer.

The rule was amended to include Exhibit L which provides that the Long-Term Care Partnership Policy (Certificate) is intended to qualify as a Partnership Policy (Certificate) under the Illinois Long-Term Care Partnership Program as of the policy's (Certificate's) effective date.

The rule was further amended to include Exhibit M which provides that a commissioner of a state implementing a qualified State Long-Term Care Insurance Partnership may provide consumer protection requirements as set forth in section 1917(b) (5) (A) of the Social Security Act (42 USC 1396p (b) (5) (A)) and principally include certain specified provisions of the Long-Term Care Insurance Model Regulation and Model Act promulgated by the National Association of Insurance Commissioners. (Effective January 2, 2014)

d) 50 Illinois Administrative Code 2026 - Premium Increase Justification and Reporting

This rule was adopted to establish requirements for health insurance issuers offering health insurance coverage in the small group or individual markets to report information concerning unreasonable rate increases to the Director by a written description justifying the rate increase which must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase. (Effective January 2, 2014)

e) 50 Illinois Administrative Code 3125 – Navigator, In-Person Counselor and Certified Application Counselor Certification

This Rule establishes requirements and responsibilities of the Applicant for the Navigator, In-Person Counselor, or Certified Application Counselor Certification.

f) 50 Illinois Administrative Code 5420 - Managed Care Reform and Patients Rights Act

Section 5420.110(b) was amended to require that emergency services be covered in a manner that those services will be provided without imposing a requirement under the plan for prior authorization of services or any limitation on coverage when the provider of services does not have a contractual relationship with the plan that is more restrictive than the requirements or limitations that apply to emergency services from providers who have a contractual relationship with the plan. (Effective January 2, 2014)

g) 50 Illinois Administrative Code 5421- Health Maintenance Organizations

This rule was amended to comply with the ACA to establish one-stop marketplaces called Exchanges. The purpose of the exchanges is to enable consumers and small businesses to choose high quality, affordable private health insurance plans that fit their health needs. The ACA specifies that beginning in 2014, new and small business plans purchased through an Exchange or otherwise must be at one of four actuarial value levels: 60% (a bronze plan), 70% (a silver plan), 80% (a gold plan), and 90% (a platinum plan). These tiers do not apply to coverage already in existence meeting certain conditions (referred to as "grandfathered" plans).

The ACA also requires that plans cap the maximum out-of-pocket limits on high-deductible plans that are eligible to be paired with a Health Savings Account. Under the federal initiative, these limits are $5,950 for an individual and $11,900 for a family and will be adjusted over time after 2014 based on increases in premiums.

Previously under part 5420, out-of-pocket costs were capped at $3,000 for individuals and $6,000 for families and were subject to a 50% floor for benefits. It was not possible under these rules for an HMO product to be offered at the Bronze level to individuals purchasing coverage through the Health Care Exchange because of the limitations. In order to make coverage available to these individuals, the Department amended the rule to conform to the ACA cost sharing maximums so they are consistent with the amendments to Section 4-20 of the HMO Act by P.A. 97-1148. In addition, housekeeping changes were made throughout the rule. (Effective January 24, 2013)

3) Other State Actions – Company Bulletins

a) Company Bulletin 2013-02

Company Bulletin 2013-02 allows insurance companies providing dental benefits to pay less than 50% of billed charges for out-of-network services, but benefits for in-network services must equal or exceed 50% of negotiated fees. In either case, the benefits remain subject to any annual aggregate limit on benefits that is stated in the policy. According to the Illinois Insurance Code, 215 ILCS 5/370c, any reimbursement of less than 50% of the billed charges for out-of-network benefits will be reviewed closely by the Department. (Issued January 24, 2013)

b) Company Bulletin 2013-03

As part of the certification process under the ACA, DOI has drafted the Qualified Health Plan (QHP) Application Guidelines and the Illinois QHP Application Checklist. The draft QHP guideline specifies the criteria issuers, including Consumer Operated and Oriented Plans (CO-Ops) and Stand-Alone Dental Plans must meet to become a certified QHP in the individual Exchange and/or Small Business Health Options Program (SHOP) Exchange. (Issued March 20, 2013)

c) Company Bulletin 2013-04

Qualified Health Plan Fees – In reviewing QHP applications for compliance with the ACA, DOI's review will include, but not be limited to the following:

(1) Coverage levels and meaningful differences between plan offerings;
(2) State licensure;
(3) Coverage that is substantially equal to the coverage offered by the Essential Health Benefits benchmark plan;
(4) Non-discrimination in benefits offered;
(5) Rate review;
(6) Marketing;
(7) Network adequacy;
(8) Service area; and
(9) Quality Reporting

As part of its administrative costs, DOI will assess the following fees:

- $3,000 per QHP plan submission
- $1,500 per QHP renewal

All fees related to the submission and review of each QHP application must be submitted electronically through SERFF with the initial application and must be consented to by the issuer before submission of the application. (Issued March 20, 2013)

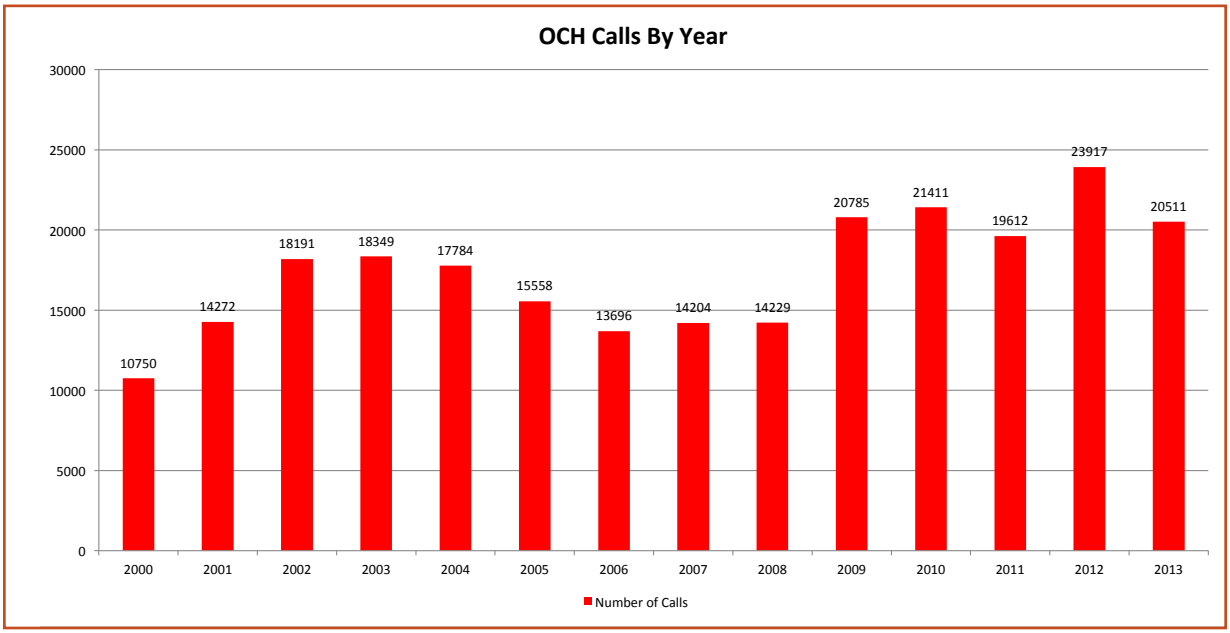
d) Company Bulletin 2013-12 (Addendum to Bulletin)

The Department received guidance issued by the federal Center for Consumer Information and Insurance Oversight ("CCIIO") that CCIIO's interpretation of ACA regulations is that if plans that will be offered for sale off the Illinois Health Marketplace are not transmitted by issuers to the Department by September 1, 2013, and therefore will not be reviewed and approved for sale by October 1, 2013, the issuers of such plans will not be able to utilize open enrollment periods as defined in the ACA. The result will be that those issuers must enroll any individual who applies during the plan year. (Issued September 19, 2013)

e) Company Bulletin 2013-19

Company Bulletin 2013-19 permits all life, accident and health service plans to renew existing health plans for plan year 2014. (Issued November 25, 2013)

Exhibits


OCH Calls By Year
30000
25000
20000
15000
10000
5000
0
10750
14272
18191
18349
17784
15558
13696
14204
14229
20785
21411
19612
23917
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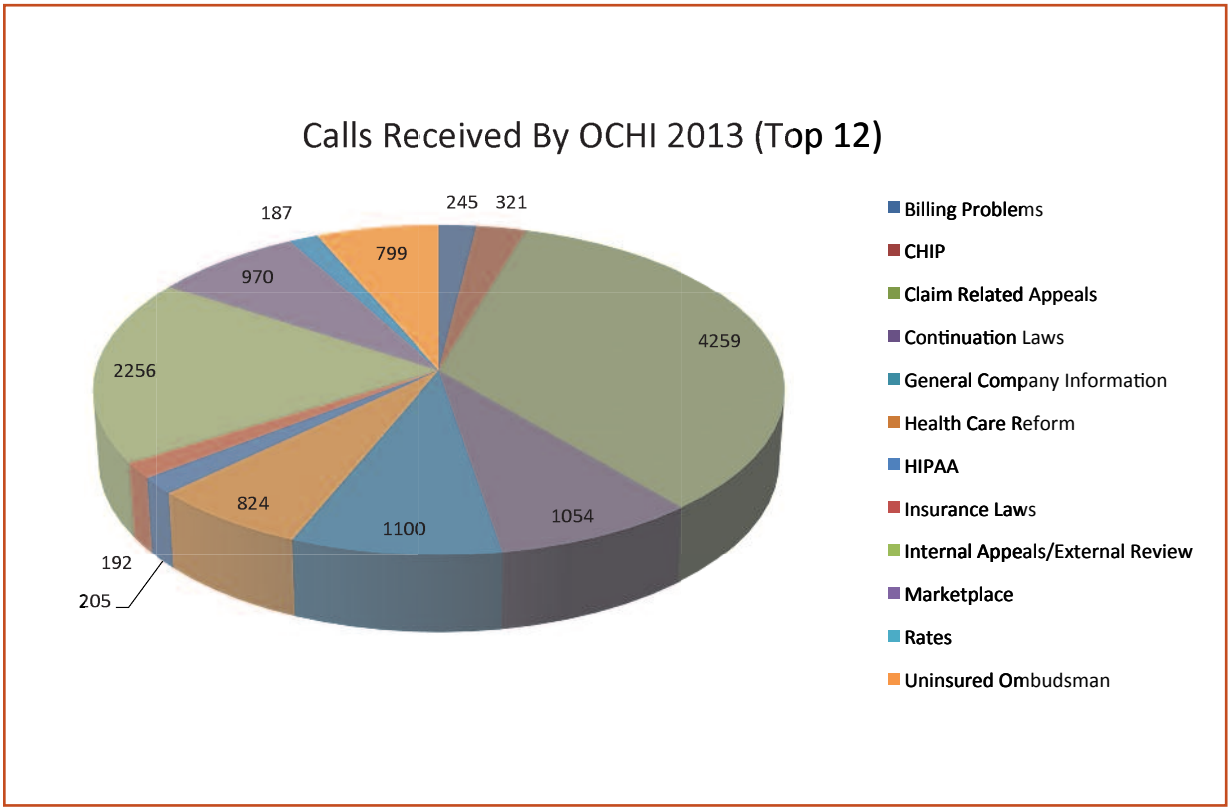
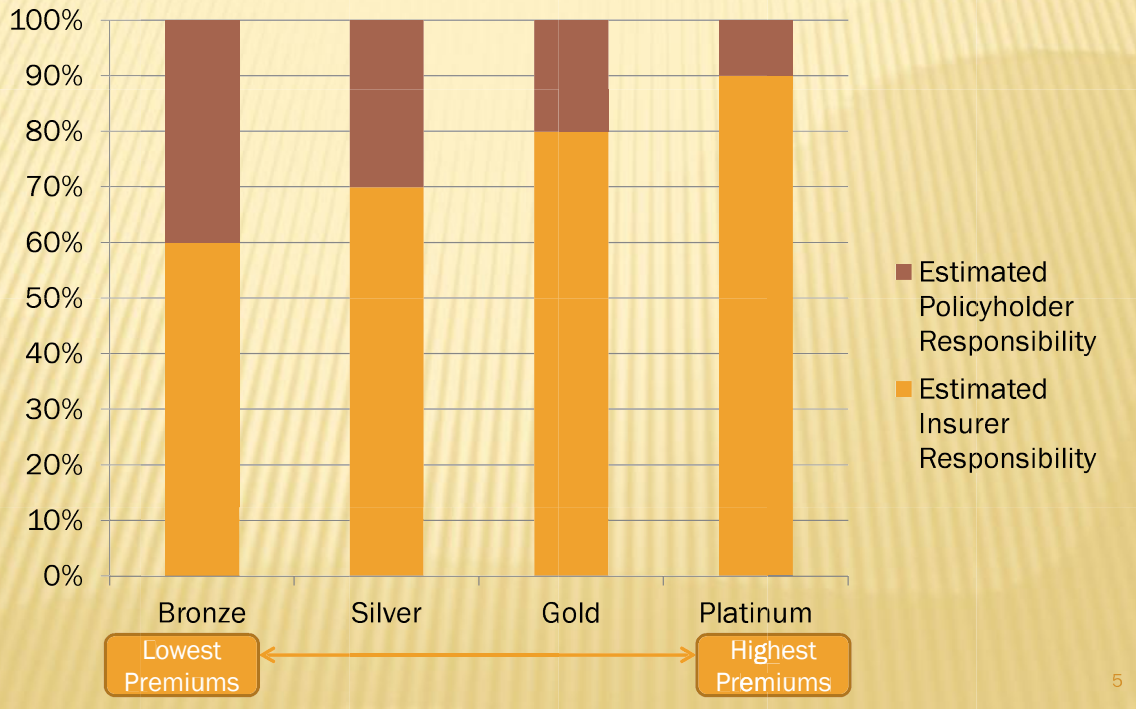
Number of Calls


Calls Received By OCHI 2013 (Top 12)
245
321
187
799
970
4259
2256
824
1100
1054
192
205
Billing Problems
CHIP
Claim Related Appeals
Continuation Laws
General Company Information
Health Care Reform
HIPAA
Insurance Laws
Internal Appeals/External Review
Marketplace
Rates
Uninsured Ombudsman

AVERAGE PLAN VALUE BY METAL LEVEL



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Health Plan Rating Areas

Rating Areas
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INDIVIDUAL PLANS OFFERED BY COUNTY: METAL LEVEL

County	Rating Area	Platinum	Gold	Silver	Bronze	Catastrophic
Adams County	10	0	11	12	8	3
Alexander County	13	0	10	11	6	2
Bond County	11	0	11	12	8	3
Boone County	5	0	13	14	11	4
Brown County	10	0	11	12	8	3
Bureau County	6	0	13	14	10	3
Calhoun County	11	0	11	12	8	3
Carroll County	5	0	11	12	8	3
Cass County	10	0	11	12	8	3
Champaign County	9	0	11	12	8	3
Christian County	10	0	11	12	8	3
Clark County	9	0	11	12	8	3
Clay County	13	0	10	11	6	2
Clinton County	11	0	11	12	8	3
Coles County	9	0	11	12	8	3
Cook County	1	3	17	19	21	6
Crawford County	13	0	11	12	8	3
Cumberland County	9	0	11	12	8	3
DeKalb County	5	0	12	13	9	3
DeWitt County	8	1	12	14	10	4
Douglas County	9	0	11	12	8	3

Rating Area Key
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INDIVIDUAL PLANS OFFERED BY COUNTY: METAL LEVEL

County	Rating Area	Platinum	Gold	Silver	Bronze	Catastrophic
DuPage County	3	0	13	14	13	2
Edgar County	9	0	11	12	8	3
Edwards County	13	0	11	12	8	3
Effingham County	13	0	11	12	8	3
Fayette County	13	0	11	12	8	3
Ford County	9	0	11	12	8	3
Franklin County	13	0	10	11	6	2
Fulton County	7	1	12	14	10	4
Gallatin County	13	0	10	11	6	2
Greene County	11	0	11	12	8	3
Grundy County	4	0	15	17	14	4
Hamilton County	13	0	10	11	6	2
Hancock County	6	0	13	14	10	3
Hardin County	13	0	10	11	6	2
Henderson County	6	0	13	14	10	3
Henry County	6	0	13	14	10	3
Iroquois County	9	0	11	12	8	3
Jackson County	13	0	10	11	6	2
Jasper County	13	0	11	12	8	3
Jefferson County	13	0	10	11	6	2
Jersey County	11	0	11	12	8	3

Rating Area Key
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INDIVIDUAL PLANS OFFERED BY COUNTY: METAL LEVEL

County	Rating Area	Platinum	Gold	Silver	Bronze	Catastrophic
Jo Daviess County	5	0	11	12	8	3
Johnson County	13	0	10	11	6	2
Kane County	3	0	13	14	13	2
Kankakee County	4	0	15	17	14	4
Kendall County	4	0	15	17	14	4
Knox County	7	1	12	14	10	4
Lake County	2	3	16	18	19	5
LaSalle County	7	1	12	14	10	4
Lawrence County	13	0	10	11	6	2
Lee County	5	0	11	12	8	3
Livingston County	8	1	12	14	10	4
Logan County	10	0	11	12	8	3
Macon County	10	0	11	12	8	3
Macoupin County	11	0	11	12	8	3
Madison County	12	0	9	9	9	3
Marion County	13	0	10	11	6	2
Marshall County	7	1	12	14	10	4
Mason County	10	0	11	12	8	3
Massac County	13	0	10	11	6	2
McDonough County	7	1	11	13	8	3
McHenry County	2	3	16	18	19	5

Rating Area Key
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INDIVIDUAL PLANS OFFERED BY COUNTY: METAL LEVEL

County	Rating Area	Platinum	Gold	Silver	Bronze	Catastrophic
McLean County	8	1	12	14	10	4
Menard County	10	0	11	12	8	3
Mercer County	6	0	13	14	10	3
Monroe County	12	0	9	9	9	3
Montgomery County	11	0	11	12	8	3
Morgan County	10	0	11	12	8	3
Moultrie County	10	0	11	12	8	3
Ogle County	5	0	12	13	9	3
Peoria County	7	2	14	16	14	6
Perry County	13	0	10	11	6	2
Piatt County	9	0	11	12	8	3
Pike County	10	0	11	12	8	3
Pope County	13	0	10	11	6	2
Pulaski County	13	0	10	11	6	2
Putnam County	7	1	12	14	10	4
Randolph County	11	0	11	12	8	3
Richland County	13	0	11	12	8	3
Rock Island County	6	0	13	14	10	3
Saline County	13	0	10	11	6	2
Sangamon County	10	1	13	14	12	5
Schuyler County	10	0	10	11	6	2

Rating Area Key
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INDIVIDUAL PLANS OFFERED BY COUNTY: METAL LEVEL

County	Rating Area	Platinum	Gold	Silver	Bronze	Catastrophic
Scott County	10	0	11	12	8	3
Shelby County	10	0	11	12	8	3
St. Clair County	12	0	9	9	9	3
Stark County	7	1	12	14	10	4
Stephenson County	5	0	11	12	8	3
Tazewell County	7	2	14	16	14	6
Union County	13	0	10	11	6	2
Vermilion County	9	0	11	12	8	3
Wabash County	13	0	11	12	8	3
Warren County	6	0	13	14	10	3
Washington County	11	0	11	12	8	3
Wayne County	13	0	10	11	6	2
White County	13	0	10	11	6	2
Whiteside County	6	0	13	14	10	3
Will County	4	0	15	17	14	4
Williamson County	13	0	10	11	6	2
Winnebago County	5	1	14	15	13	5
Woodford County	7	1	12	14	10	4

Rating Area Key
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SMALL GROUP PLANS OFFERED BY COUNTY: METAL LEVEL

County	Rating Area	Gold	Silver	Bronze
Adams County	10	11	13	4
Alexander County	13	11	13	4
Bond County	11	11	13	4
Boone County	5	12	14	5
Brown County	10	11	13	4
Bureau County	6	13	17	6
Calhoun County	11	11	13	4
Carroll County	5	11	13	4
Cass County	10	11	13	4
Champaign County	9	11	13	4
Christian County	10	11	13	4
Clark County	9	11	13	4
Clay County	13	11	13	4
Clinton County	11	11	13	4
Coles County	9	11	13	4
Cook County	1	12	15	8
Crawford County	13	11	13	4
Cumberland County	9	11	13	4
DeKalb County	5	12	14	5
DeWitt County	8	11	13	4
Douglas County	9	11	13	4

Rating Area Key
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SMALL GROUP PLANS OFFERED BY COUNTY: METAL LEVEL

County	Rating Area	Gold	Silver	Bronze
DuPage County	3	12	15	8
Edgar County	9	11	13	4
Edwards County	13	11	13	4
Effingham County	13	11	13	4
Fayette County	13	11	13	4
Ford County	9	11	13	4
Franklin County	13	11	13	4
Fulton County	7	11	13	4
Gallatin County	13	11	13	4
Greene County	11	11	13	4
Grundy County	4	14	18	7
Hamilton County	13	11	13	4
Hancock County	6	13	17	6
Hardin County	13	11	13	4
Henderson County	6	13	17	6
Henry County	6	13	17	6
Iroquois County	9	11	13	4
Jackson County	13	11	13	4
Jasper County	13	11	13	4
Jefferson County	13	11	13	4
Jersey County	11	11	13	4

Rating Area Key
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SMALL GROUP PLANS OFFERED BY COUNTY: METAL LEVEL

County	Rating Area	Gold	Silver	Bronze
Jo Daviess County	5	11	13	4
Johnson County	13	11	13	4
Kane County	3	12	15	8
Kankakee County	4	14	18	7
Kendall County	4	14	18	7
Knox County	7	11	13	4
Lake County	2	12	15	8
LaSalle County	7	11	13	4
Lawrence County	13	11	13	4
Lee County	5	11	13	4
Livingston County	8	11	13	4
Logan County	10	11	13	4
Macon County	10	11	13	4
Macoupin County	11	11	13	4
Madison County	12	7	8	3
Marion County	13	11	13	4
Marshall County	7	11	13	4
Mason County	10	11	13	4
Massac County	13	11	13	4
McDonough County	7	11	13	4
McHenry County	2	12	15	8

Rating Area Key
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SMALL GROUP PLANS OFFERED BY COUNTY: METAL LEVEL

County	Rating Area	Gold	Silver	Bronze
McLean County	8	11	13	4
Menard County	10	11	13	4
Mercer County	6	13	17	6
Monroe County	12	7	8	3
Montgomery County	11	11	13	4
Morgan County	10	11	13	4
Moultrie County	10	11	13	4
Ogle County	5	12	14	5
Peoria County	7	11	13	4
Perry County	13	11	13	4
Piatt County	9	11	13	4
Pike County	10	11	13	4
Pope County	13	11	13	4
Pulaski County	13	11	13	4
Putnam County	7	11	13	4
Randolph County	11	11	13	4
Richland County	13	11	13	4
Rock Island County	6	13	17	6
Saline County	13	11	13	4
Sangamon County	10	11	13	4
Schuyler County	10	11	13	4

Rating Area Key
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SMALL GROUP PLANS OFFERED BY COUNTY: METAL LEVEL

County	Rating Area	Gold	Silver	Bronze
Scott County	10	11	13	4
Shelby County	10	11	13	4
St. Clair County	12	7	8	3
Stark County	7	11	13	4
Stephenson County	5	11	13	4
Tazewell County	7	11	13	4
Union County	13	11	13	4
Vermilion County	9	11	13	4
Wabash County	13	11	13	4
Warren County	6	13	17	6
Washington County	11	11	13	4
Wayne County	13	11	13	4
White County	13	11	13	4
Whiteside County	6	13	17	6
Will County	4	14	18	7
Williamson County	13	11	13	4
Winnebago County	5	12	14	5
Woodford County	7	11	13	4

Rating Area Key
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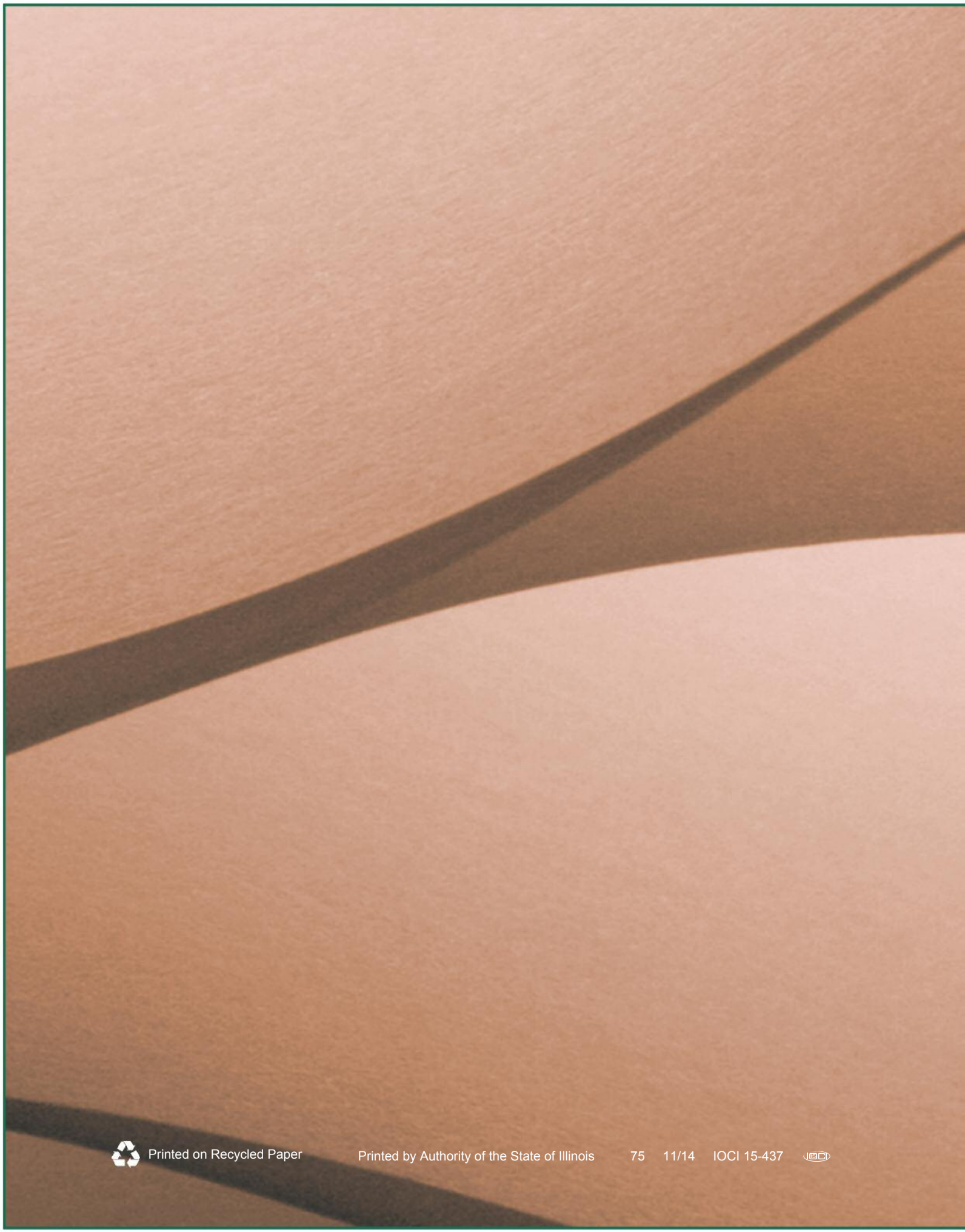

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