State of Illinois
Illinois Department of Insurance

Office of Consumer Health Insurance Report 2014

Bruce Rauner
Governor

James A. Stephens
Acting Director

Illinois Department of Insurance

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Governor

JAMES A. STEPHENS
Acting Director

January 31, 2015

To: Bruce Rauner, Governor

James A. Stephens, Acting 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 2014 Annual Report

The Office of Consumer Health Insurance (OCHI) is pleased to submit its 2014 Annual Report as required by the Managed Care Reform and Patient Rights Act (215 ILCS 134/90).

OCHI has completed fourteen 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 2014 by responding to their health-related inquiries. OCHI began 2014 with a staff of 8 full time insurance analysts (including a Licensed Practical Nurse LPN) and one full time Registered Nurse who was hired to handle External Independent Review (EIR) requests under a personal services contract. At the end of 2014, OCHI had 6 full-time analysts, with the LPN becoming primarily responsible for handling the EIR requests upon the departure of the contractual employee in April.

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 participation at Rapid Response meetings for dislocated workers, health fairs, and the development and distribution of consumer-friendly brochures and fact sheets... Through this 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 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. The Department received a no-cost extension of the grant in August 2014. 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 participated 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.

Marketplace coverage began effective January 1, 2014. OCHI assisted 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. Open enrollment for 2015 began on November 15, 2014 and ended on February 15, 2015. During open enrollment, people with Marketplace policies had the opportunity to review their coverage options and enroll in other plans, and consumers who did not have coverage were able to enroll. While still assisting consumers with problems related to 2014 coverage, OCHI also assisted consumers navigate their coverage decisions and choices for 2015.

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 more than 266,051 calls through the OCHI toll-free number and the External Review Hotline number.)Exhibit (1

Calls came into OCHI through a world-wide toll-free telephone number (877)-527-1349 the external review hotline number (877) .850474 In 2014, the OCHI toll free number received 16,681 calls, placed 4,213 outgoing calls for a total of 20,894. The external review hotline received 2,413 calls and placed 1,307 outgoing calls for a total of 3,720. OCHI received approximately 166 calls from Spanish speakers. Those calls were transferred to a DOI employee in the Chicago office who is a fluent Spanish speaker. The total number of calls for 2014 was 24,780.

OCHI staff continued to track 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 tracked 19,243 topics and sub-topics in 2014 in the PIRT system. The system also tracks resources used by OCHI staff, referrals to other entities for assistance, and what action was taken to resolve the call.

In 2014, the Department added On-line Agency Resources (OAR) to the PIRT system. The Uninsured Ombudsman Service Finder Database was transferred to OAR and many other resources such as Fact Sheets, websites and company specific information have been added. This information is at the analyst's fingertips while they are on a call and can be sent to the consumer via email, fax or through regular mail.

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 2014.

Section 8 contains the exhibits.

Educating Consumers About Their Health Insurance Rights and Options

The OCHI staff fielded over 24,780 calls in 2014 which covered a vast array of topics. Since its inception OCHI has received 266,051 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 topics by the top fourteen categories in 2014.

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 2014, OCHI responded to calls regarding the ACA, the Marketplace and related topics. These calls increased during the initial open enrollment which ended in March 2014 and again when annual open enrollment for 2015 began in November 2014. OCHI assisted consumers with Marketplace questions, concerns, and complaints including, but not limited to, 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 they are 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 the advantages are 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 the penalties are for non-compliance with the health insurance mandate;
- How a consumer can address network discrepancies; and
- How to determine the status of the Marketplace application.

Throughout 2014, OCHI staff participated in numerous training sessions, including a training session off site for Illinois navigators. This is the same training taken by registered navigators in Illinois. 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 completion of 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 better answer questions and direct consumers to the appropriate place for assistance.

OCHI fielded nearly 3,000 calls from Illinois residents who needed assistance or had questions regarding the Marketplace.

Questions regarding the Marketplace

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 assisted with eligibility related problems by providing information and 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. OCHI spoke with nearly 1,500 callers who had questions regarding enrollment, eligibility, change of status and Medicaid requirements.

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 is not generally 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) which included answering questions about their household composition and income. Based on the answers to those questions and on other 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 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 2014. 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 a Silver Plan 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. This is referred to as Cost Sharing Reductions. 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 or co-op and must offer at least one Silver Metal and one Gold Metal plan.

During 2014, eight companies offered 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 Health Insurance Company and Blue Cross Blue Shield of Illinois offer Qualified Health Plans on the Marketplace.

For 2015, there will be ten carriers offering Qualified Health Plans in Illinois. The new issuers on the individual Marketplace are IlliniCare Health Plan, Inc., UnitedHealthCare of the Midwest, Inc., and Time Insurance Company. Aetna Life Insurance Company will not be a qualified health plan in 2015.

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 (AllKids in Illinois), 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 for 2014 were 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 metal 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 three 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 and only federally approved (as of December 31, 2014) co-op in Illinois is Land of Lincoln Mutual Health Insurance Company.

7) Individual Share Responsibility Provision

Beginning in 2014, individuals were 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 was 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 116 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.

The SHOP Marketplace encountered numerous problems for those seeking coverage during 2014. Most small employers were directed to a licensed broker to assist them if they wanted to buy health coverage through SHOP.

For 2015, Health Alliance Medical Plans, Inc., Health Care Service Corporation, a Mutual Legal Reserve Company, and Land of Lincoln Mutual Health Insurance Company are selling on SHOP.

Questions regarding 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 insurance 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 one of the top reasons for calls coming in to OCHI. OCHI spoke to 4,227 callers 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 handled 3,720 calls from and to consumers, health care providers, carriers, IROs and authorized representatives regarding this topic.

2) Non-OCHI Calls

Some calls coming into OCHI do not fall under the jurisdiction of the Department of Insurance or within the scope of OCHI's mission. For example, calls related to self-insured employer plans, calls for other state agencies, calls for the carriers, and calls for other areas within the Department. OCHI assisted 4,952 callers by navigating them to the appropriate place for assistance.

3) Insurance Law

In 2014, OCHI talked to 1,256 callers about various state and federal insurance laws. As in past years, questions regarding federal and state continuation laws accounted for the majority of these questions (633). Other laws of special interest included questions about the:

i) Standardized Health Application law;

ii) Infertility mandate,

iii) Health Insurance Portability and Accountability Act (HIPAA); and

iv) Coordination of Benefits.

4) General Company Information

OCHI received 1,044 calls from consumers who had questions about a 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) Internal Appeals/External Review

OCHI noted 955 entries into the PIRT system regarding callers who had questions about how to file internal appeals and external reviews. In addition to the callers to the OCHI hot-line; the external review hotline received nearly 2,500 calls related to this topic. Detailed information regarding external review activity for 2014 is included in Section 2.

6) Uninsured Ombudsman and Shopping For Coverage

OCHI spoke to 1,148 callers regarding resources available through the Uninsured Ombudsman or for assistance in shopping for coverage such as long term care coverage and Medicare Supplement coverage. OCHI used the resources from OAR to assist uninsured callers and direct them to medical clinics, pharmaceutical companies, and other entities that provide medical care for free or at a discounted rate. For those looking for other types of coverage, OCHI was able to provide complaint history information and answers questions about the coverages being sought. Additional information regarding the activities of the Uninsured Ombudsman is included in Section 5 of this report.

7) Premium Billing Problems and Rates

OCHI spoke to 556 callers regarding billing problems with insurance carriers. This was a major problem in 2014 due to the confusion that existed between the federal Marketplace, which controls the eligibility and advance tax credits and the carriers who actually bill the consumers for coverage.

In 2014, OCHI received a large number of calls relating to escalating insurance rates for health insurance coverage. OCHI staff handled 263 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.

Consumers also called regarding long term care coverage rate increases. Some consumers experienced rate increase in excess of 100% for their long term care coverage. OCHI explained how rates are filed with the Department and encouraged consumers to file complaints in order to shed more light on this situation.

8) Other topics explored by callers to OCHI during 2014 included:

a) Health care reform – questions regarding all aspects of the Affordable Care Act reforms including grandfather plans, preventive services, annual limits and lifetime limits;

b) Disability insurance – questions and concerns regarding problems with disability insurance;

c) Marketing issues – questions and concerns regarding how carriers, producers and the Marketplace were marketing coverage.

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 2014, 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 2,652 calls regarding the Marketplace to Get Covered Illinois at the toll-free number (866) 311-1119 or the web site at getcoveredillinois.gov/ and to the federal Marketplace toll-free number (800) 318-2596 or to a navigator for help with signing up for the Marketplace coverage. Many of these calls were from consumers who encountered problems with enrollment, eligibility, and premium problems. These issues caused claim denials and unsatisfactory claim payments which could not be resolved by the Department or the carrier until the core issue was resolved at the Marketplace level.

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. OCHI referred 757 callers to ABE in 2014.

3) Carrier/TPA – OCHI referred 2,872 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 a request for 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 2014, OCHI referred nearly 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. OCHI referred 526 callers to SHIP in 2014.

   Complaints about Medicare Supplement policies are handled by the Department of Insurance.

6) Other State Departments of Insurance – OCHI receives calls from consumers whose insurance is governed under another state's laws and regulations. OCHI referred 108 callers to other state Departments of Insurance in 2014.

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 Application for Benefit Eligibity (ABE) although parent's income was over the minimum threshold;
b) Callers were concerned that they were denied advance tax credits and/or cost sharing reductions which they believed they should have qualified for;
c) People were informed that the tax credit was calculated incorrectly;
d) People were 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.

The Department worked with the Marketplace and insurance companies to assist consumers with these issues. Many times, consumers were in need of medical services which they could not access due to the problems. These cases were expedited to ensure the consumers received the care they needed.

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 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 2014, OCHI staff talked to consumers, health care providers, authorized representatives, insurance carrier, and IROs regarding external review. The number of calls accounted for total 3,720. 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 1,411 External Review Requests in 2014. Some of the reviews did not qualify for external review under state law but qualified under federal law (14); information was provided to those requestors on how and where to file the request. Others (547) 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 488 external independent reviews completed in 2013:

- 171 adverse determinations were overturned;
- 304 adverse determinations were upheld;
- 13 adverse determinations were partially overturned.

Until July 2013, an adverse IRO made prior to July 1, 2013 could be appealed to the Director of Insurance. The Department handled 17 appeals to the Director in 2014. Of those, 6 IRO decisions were found to be arbitrary and capricious and 11 reviews were found not to be arbitrary and capricious. Of the 6 that were found arbitrary and capricious, 2 were paid by the carrier without further review, and 4 were submitted to a second external independent review as requested by the carrier under the law. Of the 4 sent for a second review, 1 was upheld or partially upheld as arbitrary and capricious and 3 overturned the arbitrary and capricious determination.

Complaints

The Department investigated 8,265 complaints in 2013. Of those, 2,309 (28%) were related to individual and group, accident and health insurance and HMO products. Complaints regarding self-insured employer health plans totaled 798. 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/	Claims	Service	Total
Individual A&H (2012)	251	29	311	49	640
Individual A&H (2013)	121	10	264	58	453
Group A&H (2012)	86	11	1,541	63	1,701
Group A&H (2013)	**77**	**15**	**1,463**	**53**	**1,608**
HMOs (2012)	7	0	215	9	231
HMOs (2013	**7**	**4**	**227**	**10**	**248**

Complaint data for 2014 will be addressed in the 2015 report.

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 have 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 on-line Message Center at https://mc.insurance.illinois.gov/messagecenter.nsf.

   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 2014, 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 2014, 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. The following Fact Sheets were revised in 2014:

   a. Acronyms
   b. Autism
   c. Birth Control

d. COBRA
e. Illinois Continuation
f. Illinois Spousal Continuation
g. Illinois Dependent Child Continuation
h. Municipal Continuation
i. Diabetes
j. External Review
k. Infertility
l. OCHI
m. Prompt Pay Law
n. Uninsured Ombudsman Program.

Two new Fact Sheets were added:

a. Out of Network Benefits
b. Provider Networks

5) External Reviews

OCHI staff handle external review requests from consumers. For most of 2014, four OCHI analysts, including an LPN, handled those reviews. The Department is receiving over 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 38% overturn or partial overturn rate for completed reviews in 2014.

6) Emails

OCHI staff respond 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 2014, OCHI staff replied to nearly 300 consumer inquiries sent to the email address.

Expanding Public Awareness of OCHI

During 2014, OCHI used various methods to expand public knowledge about the services provided to Illinois consumers.

1) Brochures

   In 2014, the Department of Insurance revised 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, Polish and Spanish.

2) 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.

3) Rapid Response Meetings for Dislocated Workers

   An OCHI staff representative participated in several Rapid Response Meetings for dislocated workers in 2014. These meetings are scheduled when an employer reports lay-offs or closing of a place of business. More information regarding Rapid Response meetings can be found in Section 5.

4) Job Fairs and Health Fairs

   An OCHI staff representative participated in Job Fairs for dislocated workers in Litchfield and Decatur in 2014 and attended Health Fairs in Green County and Lincoln. More information about these events may be found in Section 5.

Uninsured Ombudsman Program

In January 2002, the Uninsured Ombudsman Program (Ombudsman) was established within the Office of Consumer Health Insurance (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 resources for low-cost or subsidized medical services. As in previous years, calls came from the uninsured, concerned advocates, organizations providing assistance to the uninsured, other state agencies, legislators, insurance agents, and families. Since its inception, the Ombudsman staff has continued to work with various state and local agencies to locate resources that provide medical services to the uninsured and underinsured populations.

In 2014, OCHI staff continue 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 are 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 and 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.

2014 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 former employer's group 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 rapid response team handed out the Office of Consumer Health Insurance folders which included the Ombudsman Brochures along with other documents to help consumers through a period of transition after the loss of employment. The Ombudsman Brochures reflected the aspects of the 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 and help explore 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 and alternative for helping consumers find qualified health plans. The rapid response team attended the following workshop/outreach events locations on the next page.

Workshop Information

Employer	Workshop Location	Number of Employees Impacted
AT&T	Springfield	150
AT&T	Springfield	*
Berkley Contact Packaging	Edwardsville	100
Bosch Tools	Watseka	20
Bosch Tools	Watseka	35
Bosch Tools	Watseka	35
HIBU	Effingham	34
IGA	Beardstown	100
J.C. Penney's	Decatur	50
J.C. Penney's	Decatur	50
Kmart	Collinsville	84
Kmart	Collinsville	*
Kmart	Bloomington	85
Kmart	Bloomington	*
Kmart	Peoria	10
Kmart	Peoria	63
Lyon	Paris	100
Lyon	Paris	*
Mt. Zion Flat Glass Mfg	Mt. Zion	187
Passage	Normal	88
Quincy Compressors	Quincy	150
Rehab & Care Center of Jackson	Murphysboro	100
Rehab & Care Center of Jackson	Murphysboro	100
Sears	Decatur	45
Southwire Co	Flora	59
Springfield Benedictine University	Springfield	100
Springfield Benedictine University	Springfield	*
Superval	Urbana	44
TSI Evolve	Effingham	28
Unit 5 School District	Bloomington	50
Wells Fargo/Cheddars	Springfield	150

*** Denotes amount employees impacted already included in the above total**

Other Outreach Events

Outreach Event	Location
Community Health Fair	Lincoln
Greene County Health Fair	Carrolton
Job Fair for Dislocated Workers Crown III Coal Mine	Litchfield
Job Fair Workforce Investment	Decatur
Naperville Benefit Fair	Naperville
Richland Community College Health Fair	Decatur

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 2014, several companies offering health insurance in Illinois discontinued their coverage because it did not meet the essential benefit requirements as mandated under ACA. These companies provided notice of discontinued sales or termination within a market as noted in the table below.

Company	Action	Discontinuance	Notice
American National Life Ins Co of TX	Uniform Termination of Coverage (non-grandfathered)		10/1/2014
Guarantee Trust Life Ins Co	Discontinuance from the Individual Market	08/04/14	03/04/2014
Aetna Life Insurance Company	Uniform Termination of Coverage- Large Group		11/01/2014
Mid-West National Life Insurance Co	Discontinuance from the Individual Market (In Nevada)	03/31/2015	10/01/2014
Mid-West National Life Insurance Co of TN	Discontinuance from the Individual Market		09/01/2014
Humana Insurance Company	Uniform Termination of Coverage – Group Association	02/28/2015	09/30/2014
The Mega Life and Health Ins Co	Discontinuance Individual (Grp Assn)	02/28/2015	08/28/2014
Mid-West National Life Insurance Co of TN	Discontinuance Individual (Grp Assn)	02/28/2015	08/28/2014
Coventry Health Care of Illinois, Inc.	Uniform Termination Small Group PPO		10/01/2014

Health Care Service Corp-(BCBS)	Uniform Termination – Small Group PPO		10/01/2014
United Healthcare Life Insurance Company	Uniform Termination Individual PPO		10/01/2014
Humana Insurance Company	Uniform Termination – Individual PPO		10/01/2014
Humana Insurance Company	Uniform Termination- Small Group PPO		10/01/2014
Aetna Life Insurance Company	Uniform Termination- Small Group PPO		10/01/2014
Coventry Health Care of Illinois, Inc.	Uniform Termination – Small Group HMO		10/01/2014
Health Care Service Corp-(BCBS)	Uniform Termination Individual HMO		12/01/2014
Humana Insurance Company	Uniform Termination- Small Group PPO		10/10/2014
Humana Insurance Company	Uniform Termination Individual PPO		10/01/2014
Health Care Service Corp-(BCBS)	Uniform Termination Individual HMO		10/01/2014
Health Care Service Corp-(BCBS)	Uniform Termination- Small Group Major Medical		10/01/2014
Coventry Health Care	Uniform termination Small Group PPO		09/01/2014
Land Of Lincoln Mutual Health Insurance Company	Uniform Termination – Small Group PPO		11/01/2014
Aetna Health Inc.	Uniform Termination –Large Group 50 + employees		09/01/2014
Land Of Lincoln Mutual Health Insurance Co	Uniform Termination – Individual PPO		09/01/2014
Coventry Health Care of Illinois, Inc.	Uniform Termination – Small Group HMO off Market		09/01/2014
American Alternative Ins Corp	Discontinuance –Small Group Market	11/30/2014	05/30/2014
American Alternative Ins Corp	Discontinuance –Large Group Market	11/30/2014	05/30/2014
Madison National Life Insurance	Discontinuance –Small Group Market	05/01/2015	13/31/2014

2) Transitional Plans

In November 2013, President Obama announced 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.

In March 2014, the federal Department of Health & Human Services announced an extension allowing State authorities and health insurance issuers to continue transition policies for an additional two years. At the option of the States, health insurance issuers who issued a transitional policy in 2014 may renew such policies any time through October 1, 2016 and affected individuals and small businesses may choose to re-enroll in such coverage through October 1, 2016. Illinois has decided to allow this option for health insurance issuers. Information regarding the Illinois determination is located at http://insurance.illinois.gov/cb/2014/CB2014-04.pdf.

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 (EHB) and meeting network adequacy requirements.

In 2014, ten companies submitted QHPs through the Illinois Marketplace:

- 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
- IlliniCare Health Plan, Inc.*
- Land of Lincoln Mutual Health Insurance Company
- Time Insurance Company*
- UnitedHealthCare of the Midwest, Inc.*

*New to Marketplace in 2015

In Illinois, there is a choice of small group and individual plans in all counties, with at least 56 plans available in all counties. There are Gold, Silver, Bronze and Catastrophic plans available in all counties. There are 17 individual plans and 13 small group plans available statewide. Detailed information regarding the Qualified Health Plans for 2015 can be found at http://insurance.illinois.gov/HealthInsurance/2015AnalysisOfILQHP.pdf.

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.

The following qualified health plans are offering stand-alone dental coverage on the individual Marketplace:

a. Best Life & Health Insurance Company
b. Health Care Service Corporation, a Mutual Legal Reserve Company (Blue Cross Blue Shield of Illinois)
c. Delta Dental of Illinois
d. Dentegra Insurance Company
e. First Commonwealth Insurance Company
f. Humana Insurance Company

The following qualified health plans are offering stand-alone dental coverage on SHOP for 2015:

a. Best Life & Health Insurance Company
b. Dentegra Insurance Company
c. First Commonwealth Insurance Company
d. The Guardian Life Insurance Company of America
e. Metropolitan Life Insurance Company

Some plans offer adult dental coverage in addition to the required pediatric coverage.

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

For 2015 and after, 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 were 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 ex-

tend 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.

For 2015, SHOP was to provide "employee choice" which would give the employer the opportunity to allow employees to choose any health plan at the actuarial value or "metal" level selected by the employer. In May 2014, the federal Department of Health and Human Services published a final rule within which it provided states with additional flexibility by allowing State Insurance Commissioners to request that the SHOP in their state not implement employee choice in 2015. Illinois requested that employee choice not be implemented in 2015.

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 (in excess of 100%) 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

The Department introduced legislation (HB2333) in 2013 and again in 2014 that would impose a 15% cap on rate increases on all existing and future long term care premiums, regardless of age or benefit configuration. To date, the legislature has not passed the bill into law.

2) Disability Claims Denied

OCHI received a multitude of calls in 2014 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 2014, the Department continued to receive 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 2014, 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 performed a more detailed review of the provider networks for the plans that are being marketed for 2015. Additionally, two new fact sheets have been added to the Department's website explaining how provider networks work (Provider Network Fact Sheet) and the ramifications of going out of network (Out of Network Benefits). Those fact sheets may be viewed at http://insurance.illinois.gov/HealthInsurance/HealthInsurance.asp.

5) Emergency Claims

The Department has noticed a trend regarding payment for emergency services incurred at a non-preferred provider under a Preferred Provider Option (PPO) plan. The PPO Rule (50 Illinois Adm. Code 2051) requires that emergency services received at a non-PPO facility be paid at no greater out of pocket expense to the member than if the services had been provided by a PPO facility. The Department received many calls and complaints regarding carriers who were not abiding by the Regulation.

Possible Remedy

Track carriers who appear to be mishandling these types of claims and request a targeted Market Conduct Exam focusing on this issue.

6) Ambulance Reimbursement

The Department has received numerous complaints regarding ambulance charges for emergency services under PPO policies. The consumers assume that these charges are part of the emergency benefit under the plan. However, many of the plans have a separate ambulance deductible and coinsurance.

Possible Remedy

The definition of emergency services contained in 215 ILCS 134/10 (The Managed Care Act) includes transportation services, included but not limited to ambulance services. This definition only applies to Health Maintenance Organizations (HMOs). Legislation is needed to make this definition applicable all health insurers.

GOVERNMENT ACTIONS

Federal

The Affordable Care Act (ACA) was passed by Congress and then signed into law by the President on March 23, 2010. Open Enrollment began on November 15, 2014. 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 2014. 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) Consumer Assistance Program Grant (CAP)

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 in 2013; a second no cost extension was granted until August 2014

The activities funded in 2014 included:

i. PIRT (Public Inquiry and Response Tracking) is an agency wide system designed to track consumer inquiries and the responses/resolutions provided by agency staff. PIRT tracks consumer de-

mographics and contact information, inquiry details (including codification of the inquiry), inquiry status, staff assignment, business unit specific details, resources provided to the consumer and non-HIPAA electronic correspondence. With the introduction of OAR (Online Agency Resources), PIRT gives our analysts relevant, problem solving information at their fingertips.

Significant enhancements have been made to PIRT:

1) System performance and user navigation upgrades which have reduced the amount of time and effort required to capture inquiry information. The net result is inquiries with greater detail and improved accuracy.

2) The introduction of the inquiry journal; a mechanism which logs significant events within the life span of an inquiry; from inception to resolution. This feature helps track the nature and amount of encounters between the consumer and Department staff and provides greater continuity when follow up conversations are necessary or when an inquiry is forwarded to another Department analyst.

3) An integrated email correspondence component allows analysts the option to send non-HIPAA electronic correspondence to the consumer without exiting the PIRT system.

4) The integration of Voice over IP (VoIP) and PIRT has been implemented. Today, an incoming VoIP call automatically launches an analysts' PIRT session and searches for previous inquiries or existing caller information based on the phone number and zip code received. Analysts have the option to retrieve this historical information with a simple click of the mouse or establish a new contact\inquiry record, whatever action is required to expedite the inquiry.

5) Introduction of OAR (Online Agency Resources). This important addition to PIRT provides an easy mechanism to search across a wide spectrum of agency resources allowing the analyst the means to quickly identify and share information regarding helpful websites and prepared materials. With OAR fully implemented, we have been able to decommission a legacy resource facility which was difficult to maintain from a technical and informative perspective.

6) Improvements in the area of reporting are paying dividends. The collection of additional metrics has allowed us to develop more informative reports.

ii. The Department's Complaint system, now known as CARE (Consumer Assistance Request Environment), has received several important enhancements under the CAP grant funding. The IBM Notes based system has always been considered a very user friendly and feature rich tool, but it lacked some automation which made day to day processing unnecessarily cumbersome.

The enhanced system now employs smarter file handling and error logging processing which has eliminated the need for manual monitoring of system errors. The revised system supports more file types (i.e. .PNG, .html, .xlsx); provides an ad-hoc reporting tool for CARE worksheets, generates email notifications to IT support when errors occur, and tracks time-based events more efficiently (i.e. issues extending past 60 days, 12 months, etc.). Improvements were also made to replace an old PDF conversion process, to expand analyst log notifications, to improve aesthetics of

graphical interfaces and to completely overhaul the automated letter generation process. The attachment preview process was rewritten to eliminate persistent errors; the External Review PDF form on the Department's website was revised and legacy system errors were resolved.

Integration between CARE and the Message Center began in late 2014. This process is very important to the Department and will provide many benefits to health carriers and consumers. Message Center has two primary interfaces, the Consumer Message Center and the Respondent Message Center.

a) Consumer Message Center

The Consumer Message Center is used by consumers and other interested parties to request assistance with insurance related matters. While some of these requests are just inquiries, many are complaints against insurance providers. By using Message Center, consumers can login to monitor the status of their requests or complaints. Consumers can also securely retrieve correspondence that is sent to them by DOI without exposing sensitive information through email (HIPAA Compliance). Consumer Message Center can be accessed from any web-enabled device including PC's, smartphones and tablets.

- Consumer Message Center Version 1.0 was launched on January, 2014.
- Consumer Message Center currently hosts over 7,908 consumer accounts.
- 6,401 consumer complaints have been filed through Message Center.
- 496 of those complaints were filed using mobile devices.

Version 2.0 of Consumer Message Center for Consumers was placed into production on 1/14/2015. This version includes hundreds of enhancements. The most notable additions are Health Care Provider accounts, Health Care Provider Requests and Health Care Provider External Reviews.

b) Respondent Message Center

The Respondent Message Center is used by insurance providers (respondents) to respond to consumer complaints filed with the DOI against them. By using Message Center, respondents can check the status of open complaints, review the resolution codes of closed complaints, view the related documentation and correspondence, reply to complaints, attach documents to the complaint for review, and dispute closing codes.

iii) The media campaign began in April 2014. The campaign includes 854 ads in newspapers throughout the state in nine different cities. The campaign also includes radio ads with 14 radio stations throughout the state. It also includes 1,556 ads on Chicago Buses and trains, which include Polish, Spanish and Chinese translations as appropriate. The media campaign will run for the month of April. It is a very simple message – OCHI can help.

Illinois

1) Public Acts

a) 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.

b) HB 3638 DHFS-INS-RX DRUGS-FORMS - (Public Act 98-1035

The purpose of this amendatory Act of the 98th General Assembly is to build on the consumers protections provided in the Federal law for policies or qualified health plan offered for sale directly to consumers through the Health Insurance Marketplace in Illinois. The Illinois Insurance Code is amended by changing Sections 155.36 and 355a as follows: (215 ILCS 5/155.36)

Insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of this Code shall comply with Sections 45, 45.1, 45.2, and 85 and the Definition of the term "emergency medical condition" in Section 10 of the Managed Care Reform and Patient Rights Act. (Source: P.A. 96-857, eff. 7-1-10.) 215 ILCS 5/355a) (from Ch. 73, par. 967a) Sec. 355a.

Standardization of terms and coverage.

The purpose of this Section shall be:

i) to provide reasonable standardization and simplification of terms and coverages of individual accident and health insurance policies to facilitate public understanding and comparisons;

ii) to eliminate provisions contained in individual accident and health insurance policies which may be misleading or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for reasonable disclosure in the sale of accident and health coverage. Effective August 25, 2014

c) SB 0646 INS Code – Domestic Societies (Public Act 98-0814)

A domestic society that provides any of the benefits specified in Section 297.1 of this Code must be governed by a Board of Directors and managed by qualified officers subject to the following requirements:

The laws of a society must provide that: (i)The board of directors shall have the powers and perform the duties ordinarily possessed and exercised by a board of directors under this Code, including, but not limited to, the authority and responsibility for the hiring and the discharge of a president, chief executive officer, or an equivalent position, except that a society that elects its president, chief executive officer, or equivalent position pursuant to its by-laws, as of the effective date of this amendatory Act of the 98th General Assembly, may continue to do so if it elects a president, chief executive officer, or equivalent position that meets qualifications set forth in a rule adopted by the

Director; and (ii) the board of directors may remove a director for cause and replace the director with another qualified director. Effective January 1, 2015

d) HB 4725 Insurance Code- Risk Management- Solvency(Public Act 98-910)

The purpose of this Article is to provide the requirements for maintaining a risk management framework and completing an own risk and solvency assessment (ORSA) and provide guidance and instructions for filing an ORSA summary report with the Director. The requirements of this Article shall apply to all insurers domiciled in this State unless exempt pursuant to Section 129.7. Effective July 1, 2015.

2) Rules

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 Ill. Adm. Code 2002 – Advertising of Accident and Sickness Insurance,

The purpose of this Part is to assure truthful and adequate disclosure of all material and relevant information in the advertising of accident and sickness insurance. This purpose is intended to be accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of accident and sickness insurance in a manner which prevents unfair competition among insurers and is conducive to the accurate presentation and description to the insurance buying public of a policy of such insurance offered through various advertising media. (Effective January 2, 2014)

f) 50 Ill. Adm. Code 5420- Managed Care Reform & Patient Rights

The purpose of the Rulemaking changed the definition of Nursing Home to: Nursing Home means skilled nursing facility that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act. (Effective November 25, 2014)

g) 50 Ill. Adm. Code 5421 – Health Maintenance Organization

Purpose of rulemaking added nursing homes to the definition of provider in the HMO Act Part 5421 has been amended to reflect this. Changes have been also been made to reflect updated mental health parity standards. (Effective November 25, 2014)

h) 50 Ill. Adm. Code 2001 – Construction and Filing of Accident and Health Insurance Policy Forms,

This regulation was amended for compliance with ACA provisions with regard to Federally Qualified Health Centers (FQHCs) for qualified health plans. Federal regulations were issued that stated that the FQHC could be paid either the Medicaid amount, or some other mutually agreed upon amount. Due to the fact that Part 2001 did not have the same language regarding "mutually agreed upon amount," issuers were faced with the situation where some provider arrangements with FQHCs did not comport with this Part. Section 2001.12 was amended so that it is consistent with the federal regulations. Additionally, a new provision was added in Section 2001.11 regarding the pediatric oral care benefit in connec-

tion with new policies issued outside of the Exchange. The benefit will be deemed satisfied if the health insurance issuer has obtained reasonable assurance that such benefits are provided. (Effective November 25, 2014)

3) Other State Actions – Company Bulletins

a) Company Bulletin 2014-01

Bulletin notifies all insurance companies doing business in Illinois that financial regulatory filings submitted for Director's approvals after December 1st of any given year may not be completely processed before December 31st of that year. The Department's review process requires sufficient time to examine the filings, related documents and applicable statutes and regulations in order for the Director to make a determination on whether to accept or approve the filing. In addition, it is sometimes necessary for the Department to request additional information related to a transaction which then requires more time to review. Companies that require a specific transaction to be reviewed and acted upon by the Department before the end of a calendar year should submit the transaction well before December 1st to increase the likelihood that the review will be completed by the end of the year. (Issued January 22, 2014)

b) Company Bulletin 2014-02

The purpose of the Bulletin is to request each issuer to inform the Department of Insurance of their intent to continue to participate in the Illinois Health Insurance Marketplace for 2015. The response to this Bulletin is not binding but will help us prepare for the recertification process. Any issuer that intends to continue in the Illinois Health Insurance Marketplace must so advise the Department in writing, including its continued use of the Standard Component IDs found in the Plan Management Binders on SERFF, please indicate which plan you are revising within your written response. (Issued March 03, 2014)

c) Company Bulletin 2014-03

The standardized Reinsurance Accounting Worksheet form prescribed for those companies entering into reinsurance agreements subject to 50 Il Adm Code 1103 was revised to gather more information from the companies regarding their reinsurance agreements. Domestic Life, Accident and Health Insurance Companies and Domestic Fraternal Organizations were asked to complete, sign and submit the revised worksheet when filing a reinsurance agreement for approval pursuant to 215 ILCS 5/174 if the conditions of 50 IL Adm Code 1103 applies to said reinsurance agreement. (Issued April 09, 2014)

d) Company Bulletin 2014-04

This bulletin was issued following the March 5, 2014 Federal Center for Medicare & Medicaid Services (CMS) notice that extended transitional policies for plans in the small group and individual markets. The bulletin advised insurers that Illinois would be complying with CMS's extension and gave insurers the choice to renew existing health insurance policies with current policyholders under plans with policy years beginning on or before October 1, 2015, in the small group and individual markets for one year. This supplemented Company Bulletin CB 2013-19. This bulletin provided guidelines that apply to renewals under this extension (Issued May 2, 2014)

e) Company Bulletin 2014-05

The purpose of this Bulletin was to provide instruction to Issuers seeking to have Illinois Qualified Health Plans (QHP) recertified or certified for the 2015 Plan Year. (Issued May 6, 2014)

f) Company Bulletin 2014-06

The Patient Protection and Affordable Care Act (ACA) expands requirement for coverage of clinical preventive service under Medicare, Medicaid and in the private insurance market. The purpose of this Bulletin was to remind all insurance companies doing business in Illinois of both the prevention and parity requirements and request each issuer to inform the Department of Insurance of their coverage of evidence based clinical preventive services. (Issued May 15, 2014)

g) Company Bulletin 2014-07

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (ACA) and its attendant regulations, require that individual and group health benefit plans issued after March 23, 2010 comply with market reforms of Title I, Subtitles C and D of the ACA. However, individual and small group plans that were sold before January 1, 2014 that will be renewed between January 1, 2015 and October 1, 2015 will not be required to comply with market reforms. This bulletin reminded issuers planning to sell off-Marketplace plans that rate and form filings must have been filed by September 15, 2014 in order for the plans to be reviewed and approved by November 15, 2014, thus allowing the issuer to limit enrollment during the Annual Open Enrollment Period under the ACA. (Issued May 20, 2014)

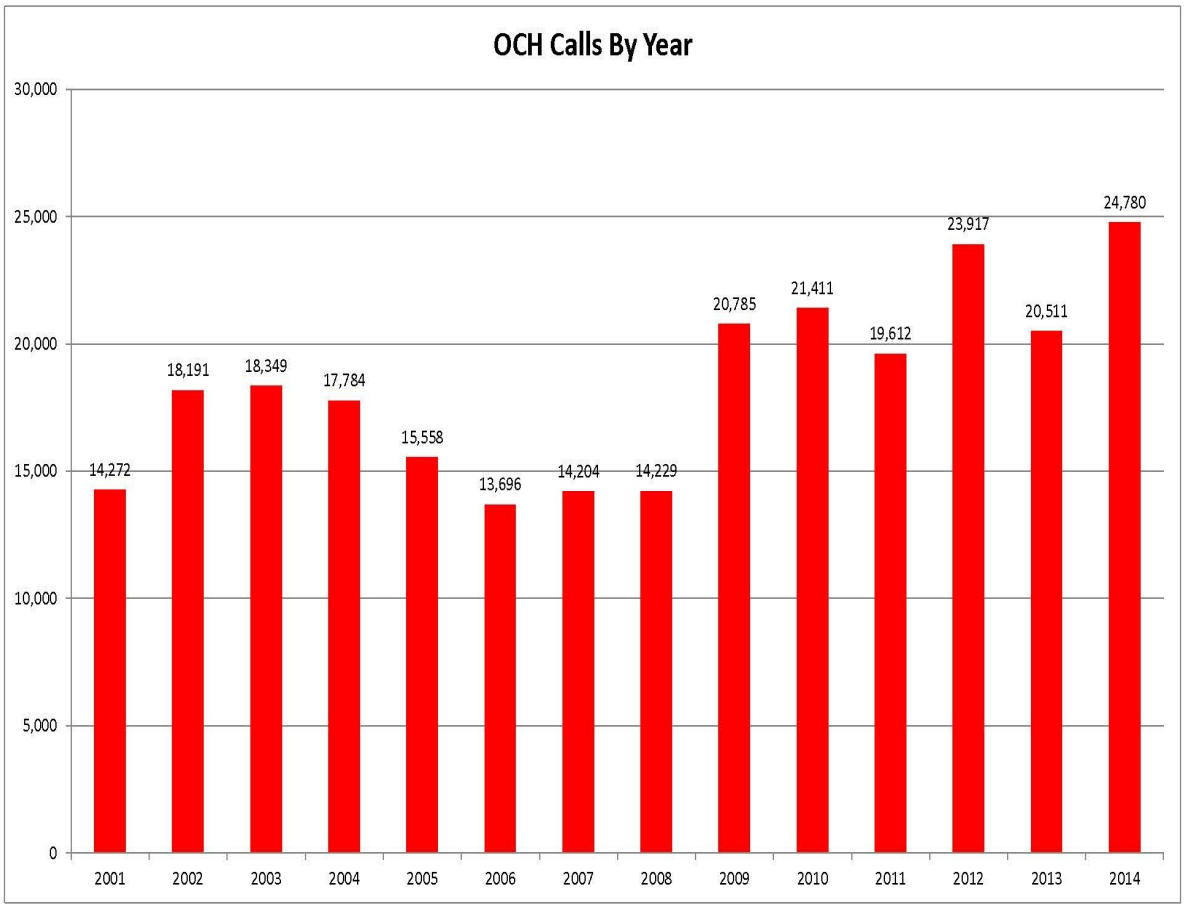
h) Company Bulletin 2014-08

The purpose of this Bulletin was to remind issuers that prohibition on discrimination applies equally to all health conditions, including but not limited to individual with HIV/AIDS. Consistent with the Affordable Care Act, Illinois Department of Insurance would not recommend certification or recertification of a plan as a Qualified Health Plan (QHP) if the plan was found to discriminate, whether in plan design or implementation, based on an insured's medical dependency or health condition, including HIV/AIDS. During the 2015 plan approval process, the Department of Insurance will continue to examine plans in depth to determine compliance with 45 C.F.R. 156.125 (Issued May 23, 2014)

i) Company Bulletin 2014-10

The purpose of this Bulletin was to provide Illinois-licensed insurance companies guidance regarding compliance with the nondiscrimination provisions applicable to transgender persons found in the Affordable Care Act, the Illinois Human Rights Act, and the Illinois Mental Health Parity Act. Together these laws prohibit discrimination against transgender persons because of their actual or perceived gender identity or health conditions. This prohibition extends to the availability of health insurance coverage, the provision of Essential Health Benefits, and the requirements for certification as a Qualified Health Plan. (Issued July 28, 2014)

Exhibit 1


OCH Calls By Year
30,000
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10,000
5,000
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14,272
18,191
18,349
17,784
15,558
13,696
14,204
14,229
20,785
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19,612
23,917
20,511
24,780
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Exhibit 2 PIRT By Topic

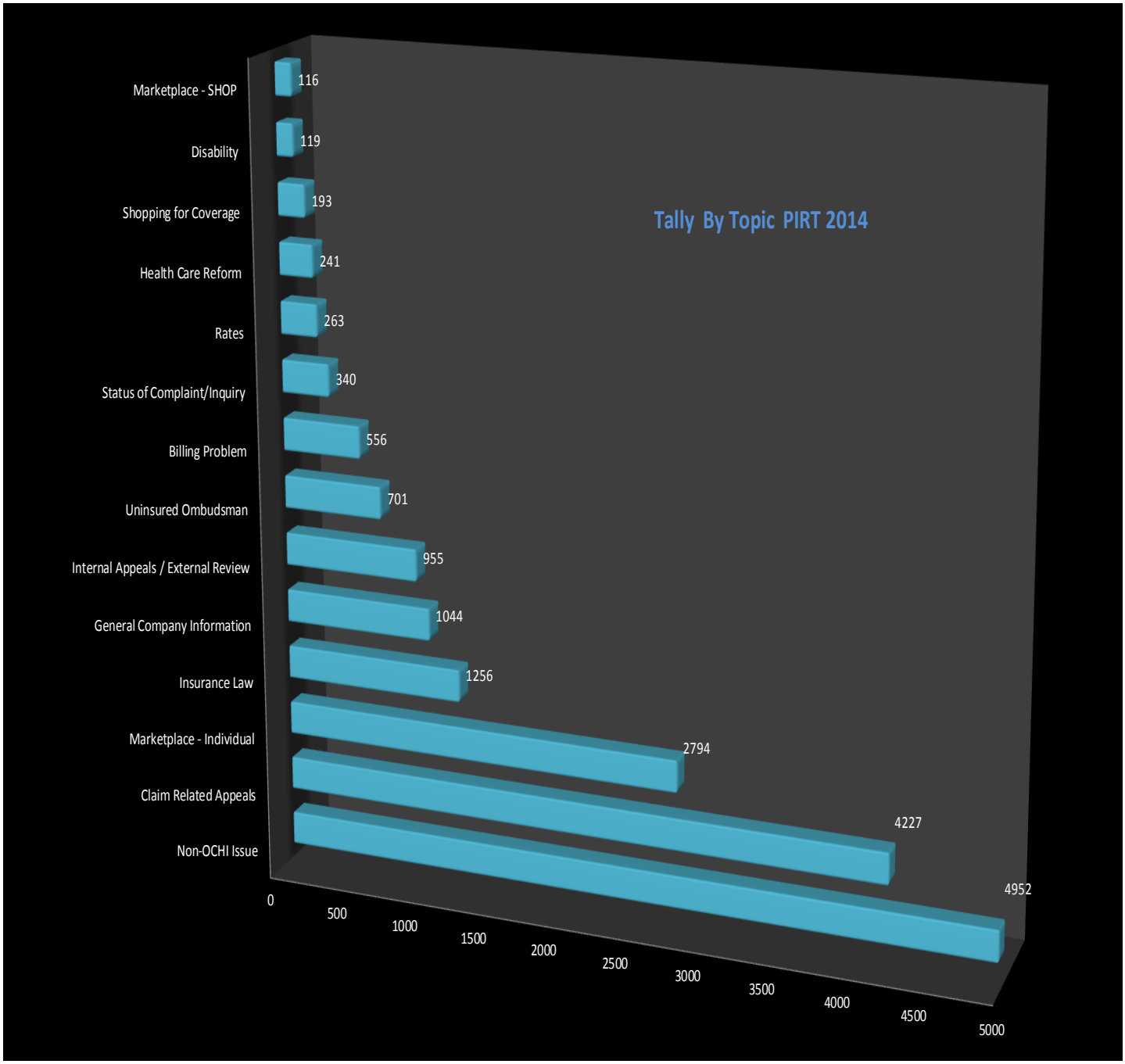

Exhibit 3 Metal Levels

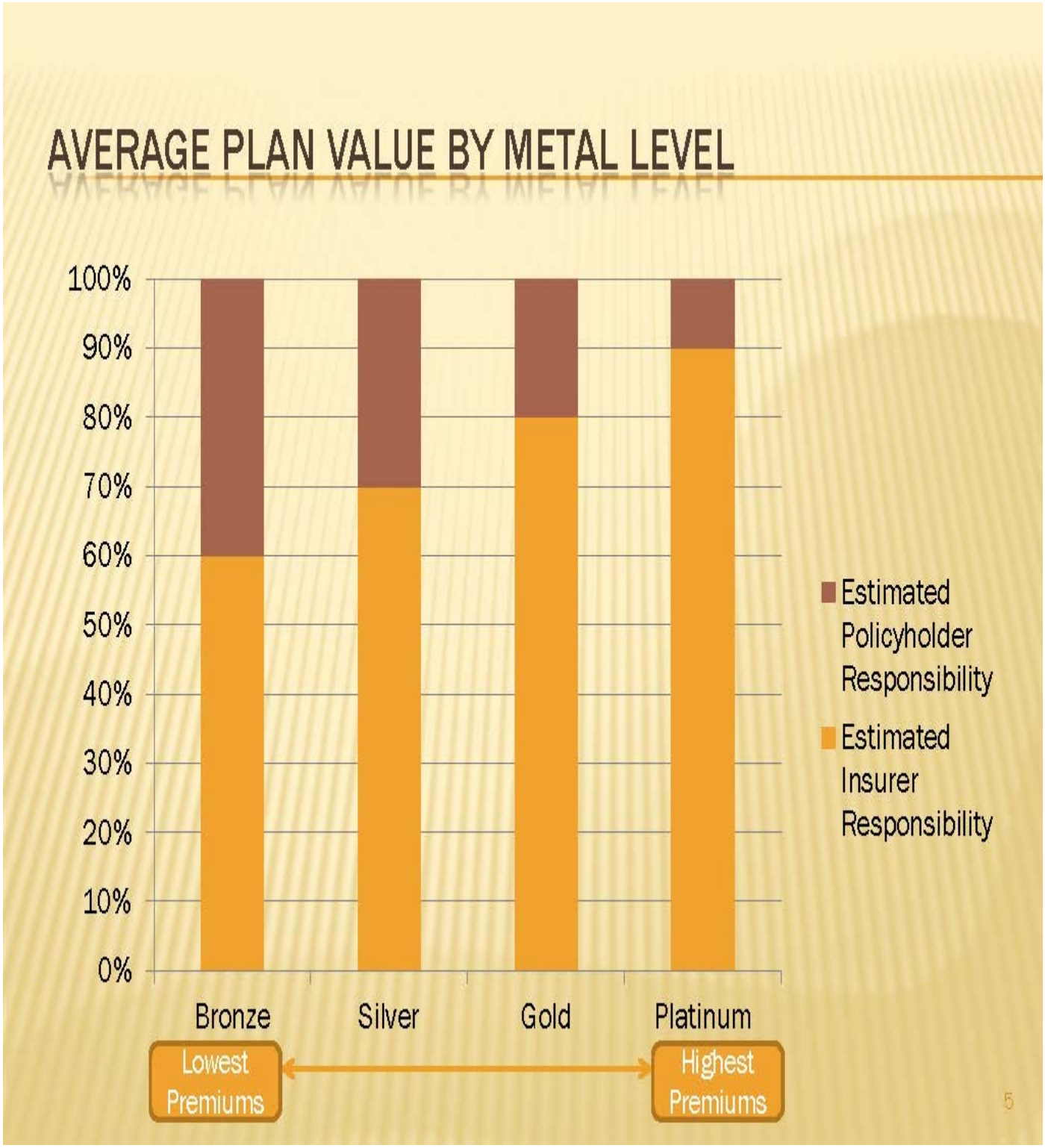

Exhibit 4 Health Plan Rating Map

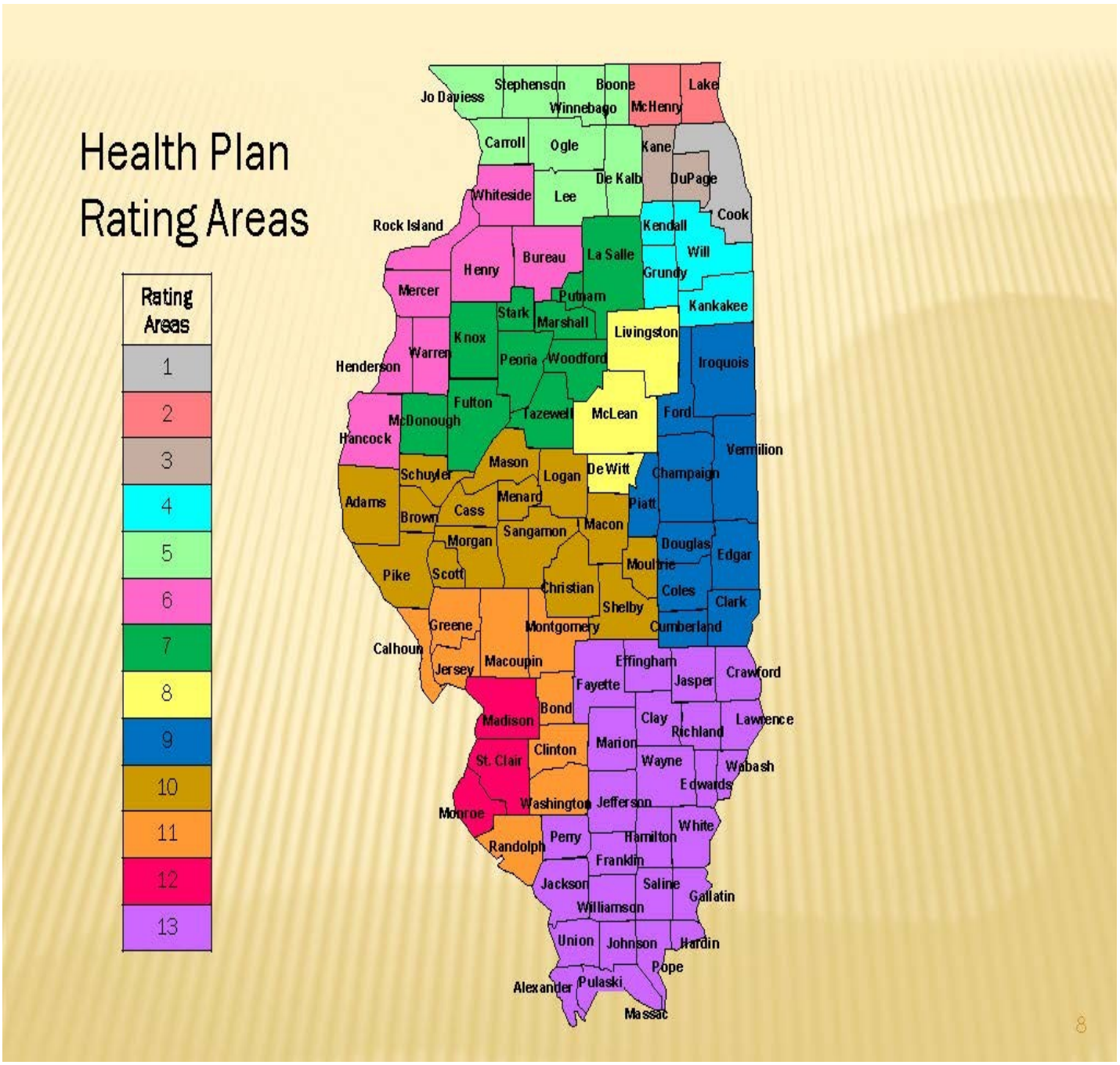

Exhibit 5 Plans By County

Individual Plans Offered by County: Metal Level

County	Rating Area	Platinum	Gold	Silver	Bronze	Catastrophic
Adams	10	1	15	15	14	2
Alexander	13	0	14	13	12	2
Bond	11	0	15	14	13	2
Boone	5	2	19	20	20	3
Brown	10	1	15	15	14	2
Bureau	6	0	16	15	14	3
Calhoun	11	0	15	14	13	2
Carroll	5	1	16	16	15	2
Cass	10	1	15	15	14	2
Champaign	9	0	14	13	12	2
Christian	10	1	15	15	14	2
Clark	9	0	14	13	12	2
Clay	13	0	14	13	12	2
Clinton	11	0	15	14	13	2
Coles	9	0	14	13	12	2
Cook	1	14	34	52	43	4
Crawford	13	0	14	13	12	2
Cumberland	9	0	14	13	12	2
DeKalb	5	1	17	17	16	2
Dewitt	8	0	16	16	15	3
Douglas	9	0	14	13	12	2

Rating Areas
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Exhibit 5 Plans By County

Individual Plans Offered by County: Metal Level

County	Rating Area	Platinum	Gold	Silver	Bronze	Catastrophic
DuPage	3	5	16	17	13	2
Edgar	9	0	14	13	12	2
Edwards	13	0	14	13	12	2
Effingham	13	0	14	13	12	2
Fayette	13	0	14	13	12	2
Ford	9	0	14	13	12	2
Franklin	13	0	14	13	12	2
Fulton	7	1	18	20	19	3
Gallatin	13	0	14	13	12	2
Greene	11	0	15	14	13	2
Grundy	4	1	19	19	18	3
Hamilton	13	0	14	13	12	2
Hancock	6	0	16	15	14	3
Hardin	13	0	14	13	12	2
Henderson	6	0	16	15	14	3
Henry	6	0	17	17	16	3
Iroquois	9	0	14	13	12	2
Jackson	13	0	14	13	12	2
Jasper	13	0	14	13	12	2
Jefferson	13	0	14	13	12	2
Jersey	11	0	15	14	13	2

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Exhibit 5 Plans By County

Individual Plans Offered by County: Metal Level

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

Rating Areas
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Exhibit 5 Plans By County

Individual Plans Offered by County: Metal Level

County	Rating Area	Platinum	Gold	Silver	Bronze	Catastrophic
McLean	8	0	16	16	15	3
Menard	10	1	15	15	14	2
Mercer	6	0	17	17	16	3
Monroe	12	1	10	15	13	1
Montgomery	11	0	15	14	13	2
Morgan	10	1	15	15	14	2
Moultrie	10	1	15	15	14	2
Ogle	5	2	18	18	18	3
Peoria	7	2	20	22	22	4
Perry	13	0	14	13	12	2
Piatt	9	0	14	13	12	2
Pike	10	1	15	15	14	2
Pope	13	0	14	13	12	2
Pulaski	13	0	14	13	12	2
Putnam	7	2	18	19	19	4
Randolph	11	0	15	14	13	2
Richland	13	0	14	13	12	2
Rock Island	6	0	17	17	16	3
Saint Clair	12	1	10	15	13	1
Saline	13	0	14	13	12	2
Sangamon	10	2	17	18	18	3
Schuyler	10	1	15	15	14	2

Rating Areas
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Exhibit 5 Plans By County

Individual Plans Offered by County: Metal Level

County	Rating Area	Platinum	Gold	Silver	Bronze	Catastrophic
Scott	10	1	15	15	14	2
Shelby	10	1	16	17	16	2
Stark	7	2	18	19	19	4
Stephenson	5	1	16	16	15	2
Tazewell	7	2	19	21	21	4
Union	13	0	14	13	12	2
Vermilion	9	0	14	13	12	2
Wabash	13	0	14	13	12	2
Warren	6	0	16	15	14	3
Washington	11	0	15	14	13	2
Wayne	13	0	14	13	12	2
White	13	0	14	13	12	2
Whiteside	6	0	17	17	16	3
Will	4	1	19	19	18	3
Williamson	13	0	14	13	12	2
Winnebago	5	2	19	20	20	3
Woodford	7	2	18	19	19	4

Rating Areas
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Exhibit 5 Plans By County

Small Group Plans Offered by County: Metal Level

County	Rating Area	Platinum	Gold	Silver	Bronze
Adams	10	0	17	17	12
Alexander	13	0	17	17	12
Bond	11	0	18	18	13
Boone	5	0	19	19	14
Brown	10	0	17	17	12
Bureau	6	0	19	20	14
Calhoun	11	0	18	18	13
Carroll	5	0	18	18	13
Cass	10	0	17	17	12
Champaign	9	0	17	17	12
Christian	10	0	17	17	12
Clark	9	0	17	17	12
Clay	13	0	17	17	12
Clinton	11	0	18	18	13
Coles	9	0	17	17	12
Cook	1	5	15	15	8
Crawford	13	0	17	17	12
Cumberland	9	0	17	17	12
DeKalb	5	0	19	19	14
Dewitt	8	0	18	18	13
Douglas	9	0	17	17	12

Rating Areas
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Exhibit 5 Plans By County

Small Group Plans Offered by County: Metal Level

County	Rating Area	Platinum	Gold	Silver	Bronze
DuPage	3	4	13	13	8
Edgar	9	0	17	17	12
Edwards	13	0	17	17	12
Effingham	13	0	17	17	12
Fayette	13	0	17	17	12
Ford	9	0	17	17	12
Franklin	13	0	17	17	12
Fulton	7	0	18	18	13
Gallatin	13	0	17	17	12
Greene	11	0	18	18	13
Grundy	4	0	21	22	16
Hamilton	13	0	17	17	12
Hancock	6	0	19	20	14
Hardin	13	0	17	17	12
Henderson	6	0	19	20	14
Henry	6	0	19	20	14
Iroquois	9	0	17	17	12
Jackson	13	0	17	17	12
Jasper	13	0	17	17	12
Jefferson	13	0	17	17	12
Jersey	11	0	18	18	13

Rating Areas
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Exhibit 5 Plans By County

Small Group Plans Offered by County: Metal Level

County	Rating Area	Platinum	Gold	Silver	Bronze
Jo Daviess	5	0	18	18	13
Johnson	13	0	17	17	12
Kane	3	4	13	13	8
Kankakee	4	0	21	22	16
Kendall	4	0	21	22	16
Knox	7	0	18	18	13
Lake	2	1	10	11	7
LaSalle	7	0	18	18	13
Lawrence	13	0	17	17	12
Lee	5	0	18	18	13
Livingston	8	0	18	18	13
Logan	10	0	17	17	12
Macon	10	0	17	17	12
Macoupin	11	0	18	18	13
Madison	12	0	6	6	4
Marion	13	0	17	17	12
Marshall	7	0	18	18	13
Mason	10	0	17	17	12
Massac	13	0	17	17	12
McDonough	7	0	18	18	13
McHenry	2	1	10	11	7

Rating Areas
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Exhibit 5 Plans By County

Small Group Plans Offered by County: Metal Level

County	Rating Area	Platinum	Gold	Silver	Bronze
McLean	8	0	18	18	13
Menard	10	0	17	17	12
Mercer	6	0	19	20	14
Monroe	12	0	6	6	4
Montgomery	11	0	18	18	13
Morgan	10	0	17	17	12
Moultrie	10	0	17	17	12
Ogle	5	0	19	19	14
Peoria	7	0	19	19	14
Perry	13	0	17	17	12
Piatt	9	0	17	17	12
Pike	10	0	17	17	12
Pope	13	0	17	17	12
Pulaski	13	0	17	17	12
Putnam	7	0	18	18	13
Randolph	11	0	18	18	13
Richland	13	0	17	17	12
Rock Island	6	0	19	20	14
Saint Clair	12	0	6	6	4
Saline	13	0	17	17	12
Sangamon	10	0	17	17	12
Schuyler	10	0	17	17	12

Rating Areas
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Exhibit 5 Plans By County

Small Group Plans Offered by County: Metal Level

County	Rating Area	Platinum	Gold	Silver	Bronze
Scott	10	0	17	17	12
Shelby	10	0	17	17	12
Stark	7	0	18	18	13
Stephenson	5	0	18	18	13
Tazewell	7	0	18	18	13
Union	13	0	17	17	12
Vermilion	9	0	17	17	12
Wabash	13	0	17	17	12
Warren	6	0	19	20	14
Washington	11	0	18	18	13
Wayne	13	0	17	17	12
White	13	0	17	17	12
Whiteside	6	0	19	20	14
Will	4	0	21	22	16
Williamson	13	0	17	17	12
Winnebago	5	0	19	19	14
Woodford	7	0	18	18	13

Rating Areas
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