



**State of Illinois  
Office of Attorney General  
Health Care Bureau**

**2004/2005  
Health Care Bureau  
Bi-Annual Report**

**Complaint Patterns  
Consumer Tips**



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## **EXECUTIVE SUMMARY**

### **Introduction:**

The Health Care Bureau's principal mandate is to protect and advocate for the rights of health care consumers statewide. The Bureau operates a toll-free hotline to assist Illinoisans with individual health care problems and identify systemic problems in the health care system. The Health Care Bureau seeks to address issues through mediation and dispute resolution, education, legislation, and law enforcement actions. This report describes and gives an overview of the complaint trends and the initiatives undertaken by the Illinois Attorney General's Health Care Bureau during 2004 and 2005.

This report does not specifically address issues regarding charity care and financial assistance. For many years, the primary focus of complaints to the Health Care Bureau has been problems that arise from the processing and payment of claims by health insurance providers. While the Office of the Attorney General has received complaints from consumers regarding the denial or refusal of charity care, the Health Care Bureau has not tracked this information.

In recent years, the Health Care Bureau and the Office of the Attorney General have become increasingly concerned about problems in the provision of charity care and the billing of uninsured patients. As a result of meetings between the Office of the Attorney General, legislators, and community groups, the office developed a task force to investigate charity care in greater detail. This investigation yielded substantial information regarding problems which exist in the offering of charity care and financial assistance by hospitals. As a result of this investigation, the task force recommended legislation as a means to solve the problems which affect consumers when they are unable to afford medical care at hospitals. The task force drafted two bills to address this issue: House Bill 4999, the Hospital Fair Billing and Collection, and House Bill 5000, the Hospital Charity Care. On June 20, 2006, House Bill 4999 was signed into law as the Fair Patient Billing Act, with an effective date of January 1, 2007.

The passage of the Hospital Fair Patient Billing Act provides the Health Care Bureau with new tools to assist consumers. With this law in place, the Health Care Bureau will assist both uninsured and insured consumers in receiving appropriate financial assistance with hospital bills. The Health Care Bureau will track all complaints regarding this issue and enforce violations of the Fair Patient Billing Act. Moreover, the Health Care Bureau will publicize this new law so that all consumers know to seek assistance from the Office of the Attorney General regarding hospital billing and financial assistance problems.

### **Mediation of Health Care Consumer Complaints:**

Staff of the Attorney General's Health Care Bureau opened 2,143 cases in 2004 and 2,094 cases in 2005. In addition to fielding complaints, the Health Care Bureau staff

give direct assistance over the phone to consumers, makes referrals to other government agencies and provide education materials on various health care issues.

The Health Care Bureau recovered approximately \$1,774,250 in coverage benefits from health care plans for consumers in 2004 and approximately \$2,734,707 in 2005. Without the assistance of the Health Care Bureau, consumers may have paid for health care costs that should have been covered by their health plans.

This report describes the types of health care complaints the Bureau has received from consumers. Many of the complaints received by the Health Care Bureau raise multiple issues. This report goes beyond the number of complaints received and analyzes the *issues* raised in the complaints. In 2004, the Bureau received 2,143 complaints but the total number of issues raised in these complaints was 2,460. In 2005, the Bureau received 2,094 complaints but the total number of issues raised in these complaints was 2,608.

Below is the list of complaint issues reported and analyzed by the Health Care Bureau:

- 1) billing errors by providers;
- 2) claims processing and payment problems by health plans and providers;
- 3) denials of health care or coverage by health plans;
- 4) problems gaining access to specialty care and out-of-network care;
- 5) problems obtaining and keeping health insurance coverage;
- 6) access to prescription drugs;
- 7) misleading or confusing advertising by providers and health plans;
- 8) quality of care issues regarding providers;
- 9) misinformation given by providers; and
- 10) miscellaneous complaints.

### **Enforcement Actions and Consumer Education**

The report also describes enforcement actions instituted against entities operating in the health care market and provides tips to consumers on how to protect their rights and maximize their health care coverage.

### **Findings:**

An analysis of Health Care Bureau (“HCB”) complaint statistics demonstrates the following:

1. Billing errors by providers to consumers, the issue raised most frequently in complaints, account for almost one-fourth of all consumer complaints received by the HCB during the 24-month period covered by this report. Additionally, from 2004 to 2005, billing errors by providers increased from 22% to 27% of all complaint issues. As a result of provider billing errors, consumers frequently must expend effort and time in an attempt to rectify the billing error by contacting

both the provider and the insurance company. Depending on the provider, a consumer account may be sent to a collection agency before the billing dispute is resolved. For example, these errors often occur when a provider submits a bill to the patient's health plan for payment; the provider receives payment from the health plan but then mistakenly bills the patient for the same amount.

2. Claim processing and payment problems by insurance companies when they process a claim submitted by a provider, and by providers when they submit a claim to an insurance company, were the second most frequent complaint issue received by the HCB for both 2004 and 2005. As with provider billing errors, consumers are caught in the middle when health insurance claim processing and payment problems arise. The burden of correcting the claim processing error is placed on the consumers. These errors occur, for example, when a provider submits a bill to the consumer's health plan in a timely manner, but the consumer's insurance company states that the provider failed to submit the bill in a timely manner and refuses to pay the bill. To rectify the situation, the consumer must act as an intermediary between the provider and the health plan to acquire proof that the provider submitted the bill in a timely manner.
3. An increasing number of consumers are experiencing a reduction or complete loss of health care benefits. Statistics show the number of uninsured Illinois residents is growing. Complaints regarding obtaining and keeping health coverage increased from 3% of all complaint issues in 2004 to 5.4% of all complaint issues in 2005. Approximately 14% or 1,790,790 Illinois residents are uninsured. 61% of Illinois residents have health coverage through employment, 5% of Illinois residents have individual coverage, 9% of Illinois residents receive health coverage through the state Medicaid program, and 12% of Illinois residents receive health coverage through Medicare. The remaining 1% of Illinois residents receive health coverage through other public programs.
4. The uninsured are turning to alternative products such as discount medical cards to provide relief from the high cost of medical services. Discount cards are not insurance but offer consumers a discount off the average price of medical treatment. Based on their marketing, these discount cards can appear to be an attractive alternative for the uninsured because they do not require medical underwriting and do not exclude people because of preexisting conditions. However, some of these products have been marketed in a deceptive way, leading consumers to believe they are purchasing insurance products when, in fact, they are only purchasing a discount. Other marketed discount card products are just scams and do not offer any benefits.
5. A number of consumers with health care policies are experiencing coverage problems due to erroneous health plan coverage adjudications and overly broad interpretations of policy exclusions. In responding to complaints, the Health Care Bureau has found instances in which health care plans have erroneously denied coverage by applying the provisions of a wrong policy to a benefit request. An

example of an overly broad interpretation of policy provisions includes a situation where the health care plan denied coverage for speech therapy for a minor child. However, once the policy was reviewed, it was discovered that the policy only excluded coverage for speech therapy for adults. Additionally, more families are being required to perform skilled nursing care for family members with disabilities. The HCB has found instances where parents are being forced to administer and maintain tracheostomies, ventilators and gastric feeding tubes for their ill family members 24 hours a day, 7 days a week because their health insurance plan has found that this type of care does not require the specialized skills of a medical professional. The health insurance plans state that this type of care is custodial and, therefore, is not covered under the insurance policy. However, in the past, the health insurance plans paid for this type of care as skilled nursing services.

6. The HCB has seen an increase in complaints that concern health plans underwriting short-term insurance policies several months after their effective dates and then denying a claim and canceling policies. In general, insurance companies deny claims based on a pre-existing condition or problems related to the application. Underwriting is a process whereby an insurance company reviews a consumer's medical history to determine whether the insurance company will issue a policy of insurance for the individual. This latest trend of underwriting denial, after an insurance policy has been issued and after a consumer submits bills for payment, often leaves a consumer without insurance and with high medical bills to pay. Sometimes consumers are forced to file for bankruptcy protection because they are unable to pay their medical bills.
7. The HCB receives numerous complaints from consumers who were charged out-of-network rates by insurance companies for services they did not understand were considered out-of-network. For example, this situation arises when a consumer makes a trip to an in-network emergency room and later receives a bill for services from one of the doctors in the emergency room who is not included in the insurance network. The consumer is then responsible for a much higher medical bill because the provider is not included in their insurance network.

Of all the players in the health care system, individual consumers usually know the least about how the health care system works. Many consumers who call the Health Care Bureau Hotline are confused about their benefits, about the rules to follow to secure coverage for care, about doctor or hospital charges, about appeal rights, or about where to get help with some other aspect of health care. Insurance companies and government agencies must do more to educate consumers about their health care benefits. As part of its mission, the Health Care Bureau will continue to work to educate consumers concerning their health care options. To help educate consumers about their health care rights, the Health Care Bureau is releasing four brochures which describe the rights that consumers have under the various types of health care plans.

## REPORT FORMAT

This report analyzes the 2,460 complaint issues for 2004 and the 2,608 complaint issues for 2005. These issues fall into ten general areas:

<b>Complaints by Type and Issue</b>		<b>2004</b>
Table	Consumer Complaints – Issues	
1	Billing errors by providers	547
2	Claim processing and payment problems by health plans & providers	459
3	Denials of care or coverage by health plans	291
4	Advertising	176
5	Quality of Care	158
6	Access to specialty care and out-of-network care	149
7	Misinformation	105
8	Problems obtaining and keeping coverage	83
9	Access to prescription drugs	57
10	Miscellaneous Issues <sup>1</sup>	435
<b>TOTAL</b>		<b>2460</b>

<b>Complaints by Type and Issue</b>		<b>2005</b>
Table	Consumer Complaints – Issues	
1	Billing errors by providers	706
2	Claim processing and payment problems by health plans & providers	296
3	Denials of care or coverage by health plans	235
4	Quality of Care	192
5	Misinformation	178
6	Advertising	155
7	Problems obtaining and keeping coverage	142
8	Access to specialty care and out-of-network care	122
9	Access to prescription drugs	83
10	Miscellaneous Issues <sup>1</sup>	499
<b>TOTAL</b>		<b>2608</b>

Included in each section of this report are descriptions of HCB complaints that illustrate the nature of the issue and the type of assistance the HCB provided to individual consumers. In addition, side-panels describe enforcement actions pursued by the HCB regarding particular issues, offer tips to consumers on how to deal with problems or questions more effectively and present recommendations for reform of various systemic problems identified by the HCB.

<sup>1</sup> Issues included in the miscellaneous section involve complaints unrelated to health plan and provider billing and coverage problems. Several of the topics included in this section involve requests for information, non-release of medical records, legal inquiries and telemarketing issues.

**GENERAL SUMMARY OF TOP 10 2004  
HEALTH CARE BUREAU COMPLAINT ISSUES<sup>2</sup>**

The following is a general summary of the 2,460 complaint issues received by the HCB for the year 2004 in descending order. Each of these issues will be fully described and analyzed in the report:

1.     **IMPROPER BILLING OF PATIENTS BY PROVIDERS (547)**
  - wrong amount/wrong code
  - bill already paid
  - wrong person billed
  - balance billing
  - usual and customary billing issues
  
2.     **CLAIM PROCESSING AND PAYMENT PROBLEMS BY HEALTH PLANS AND PROVIDERS (459)**
  - health plan not processing/paying claims
  - health plan paid wrong amount
  - health plan error regarding deductible/co-payment
  - provider filed claim late
  - provider failed to provide sufficient clinical information to the health plan
  
3.     **HEALTH PLAN DENIALS OF CARE OR COVERAGE (291)**
  - medical necessity denials
  - denials due to health plan errors
  - covered benefit denials
  - pre-existing condition denials
  - service is cosmetic denial
  - service is custodial denial
  - procedure considered experimental/investigational denial
  
4.     **ADVERTISING (176)**
  - fax advertisements by discount health plans
  - internet advertisements by dietary supplements or herbal remedies
  - newspaper advertisements by providers for clinics or offices
  
5.     **QUALITY OF CARE BY PROVIDER (158)**
  - patient dissatisfaction with provider's medical treatment/services
  - durable medical equipment is faulty
  - glasses are wrong prescription
  
6.     **PROBLEMS ACCESSING SPECIALTY CARE (149)**
  - consumer received services from an out-of-network provider

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<sup>2</sup> See Appendix A for a detailed breakdown of the number of complaints received and specific categories within each complaint issue type for 2004.

- consumer disputes balance owed to out-of-network provider
  - health plan issued a “no pre-authorization/no referral” denial
  - health plan refused referral to out-of-network provider
7. MISINFORMATION (105)
    - provider misinforms consumer of his status as an in-network physician
    - provider charges higher price than quoted for the service
  8. DIFFICULTIES OBTAINING AND KEEPING COVERAGE (83)
    - policy terminated by employer
    - policy terminated by health plan due to employer premium default
    - consumer error regarding enrollment or termination of policy
    - health plan error regarding enrollment or termination of policy
  9. ACCESS TO PRESCRIPTION DRUGS (57)
    - problems with receiving prescriptions through a mail order pharmacy
    - inquiries regarding prescription benefits and formularies
    - formulary issues: a consumer’s prescription drug is taken off health plan’s formulary or a consumer is erroneously told that a prescription drug is on the formulary
    - health plan cut number of pills dispensed per visit
  10. MISCELLANEOUS ISSUES (435)
    - non-release of medical records
    - telemarketing scams and misrepresentations
    - requests by consumers for information on specific health topics
    - information provided by consumers to the Attorney General’s Office on specific health topics

## **GENERAL SUMMARY OF TOP 10 2005 HEALTH CARE BUREAU COMPLAINT ISSUES<sup>3</sup>**

The following is a general summary of the 2,608 complaint issues received by the HCB for the year 2005 in descending order. Each of these types of issues will be fully described and analyzed in the report:

1. **IMPROPER BILLING BY PROVIDERS (706)**
  - wrong amount/wrong code
  - bill already paid
  - wrong person billed
  - balance billing
  - usual and customary billing issues
  
2. **CLAIM PROCESSING AND PAYMENT PROBLEMS BY HEALTH PLANS AND PROVIDERS (296)**
  - health plan not processing/paying claims
  - health plan paid wrong amount
  - health plan error regarding deductible/co-payment
  - provider filed claim late
  - provider failed to provide sufficient clinical information to the health plan
  
3. **HEALTH PLAN DENIALS OF CARE OR COVERAGE (235)**
  - medical necessity denials
  - denials due to health plan errors
  - covered benefit denials
  - pre-existing condition denials
  - service is cosmetic denial
  - service is custodial denial
  - procedure considered experimental/investigational denial
  
4. **QUALITY OF CARE BY PROVIDER (192)**
  - patient dissatisfaction with provider's medical treatment/services
  - durable medical equipment is faulty
  - glasses are wrong prescription
  
5. **MISINFORMATION (178)**
  - provider misinforms consumer of his status as an in-network physician
  - provider quotes consumer one price but charges higher price for the service
  
6. **ADVERTISING (155)**
  - fax advertisements by discount health plans
  - internet advertisements by dietary supplements or herbal remedies

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<sup>3</sup> See Appendix B for a detailed breakdown of the number of complaints received and specific categories within each complaint issue type for 2005.

- newspaper advertisements by providers for clinics or offices
7. PROBLEMS WITH OBTAINING AND KEEPING COVERAGE (142)
    - policy terminated by employer
    - policy terminated by health plan due to employer premium default
    - consumer error regarding enrollment or termination of policy
    - health plan error regarding enrollment or termination of policy
  8. PROBLEMS ACCESSING SPECIALTY CARE (122)
    - consumer received services from an out-of-network provider
    - consumer disputes balance owed to out-of-network provider
    - health plan issued a “no pre-authorization/no referral” denial
    - health plan refused referral to out-of-network provider
  9. ACCESS TO PRESCRIPTION DRUGS (83)
    - problems with receiving prescriptions through a mail order pharmacy
    - inquiries regarding prescription benefits and formularies
    - formulary issues: a consumer’s prescription drug is taken off health plan’s formulary or a consumer is erroneously told that a prescription drug is on the formulary
    - health plan cut number of pills dispensed per visit
  10. MISCELLANEOUS ISSUES (499)
    - medical record issues
    - telemarketing scams or misrepresentations
    - legal inquiries
    - requests by consumers for information on specific health topics
    - information provided by consumers to the Attorney General’s Office on specific health topics

## INTRODUCTION

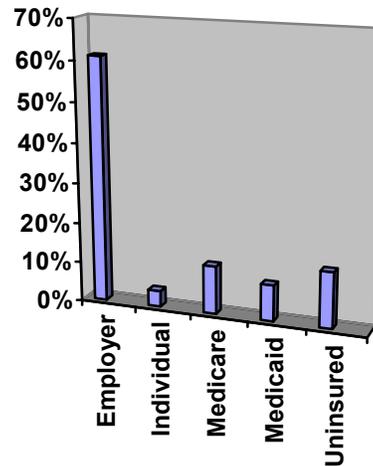
### I. Health Insurance in Illinois: Coverage Options and Benefit Eligibility Rules

Most Illinois residents have health insurance coverage of some kind. However, the types of health insurance coverage vary greatly among Illinois residents – 61% receive health coverage through employment, 9% have coverage through Medicaid, 12% have Medicare and 4% have individual direct-pay insurance contracts with private insurers. Over 1,790,740, or 14% of Illinois residents, have no health insurance coverage at all.<sup>4</sup>

The health insurance marketplace offers consumers a wide variety of coverage options. Within this report, the term “health plan” is used to refer generally to health insurance and managed care plans, except when a particular type of plan is specifically mentioned. The following is a list of various types of health plan options:

- Network-model Health Maintenance Organizations (HMOs) create a provider “network” by contracting with a variety of hospitals and physicians to provide services. “Classic” or “pure” HMOs require patients to have pre-authorizations for certain services and referrals to see specialists, and generally do not pay for services received from an “out-of-network” or “non-participating” provider.
- HMO-Point of Service (HMO-POS) Plans are a more flexible version of the Network HMO. They provide some level of coverage for members to go out-of-network and may not require pre-authorizations and referrals.
- Preferred Provider Organizations (PPOs) create networks of doctors, hospitals and other providers that contract with the PPO to provide services. In PPOs, consumers typically have more flexibility to choose their doctors and are not limited to doctors in one particular group. In general, PPO members do not have to obtain a referral to see a specialist.
- Fee-for-Service means that the doctors and hospitals are paid a fee for each service provided to a health care consumer. Consumers are not restricted to any particular doctor or hospital.

**Health Insurance Coverage Sources for Illinois Residents**



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<sup>4</sup> Kaiser Family Foundation, “State Health Facts Online,” at <http://statehealthfacts.kff.org>.

## II. Illinois Residents Without Health Insurance

Approximately 1.7 million Illinois residents are uninsured.<sup>5</sup> Roughly 64% of the uninsured are currently employed and nearly half of the working uninsured do not have employer-sponsored health insurance available.<sup>6</sup> Uninsured consumers seldom seek medical care or, if they do seek such care, struggle to pay high bills. The uninsured are vulnerable to scams that involve unauthorized health insurers or unscrupulous medical discount card offerings that promise low premiums and great savings on health costs – promises that are often too good to be true. (See Section 5).

## III. Consumer Health Care Rights

Illinois consumers are entitled to a wide variety of health care rights and protections, depending on the type of health plan in which they are enrolled: managed care, individual, self-insured or fully-insured group. The chart below lists a summary of the *primary* rights to which consumers are entitled to receive. As always, refer to your Certificate of Benefits or Summary Plan Description for specific information.

The Employee Retirement and Income Security Act of 1974 (hereinafter “ERISA”)<sup>7</sup> governs employee welfare benefit plans, including plans which establish health, surgical, or hospital benefits. A self-insured health plan is a health benefit plan where the plan sponsor (i.e. the employer or union) is at risk for the claims incurred by the members of the plan.

Most self-insured health plans are regulated by the United States Department of Labor, except self-insured plans that are sponsored through school districts, municipalities, and churches. **State insurance laws do not apply to self-insured health plans.**

In addition, the Illinois Consumer Fraud and Deceptive Business Practices Act, which prohibits deceptive business practices, fraud, and false advertising, protects both insured and uninsured consumers from the illegal practices of entities that operate in the health care marketplace – health plans, hospitals, pharmaceutical manufacturers, and laboratories.

A primary function of the HCB is to ensure that consumers are aware of these rights, understand how to exercise them, and receive assistance in asserting their rights.

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<sup>5</sup> State of Illinois Department of Insurance “Office of Consumer Health Insurance 2003 Annual Report” at [http://www.ins.state.il.us/Reports/OCHI/OCHI\\_2003\\_Annual\\_Report.htm](http://www.ins.state.il.us/Reports/OCHI/OCHI_2003_Annual_Report.htm)

<sup>6</sup> HRSA Illinois State Planning Grant “Final Report to the Secretary, March 29, 2002” at <http://www.statecoverage.net/statereports/il5.pdf>

<sup>7</sup> 29 U.S.C. §1001 *et. seq.*

Rights	Plan	Managed Care Plan	Individual Health Policy	Self-Insured Employer Plan	Fully-Insured Employer Plan
Right to Receive Detailed Information about HMO Coverage <sup>8</sup>		X	*	-	*
Right to Receive Coverage for Emergency Services when a Prudent Person Believes the Condition is Serious <sup>9</sup>		X	*	-	*
Right to Apply for a Standing Referral to a Physician <sup>10</sup>		X	*	-	*
Right to Appeal Service Denial Decisions <sup>11</sup>		X	*	X <sup>12</sup>	X
EMTALA Right to Emergency Medical Screening at a Hospital <sup>13</sup>		X	X	X	X

<sup>8</sup> This right is included in the Illinois Managed Care Reform and Patients Right Act, (IMCRPRA), 215 ILCS 134/1 *et. seq.*, which gives Illinois consumers more control of their health care through tighter requirements on health maintenance organizations (HMOs), insurance companies, doctors and other health care providers. The Act generally applies to state regulated managed care plans, including all state regulated HMO plans. The Act only partially applies to other insurance plans, including PPO plans. The Act does not apply to self-insured plans regulated by the U.S. Department of Labor.

<sup>9</sup> Under IMCRPRA, a consumer has a right to receive coverage for emergency services when a “prudent person”, as defined by the statute, would reasonably believe that the condition is serious enough to require an emergency medical condition.

<sup>10</sup> Another right under the IMCRPRA, a consumer has the right to apply for a standing referral from their primary care physician when the consumer has a condition which requires ongoing care from a specialist.

<sup>11</sup> Under the IMCRPRA, a consumer has a right to appeal service denial decisions made by the consumer’s HMO.

<sup>12</sup> The federal ERISA regulations, which apply to self-funded employer plans, do provide some appeal procedures. To find out if a plan is protected by those regulations, refer to the plan document.

<sup>13</sup> EMTALA is an acronym for the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd. Under EMTALA a person has a right to receive a medical screening by a hospital emergency room. If the hospital determines that the individual has an emergency medical condition, the hospital must treat and stabilize the emergency medical condition or transfer the individual and a hospital may not transfer an individual with an emergency medical condition that has not been stabilized except if several conditions are met.

Specific Health Mandates Apply	X	X	-	X
Right to See & Receive a Copy of Medical Record <sup>14</sup>	X	X	X	X
Right to Have Medical Bill Paid Promptly <sup>15</sup>	X	X	-	X
Coverage Continuation Rights under COBRA <sup>16</sup>	X	-	X	X
Pre-existing Condition Limitations and Increased Insurance Portability <sup>17</sup>	X	-	X	X

\* Only if the plan is an HMO

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<sup>14</sup> The HIPAA Privacy Rule and Illinois Law gives consumers the right to view and receive a copy of their medical record. See 45 C.F.R. §164.524(a), 45 C.F.R. §164.524(b)(2) and 735 ILCS 5/8-2001 and 5/8-2003.

<sup>15</sup> 215 ILCS 5/368a.

<sup>16</sup> COBRA is an acronym for the Consolidated Omnibus Budget Reconciliation Act, 29 U.S.C. §1161 *et. seq.* COBRA allows consumers the right to continue employer-sponsored health benefits at group rates if the consumer loses their benefits because of a qualifying condition as defined by the statute.

<sup>17</sup> HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §300gg(a)(2) and 300gg(c)(2)(A). Both HIPAA and Illinois law, 215 ILCS 97/20 (A)(2) and 97/20(C)(3)(a), place limits on exclusion periods that insurers may impose on pre-existing conditions. Additionally, these statutes allow specific rights which increase the portability of insurance when an individual changes jobs.

## DUTIES OF THE ATTORNEY GENERAL'S HEALTH CARE BUREAU

The HCB is part of the Consumer Protection Division of the Office of the Illinois Attorney General. The HCB protects and advocates for the rights of all Illinois health care consumers through:

- **Operation of the Health Care Hotline.** Intake staff for the toll-free hotline assists consumers by providing helpful information and referrals. The HCB Hotline is the Attorney General's front line in registering and resolving consumer complaints regarding health care. During 2004, the HCB received 2,143 complaints. Of these 2,143 complaints, 1,505 were actively mediated and 638 complaints involved consumer inquiries to which Hotline intake staff responded by providing information or referrals to other agencies. In 2005, the HCB received 2,094 complaints. Of these 2,094 complaints, 1,409 cases were actively mediated and 685 complaints involved consumer inquiries to which Hotline intake staff responded by providing information or referrals to other agencies.
- **Mediation of Health Care Complaints.** The HCB mediators investigate individual complaints by contacting the persons involved to gather information. The mediators attempt to find a resolution that will allow each consumer to obtain access to the health care and insurance coverage to which the consumer is entitled. This work is supported by the HCB attorneys and Medical Advisor as well as the Medical Director for the Office of the Attorney General. The work of the HCB mediators can be divided into three critical consumer assistance functions. Mediators help consumers:
  - Challenge a denial of care or coverage for care by a health plan. The HCB Mediators assisted consumers in recovering \$1,774,250 during 2004 and \$2,734,707 during 2005 in additional care or coverage for care from health plans, providers, and other entities;
  - Correct mistakes by providers or health plans that resulted in denials of care or coverage for care and a range of claim, billing and payment problems; and
  - Understand how to obtain benefits through their health plans or to understand the limitations of their health plans.
- **Investigations and Enforcement Actions.** HCB attorneys focus on plans, providers, pharmaceutical manufacturers, and other individuals and entities that engage in unlawful practices in the health care market. This work is supported by the HCB Medical Advisor and mediators, and the Medical Director.

- **Consumer Education.** Through education initiatives, the HCB seeks to acquaint Illinois residents with their rights under the IMCRPRA and other health and consumer protection laws.
- **Legislation and Policy Initiatives.** These projects are aimed at enhancing the rights of health care consumers and their ability to obtain good quality, affordable health care in Illinois.

## COMPLAINT ISSUES – FINDINGS

### 1. IMPROPER BILLING BY PROVIDERS: LARGEST COMPLAINT TYPE

Table 1 shows that complaint issues regarding improper billing by providers increased from 22% of complaint issues in 2004 to 27% of complaint issues in 2005.<sup>18</sup> This increase is due, in part, to the addition of 8 new complaint issue types in 2005.<sup>19</sup> The most prevalent of these complaints concern billing the wrong amount or wrong code, while the remainder involve the balance billing of health plan members by participating providers, processing errors by doctor’s offices, hospital billing departments, diagnostic facilities, and other health care providers.

Table 1 Complaint Issues: Improper billing by provider	2004	2005
Wrong amount or wrong code	189	195
Other billing problems <sup>20</sup>	181	63
Bill Already Paid	92	92
Wrong Person Billed	43	25
Balance billing by participating provider	24	25
Usual and Customary	18	26
Bill Never Received <sup>21</sup>	0	13
Provider will not remove bill from the credit bureau <sup>22</sup>	0	12
Unknown Bill <sup>23</sup>	0	18

<sup>18</sup> This section discusses only *improper* billing of consumers by providers. When consumers complained about a provider’s bill but further investigation revealed that the provider’s bill was appropriate, those complaints were assigned to other categories. For example, if a consumer received a bill from a non-participating provider for the full cost of health services because the consumer had received services out-of-network without health plan pre-authorization, the complaint was classified under “Access to specialty care: Consumer received out-of-network services without pre-authorization.”

<sup>19</sup> These new complaint issue types were previously categorized as other billing errors, other provider errors, other and/or miscellaneous.

<sup>20</sup> Table 1 includes issues of “Other Billing Problems”. These issues include claims that the provider:

- Refused to issue an itemized bill;
- Sent the consumer to collections without ever sending the consumer a bill;
- Billed the consumer for a missed appointment;
- Engaged in fraudulent billing;
- Charged interest or late fees; and
- Sent the consumer to collections even though the consumer was making payments.

<sup>21</sup> Bill never received is a new issue type added in 2005.

<sup>22</sup> Provider will not remove the bill from the credit bureau is a new issue type added in 2005.

Consumer requests refund from the provider <sup>24</sup>	0	109
Fraudulent Billing <sup>25</sup>	0	55
Itemized bill – refuse to issue <sup>26</sup>	0	18
Late fees/Interest charges <sup>27</sup>	0	12
Service never received <sup>28</sup>	0	43
<b>TOTAL</b>	547	706

### **Balance billing by participating providers**

State regulations prohibit a provider from billing a consumer who is properly enrolled as a member of an HMO licensed to do business in the State of Illinois if (1) the provider participates in the consumer’s HMO, and (2) the services rendered by the provider are covered benefits. If these two conditions are met, the provider must seek payment for *covered* services (other than applicable deductibles, co-insurance or amounts designated by the HMO as the consumer’s responsibility in the certificate of coverage) solely from the HMO, not the consumer. The provider can only bill a consumer if: (1) the consumer is not an eligible member of the HMO or (2) the services provided are not covered benefits under the consumer’s certificate of benefits. To bill a consumer for any other reason constitutes prohibited “balance billing.”

Participating providers who balance bill their patients often argue that they are forced to do so due to the failure of the health plan to process and pay their claims in a timely manner. Some providers even assume from a plan’s lack of response to a claim that the patient was never a member of the plan or has lost coverage.

While health plan mistakes and omissions may cause problems for providers, no justification exists for balance billing consumers in violation of state regulations and participating provider contracts. Unfortunately, some of the members who receive these providers’ bills pay them because they do not know that laws or contract provisions specifically forbid the practice. Balance billing is not restricted to HMOs but can apply to PPOs and other types of health plans through contractual obligations between the provider and the health plan.

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<sup>23</sup> Unknown bill is a new issue type added in 2005.

<sup>24</sup> Consumer requests refund from the provider is a new issue type added in 2005.

<sup>25</sup> Fraudulent billing is a new issue type added in 2005.

<sup>26</sup> Itemized bill – refuse to issue is a new issue type added in 2005.

<sup>27</sup> Late fees/interest charges is a new issue type added in 2005.

<sup>28</sup> Service never received is a new issue type added in 2005.

## **Remaining Complaints: Improper Billing by Providers**

The remaining complaints in this category result from a provider using the wrong diagnostic or procedure code on an otherwise appropriate bill for a consumer; and billing the wrong consumer entirely.

### Example:

One of the HCB complaints concerning these issues involved a consumer who had been diagnosed with breast cancer and went to a participating hospital for outpatient services. However, the consumer was balance billed by the participating hospital in the amount of \$3,421. After HCB intervention with the hospital and the consumer's health plan, the hospital ceased billing the consumer because it did so in violation of its provider contract with the plan.

### Example:

A consumer contacted the HCB after receiving bills from an HMO-participating provider medical group and laboratory. The consumer had received services at the medical group and laboratory and had paid his deductible and co-insurance amounts for the services in question, but the provider continued to bill the consumer for outstanding balances. The HCB contacted the provider and the balances were removed, resulting in \$1,139.50 in savings to the consumer.

## **2. CLAIM PROCESSING AND PAYMENT PROBLEMS BY HEALTH PLANS AND PROVIDERS**

Hotline complaint patterns indicate that providers and health plans sometimes do an inferior job of managing claim processing and payment. As Table 2 shows for 2004, 459 of all Hotline complaint issues (18.7%) arose from provider or health plan mistakes in claim preparation, processing, and payment and almost 60% of these mistakes were attributable to health plans. In 2005, the percentage of HCB complaint issues attributable to health plan mistakes in claim processing and payment problems decreased to 11% of all complaint issue types and approximately 51% of these mistakes were attributable to health plans.

Based on a review of complaints, consumers' problems with the health care system tend to begin with the paperwork and electronic transmissions that inevitably follow any consumer encounter with a

Table 2 Complaint Issues: Claim Processing and Payment Problems	2004	2005
Due to health plan errors	271	152
Due to provider errors	188	132
Due to contract dispute <sup>29</sup>	0	12
<b>TOTAL</b>	<b>459</b>	<b>296</b>

health care provider. This paperwork consists of claim submissions, claim processing by health plans and the issuance of payment by those health plans. In HMO, HMO-POS plans or PPO plans,<sup>30</sup> most of this paperwork passes between providers and health plans, increasingly by electronic means. The efficiency and accuracy of the entire claim processing system depends on the diligence of providers and the administrative competence of health plans. Consumers generally play a small role in these processes and have little expertise.

## 2A. Claim Processing & Payment Problems: Health Plan Errors

In 2004, a health plan's failure to process claims at all or in a timely manner accounted for nearly 11% of all complaint issue types. However, in 2005, this percentage dropped to approximately 6% of all complaint issue types (see Table 2.1 below).

### Example:

A consumer complained to the HCB that her plan did not pay her claims at the appropriate rate. The plan had paid the claims at an out-of-network rate. The consumer stated that the plan told her that the provider was an in-network provider. The consumer, with the help of the HCB, filed an appeal to reprocess the claims at an in-network rate. The appeal was successful and the consumer's balance was reduced from \$4,000 to \$400.

The state's prompt payment law requires health plans to pay claims for health care services within 30 days after receipt of proof of loss.<sup>31</sup> If the health plan believes that the insured failed to provide sufficient documentation of proof of loss, the health plan must notify the insured within 30 days of receipt of the claim for health care services. If the health plan fails to pay the claim within the 30 day time frame it must pay interest at the rate of 9% per year.<sup>32</sup>

<sup>29</sup> The sub-group, Due to Contract Dispute, was a new issue type added in 2005.

<sup>30</sup> For an explanation of the acronyms, see the panel titled, "Types of Health Plans," on page 13.

<sup>31</sup> 215 ILCS 5/368a.

<sup>32</sup> 215 ILCS 5/368a.

<b>Table 2.1 Complaint Issues: Claim Processing and Payment Problems Due to Health Plan Errors</b>	<b>2004</b>	<b>2005</b>
Health plan not processing or paying claims	161	84
Health plan paid wrong amount	64	46
Other claim processing or payment problems	18	11
Health plan error regarding deductible or co-payment	15	5
Health plan overpaid provider	11	6
Health plan paid wrong person	2	0
<b>TOTAL</b>	<b>271</b>	<b>152</b>

Complaints classified as other claim processing or payment problems in Table 2.1 include consumer claims that their health plan:

- Charged a different price for procedures by out of network physicians;
- Refused to issue an Explanation of Benefits; and
- Refused to issue a Medicare Summary.

## 2B. Claims Processing & Payment Problems: Provider Errors

Health plans rely upon the submission of timely, accurate and complete information by providers in order to properly process claims. Therefore, if a provider commits an error in the submission of a claim, the claim will not be processed correctly by the health plan.

For both 2004 and 2005, use of the wrong diagnostic or procedure code is the most common provider error when submitting claims to a health plan. In most situations where the provider's mistake is an unintentional typographical error, only one or at most two codes will be incorrect. However, an improper code will almost always cause a mismatch between the diagnosis and the treatment. Health plan computer systems, which are set up to catch these types of problems, will reject such a claim, typically stating that the health service identified by the incorrect code is not medically necessary or is not a covered benefit.

The second most common provider error for both 2004 and 2005 is the late filing of a medical claim by the provider to a health plan. The failure to provide insufficient clinical information is the third most common provider error. Medical necessity determinations – otherwise known as “utilization review” – are a key aspect of managed care, and health plans will routinely demand to review additional clinical information from providers before approving coverage.

Table 2.2 Complaint Issues: Claim processing and payment problems Due to Provider Errors	2004	2005
Other provider error <sup>33</sup>	83	34
Wrong diagnostic or procedure code	68	40
Late filing of claim	30	27
Insufficient clinical information	7	8
Provider failed to bill plan <sup>34</sup>	0	23
<b>TOTAL</b>	<b>188</b>	<b>132</b>

<sup>33</sup> Complaints classified as “Other Provider Error” in Table 2.2 include claims that the provider:

- Billed the wrong insurance;
- Billed the wrong insurance site;
- Filled in the wrong claim form;
- Filled in the correct form improperly;
- Listed the wrong social security number on the claim; or
- Listed the wrong group number on the claim.

<sup>34</sup> Provider failed to bill plan was a new issue added to the sub-group, claims processing and payment problems due to provider errors for 2005.

Example:

The HCB received a complaint relating to consumer's services at an emergency department. The claim was submitted to the hospital's billing service, which used an incorrect address when submitting the claim to the health care plan. As a result, it was never processed. The consumer attempted to rectify this problem by giving the billing service the correct address several times, but the claim continued to be submitted to the wrong address. The billing company finally submitted the claim to the correct address but the plan rejected the claim due to for late filing. The HCB contacted the billing service and requested that the consumer not be responsible for this bill because of the billing services' error. The billing company paid the consumer's bill of \$536.

HCB mediators often resolve cases by contacting the provider and requesting that corrected information, or additional information, be submitted to the health plan.

**2C. Claims Processing & Payment Problems: Denials of Claims Due to Contract Dispute between the Health Plan and the Provider**

This new complaint issue for 2005 involves situations where a consumer is caught in the middle of a dispute between their health care provider and health care plan.<sup>35</sup> Generally, this dispute arises when the provider states that the health care plan has not paid the provider the appropriate amount for the health care service provided to the consumer. The health care plan states that the plan has paid the correct amount. Ultimately, the consumer may be billed by the provider during the dispute and threatened with action by a collection agency.

Table 2.3	2004	2005
<b>Complaint Issues:</b>		
<b>Claim processing and payment problems</b>		
<b>Due to Contract Dispute</b>		
Denials due to contract dispute	0	12
<b>TOTAL</b>	0	12

<sup>35</sup> This new complaint issue type, Denial due to Contract Dispute, was added in 2005 because this was the first year in which the HCB began to receive complaints regarding this issue type.

### Consumer Tips

#### Avoiding Provider and Health Plan Claim Errors

- Understand the covered benefits and exclusions of your insurance policy by reading your health insurance policy carefully.
- Take special note of the services for which you have to pay – co-payments, deductibles or co-insurance – and make sure you understand how much you have to pay and when.
- Carefully record all health care expenses that may be applied toward your deductible. Keep receipts showing co-payments and co-insurance payments.
- Ask your insurance plan or provider to explain any charges that you do not understand and to direct you to the relevant clause of your policy that relates to questionable charges.

### 3. HEALTH PLAN DENIALS OF CARE OR COVERAGE FOR CARE

Managed care and health insurance plan routinely deny coverage for health services according to established and legally permissible criteria.

Health plan denials fall into two broad categories: medical necessity denials and covered benefit denials. As shown in Table 3, for the year 2004, the HCB found that the most common complaint issue was denial due to health plan errors.

In 2005, the most common complaint issue for health plan denials of care or coverage is medical necessity denials.

Table 3	2004	2005
<b>Complaint Issue</b>		
<b>Health plan denials of care or coverage for care</b>		
Denials due to health plan errors	144	61
Medical necessity denials	114	114
Covered benefit denials	33	60
<b>TOTAL</b>	<b>291</b>	<b>235</b>

#### 2004 - 2005 Trends

From 2004 to 2005, consumer complaints to the Hotline about health plan denials of care or coverage for care slightly decreased from 11.8% to 9% of all complaints.

### 3A. Health Plan Denials of Care or Coverage: Denials Due to Health Plan Errors

Health plans sometimes erroneously issue denials and send bills to members, claiming that a member or a provider has made an error or failed to provide information when, in fact, the plans are at fault for the supposed error or lack of information. Table 3.1 shows the most common types of errors by health plans.

Table 3.1 Complaint Issues: Health plan denials of care or coverage for care Denials due to health plan errors	2004	2005
Improper “Not a covered benefit” denials	76	29
Improper “Late filing of claim” denials	23	10
Improper “Lack of Information” denials	21	8
Coordination of Benefits – primary/secondary	16	10
Other health plan denial errors <sup>36</sup>	8	4
<b>TOTAL</b>	<b>144</b>	<b>61</b>

Complaints about improper denials also arise from the following circumstances:

- Claims submitted by both members and providers to the health plan within the required time-frame are not received and processed by the proper health plan staff and the services are therefore denied for “late filing of claim”;
- Clinical information submitted by a member or a provider to support a request for coverage is not forwarded to the proper health plan department, and a denial is issued for “lack of information”;
- Health plan denies as “not a covered benefit” a health service that is in fact covered under the contract;
- A health plan processes a claim according to the wrong contract terms;
- The health plan enters or uses incorrect provider information, such as an incorrect tax ID number, and all claims submitted by that provider (using the correct number) are rejected as coming from a non-participating provider; or
- The health plan enters an incorrect diagnosis or procedure code, causing the claim to be denied.

<sup>36</sup> Complaints categorized as “Other Health Plan Denial Errors” in Table 3.1 include claims that:

- A Health Plan is denying payment because the claim is related to worker’s compensation; and
- A reason for the denial cannot be determined after a review of the consumer complaint because there was not enough information in the file and the consumer never responded to the HCB’s request for further information.

### **Denials due to Health Plan Errors: Coordination of benefits – primary/secondary**

Individuals are often covered by more than one health plan (e.g. their own plan and their spouse's plan). In these situations, health plans need to “coordinate” the benefits being provided to the member. One plan will be primary, meaning that it must pay first. Once the primary plan has paid, it issues an Explanation of Benefits (EOB). The consumer then submits this EOB to the secondary plan, which may then issue a payment to cover its responsibility.

When dependent children are involved and both parents work and have health insurance coverage, the Birthday Rule is used to determine which plan is primary for the dependent child. According to the Birthday Rule, the health plan of the parent with the first birthday in the calendar year provides primary insurance coverage for the dependent child.<sup>37</sup> In cases of divorce, the custody rule may apply. Under the custody rule, the insurance of the parent who has custody of the dependent child is the primary insurance. However, in cases of joint custody, the Birthday Rule applies.

#### Example:

A consumer called the Hotline to complain that her insurance plan was denying payment for an office visit for her daughter. The Health Care Bureau contacted the consumer's insurance company to inquire as to the reason for denial. The Health Care Bureau discovered that the consumer's husband also had health insurance coverage. Because the husband's birthday was earlier in the year than the consumer's, the husband's insurance was the primary coverage for the child. The Health Care Bureau informed the consumer who resubmitted the bill to her husband's insurance company for payment.

### **3B. Health Plan Denials of Care or Coverage: Medical Necessity Denials**

Many health plans spend significant resources determining whether a service or procedure is medically necessary. A denial of coverage on the ground that the service is not medically necessary is called an “adverse determination.” While each plan may apply and interpret medical necessity differently, common elements used to determine whether a service is medically necessary include:

- Whether the service provided is appropriate and required for the diagnosis or treatment of the patient's illness, pregnancy or injury;
- Whether the service is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications; and

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<sup>37</sup> 50 Il. Admin. Code 2009.40(b).

- Whether a less intensive or more appropriate diagnostic or treatment alternative exists this can be used in lieu of the service requested.

Insurance companies and HMOs exclude coverage for treatment that is not medically necessary because they do not want to pay for what they consider unnecessary treatment. The problem is that medical necessity is not solely determined by the judgment of the patient's physician. Just because a doctor prescribes a treatment or procedure, it does not mean the insurance company or HMO will agree it is medically necessary because medical necessity is based on the definitions within the health policy.

The medical necessity decision-making process is also known as Utilization Review (UR). UR can take place at three different points during the health care process: prior to receiving a requested service (known as pre-authorization or pre-certification), after the service has been delivered (known as retrospective review), and during the delivery of an ongoing service (known as concurrent review).

If an insurer or HMO denies a claim due to lack of medical necessity, the consumer may appeal the decision.

**For HMOs:** Appeal procedures for HMOs are set forth within Section 45 of the IMCRPRA. The patient or the physician can file an oral or written appeal with the HMO. If the HMO denies the patient's request for service during pre-authorization, the Act requires the HMO to render a decision on an appeal for urgently needed treatment within 24 hours after submission of the appeal. All other appeals must be handled within 15 business days of receipt of all necessary information. If the appeal is denied, the consumer is entitled to an external independent review. The patient, the physician and the HMO select the independent reviewer jointly. The decision of the independent reviewer is final.

**For Insurance Companies:** There are no state laws or rules governing appeals to insurance companies. The federal ERISA regulations do provide some appeal procedures. To find out if a plan is protected by those regulations, refer to the plan document. Most companies have an appeal procedure that requires a company Medical Director to review appeals of medical necessity denials. Ask a doctor to write a letter to the company explaining why the treatment is medically necessary. The appeal letter should include pertinent medical records. State law does not require an insurance company to grant an external independent review.

You may contact the HCB for assistance in filing your appeal. The HCB mediators can help the consumer assemble all necessary information and documents required for an appeal. If an appeal is denied, the consumer may contact the State of Illinois Division of Insurance for assistance. While the Division of Insurance is unable to review the consumer's medical records and make medical determinations, the Division can contact the insurance company to verify that all appeal and review processes were followed. If the matter is not resolved through this process, it is possible to seek a remedy through the legal system.

Table 3.2 shows the frequency with which Illinois consumers contacted the HCB Hotline with complaints concerning health plans' UR practices.

Table 3.2 Complaint Issues: Health plan denials of care or coverage for care Medical necessity denials	2004	2005
Other Medical Necessity Denials <sup>38</sup>	48	35
Denials of care as experimental or investigational	21	14
Retrospective denials	17	17
Pre-authorization denials	8	15
Plan considered service to be "cosmetic"	8	22
Plan considered service to be "custodial"	6	4
Concurrent denials	6	7
<b>TOTAL</b>	<b>114</b>	<b>114</b>

### Medical Necessity Denials: Pre-authorization denials

If a consumer does not obtain pre-authorization from their health care plan for a service which requires it, the plan may refuse to pay for the service, even if it would have "pre-authorized" the service if the consumer (or the attending doctor) had asked in advance. The health plan may also refuse to pay for follow-up visits for services that were not pre-authorized, even if the consumer requests approval for later visits.

#### Example:

A consumer contacted the Health Care Bureau after her insurance company denied her request to pre-authorize breast reduction surgery. The Health Care Bureau reviewed the consumer's complaint and, in an effort to assist her in appealing the denial, requested that a plastic surgeon, who specializes in breast reduction surgery, write a support letter explaining the medical necessity for the surgery. Based on the plastic surgeon's letter, the insurance company pre-authorized the breast reduction surgery, resulting in approximately \$20,000 in savings for the consumer.

If the consumer is somehow physically or mentally unable to request pre-authorization, or is prevented from doing so by some extraordinary situation, there is a chance that the plan may reverse the denial of the claim. In most cases, however, the consumer will pay a financial penalty for not receiving pre-authorization from the health plan.

<sup>38</sup> Complaints categorized as "Other Medical Necessity Denials" in Table 3.2 include claims that involve:

- Care for chronic conditions (i.e. Treatment and care given to individuals whose health problems are long term and continuing. Rehabilitation facilities, nursing homes, and mental hospitals may be considered chronic care facilities. Chronic conditions include diabetes and arthritis.);
- Acute care (i.e. Acute means sudden or severe. Symptoms appear, change, or worsen rapidly); and
- Care denied by the health plan as not medically necessary without any other explanation.

Most major medical policies and all HMOs require that elective inpatient hospital stays and major surgical procedures be pre-authorized. Failure to pre-authorize the service can result in a penalty or denial of the claim. If the policy requires pre-authorization, follow the required procedure to determine whether coverage is available. If a policy does not require pre-authorization of the service, the consumer will not know if it is covered until the claim is submitted.

**NOTE: Preauthorization by an insurance company is not a guarantee that benefits will be paid. All policy provisions, such as preexisting condition waiting periods, apply. Additionally, benefits are only payable if you are eligible for coverage on the date the service is provided.**

### **Medical Necessity Denials: Concurrent Denials**

Concurrent review occurs when the medical care is still being rendered. Concurrent review tends to occur during inpatient hospital stays, including inpatient mental health treatment. Concurrent reviews involve the review of clinical information that passes between the health care provider and the health plan. After reviewing the clinical information, the health plan makes a decision about the appropriateness of the care being provided.

Most concurrent review denials state that the patient's condition does not justify the level of care being provided. This occurs most commonly when a hospital patient's condition has improved to the point where, according to the health plan, the patient can be safely discharged.

Example:

The HCB received a complaint concerning the care for a minor child suffering from leukodystrophy, a central nervous system disease. The child was receiving skilled nursing care in the home for G-tube feedings, a tracheotomy and a respirator. The health plan reviewed the care being offered in the home and determined that the care was custodial in nature. Consequently, the health plan decided to discontinue paying for skilled nursing care in the home. The child's parents contacted the HCB to appeal the health plan's decision to deny coverage. An appeal was written and the health plan agreed to cover the skilled nursing care in the home.

### **Medical Necessity Denials: Retrospective Denials**

Retrospective review occurs, by definition, after care has been provided. Most retrospective denials occur when a consumer receives emergency health services. Under Illinois law, it is illegal to deny an emergency claim for lack of a physician referral

where the presenting symptoms meet the “prudent layperson” standard.<sup>39</sup> Under this standard, health plans must cover emergency claims when the individual has symptoms that an ordinary, prudent layperson would consider to pose a serious health risk.

The medical director of the health plan determines whether the insured meets the standard of an emergency medical condition by looking at the presenting symptoms documented in the insured’s medical record at the time care was sought.<sup>40</sup>

**Example:**

The HCB received a complaint from a consumer who had received pre-approval for bariatric surgery. After undergoing surgery, the patient’s plan requested a return of payment. The HCB assisted the consumer in filing an appeal arguing that the plan had approved the procedure as medically necessary and should provide payment. The appeal was granted and the plan approved payment in the amount of \$19,203.50.

The health plan may deny claims if: (1) emergency services were never performed; (2) the services rendered were not for an emergency medical condition; (3) the patient receiving services was not a member of the health plan; or (4) a material misrepresentation was made by the insured or the health care provider.<sup>41</sup>

**Medical Necessity Denials: Service “cosmetic” or “custodial”**

Illinois law permits health plans to exclude coverage for cosmetic and custodial services.<sup>42</sup> Generally, the determination of whether a health service is cosmetic or custodial is a medical necessity determination. Cosmetic services are generally defined as services that are provided to enhance appearance and are aesthetic in nature. Custodial services are generally defined by health plans to be medical services that do not require skilled nursing services and are provided on an on-going maintenance basis. The interpretation and application of custodial care is an area where frequent disputes arise between consumers and their health plans. The HCB mediators attempt to assist consumers in receiving coverage for these benefits.

**Medical Necessity Denials: Service “experimental” or “investigational”**

Most health plans only pay for services that have been proven safe and effective, rejecting those they deem “experimental” or “investigational.” Some providers, particularly specialists at the forefront of their field, may recommend procedures and treatments that have not yet been fully accepted in the broader health profession. Suspicious of approving a procedure that later turns out to be unsafe or ineffective, some

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<sup>39</sup> 215 ILCS 134/65.

<sup>40</sup> 215 ILCS 134-64(f).

<sup>41</sup> 215 ILCS 134/65(c).

<sup>42</sup> 50 Il. Admin. Code 2007.60.

health plans may rely on directories and manuals that list only the most widely used procedures and treatments.

Example:

The HCB received a complaint concerning a consumer who suffers from hypogammaglobulinemia which makes him susceptible to bacterial infections. The consumer’s doctors recommended IVIG treatments for the consumer. However the consumer’s insurance plan denied the IVIG treatments as investigational and, thus, not a covered benefit. The HCB Medical Advisor, in conjunction with the HCB mediator, wrote a support letter arguing that the IVIG treatments were not investigational for the consumer’s specific health condition. The insurance plan agreed to cover the IVIG procedure resulting in savings of approximately \$18,000.

### 3C. Health Plan Denials of Care or Coverage: Covered Benefit Denials

According to HCB Hotline complaints, if health plans deny coverage for a service as not a covered benefit, they often argue that the consumer has reached the benefit maximum under the health insurance contract or that treatment involves a “pre-existing condition” (see Table 3.3).

<b>Table 3.3</b>	<b>2004</b>	<b>2005</b>
<b>Complaint Issue</b>		
<b>Health plan denials of care or coverage for care</b>		
<b>Covered benefit denials</b>		
Pre-existing condition	23	26
Other covered benefit denials <sup>43</sup>	6	10
Consumer has reached benefit maximum	4	21
DME: Service considered a convenience <sup>44</sup>	0	3
<b>TOTAL</b>	<b>33</b>	<b>60</b>

<sup>43</sup> Complaints classified as “Other Covered Benefit Denials” in Table 3.3 include complaints regarding:

- Denial of Durable Medical Equipment; and
- General Denial of Coverage.

<sup>44</sup> Durable Medical Equipment – Service Considered a Convenience is a new issue type added to Covered Benefit Denials in 2005.

### **Consumer Tips**

#### **Preventing Covered Benefit Denials**

- *Before* receiving care, read your health plan Certificate of Benefits and check with your health plan to verify that the treatment is a covered benefit.
- If the procedure or treatment is not a covered benefit, discuss your needs with your doctor; your health insurance contract may cover a similar health service.
- Be sure to obtain a pre-authorization if required.
- Keep copies of all documents and notes of all conversations with your plan.
- If you receive a denial, file an appeal with your plan, stating why you think the care is covered. Get help from your doctor or from the Attorney General's Health Care Hotline at 1-877-305-5145.

### **Covered Benefit Denials: Pre-existing Condition**

In 2004 and 2005, HCB mediators assisted consumers who were denied coverage for medical care based on an alleged pre-existing condition. State and federal law require that a pre-existing condition be covered for an individual covered by group insurance unless diagnosis or treatment of the condition was actually recommended or received within the six months prior to the consumer's enrollment in the plan.

If a pre-existing condition does exist, health plans can impose a waiting period before providing coverage for the pre-existing condition, but the period cannot exceed twelve months after the enrollment date. A waiting period due to a pre-existing condition must be reduced by any amount of time the insured was previously covered under another health plan, as long as there was no break in coverage of more than 63 consecutive days between the end of membership in the prior plan and the start of membership in the current plan.<sup>45</sup>

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<sup>45</sup> Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §300gg(a)(2) and 300gg(c)(2)(A) and 215 ILCS 97/20 (A)(2) and 97/20(C)(3)(a).

Example:

A consumer transferred from one group insurance plan to another and was enrolled within 60 days. The consumer received medical treatment from a participating provider immediately after the transition. The new insurance company delayed paying the provider's bill to determine whether the condition was pre-existing. The consumer's account was sent to a collection agency by the provider. The consumer contacted the HCB to get her new insurance company to pay the \$265 bill. The HCB contacted the new insurance company and the insurance company agreed that the bill should have been paid.

**Covered Benefit Denials: Consumer Reached Benefit Maximum**

A benefit maximum is a limit on the amount of benefits a health plan will provide to a given enrollee. The health plan may limit how many times a service can be received or the overall cost of services. A few examples of benefit limits are annual or lifetime limits on prescription drugs, out-of-network benefits, or mental health care, and limits on total medical services.

Example:

The HCB received a complaint from a consumer who had paid for a mental health office visit because her health plan claimed that she had reached her annual benefit maximum. The HCB contacted the health plan and learned that the consumer has an annual benefit limit of 10 mental health office visits per year. After the HCB's inquiry, the health plan determined that the consumer had used only 9 visits of her annual maximum and accordingly refunded the consumer for the office visit that she had paid resulting in savings of approximately \$250.

**Covered Benefit Denials: Durable Medical Equipment Service Considered a Convenience**

Durable medical equipment includes items such as wheelchairs, walkers, adjustable beds, orthopedic shoes, and bed tables. Some insurance policies specifically exclude coverage for certain types of durable medical equipment. While not all insurance policies deny coverage for such items, some insurance companies may issue denials for such items based on the rationale that the items are not necessary for daily living but are merely a convenience for the consumer.

## **Consumer Tips**

### **Appealing Coverage Denials**

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- Appeal. Very few people who are denied coverage appeal, but most of those who appeal are successful. So, consider appealing any denial of coverage for care that you and your doctor think is necessary.
- If you have not received one, request that your health plan provide a clear explanation in writing of the reason why your care was denied. You have a right to this explanation and it will help you prepare your appeal.
- Ask your doctor to help by writing a letter explaining why you need the care. If possible, have your doctor call the health plan's medical director on your behalf.
- Beware of deadlines in which to file an appeal – submit it on time, send it by certified mail, and follow-up by calling to find out the status. Keep copies of everything you send to the health plan and make notes of each conversation with each person when you call the health plan.
- Do not hesitate to seek help with your appeal. Call the Attorney General's Health Care Bureau at 1-877-305-5145.

## **4. ACCESS TO SPECIALTY CARE**

HMOs require and PPOs encourage their members to receive health care services from “participating” providers who are in the plan’s network and who have agreed to accept the plan’s fixed rates as payment for services. As a general rule, HMOs cover only services received from participating providers and require a referral before covering services from a specialist (e.g., a dermatologist). If HMO members follow these rules, their personal liability for such services is limited to a small co-payment amount.

PPOs encourage members to use participating providers by generally providing full coverage (except for a co-payment) for their services. Generally, PPO members do not need a referral to see a specialist and are usually free to visit non-participating providers, but they pay a much higher share of the cost for such out-of-network care.

Table 4 Complaint Issues: Access to Specialty and Out-of-Network Care	2004	2005
Consumer received out-of-network services without pre-authorization	68	52
Consumer disputed balance owed to non-participating provider	19	21
Plan issued improper “No pre-authorization” or “No referral” denial	16	7
Other specialty care access problems <sup>46</sup>	14	17
Plan refused a referral to an out-of-network provider	12	1
Plan gave incorrect information on the “participating” status of a provider	7	9
Consumer received an in-network service without pre-authorization	7	3
Consumer received surprise bill from non-participating provider	6	9
<b>TOTAL</b>	<b>149</b>	<b>122</b>

Some health plans do not always appropriately reimburse consumers for out-of-network care. Moreover, some consumers may be confused by the rules concerning in-network and out-of-network care and the requirement for a referral or pre-authorization to access certain types of care from specialists. Additionally, plans make mistakes administering provider networks and processing requests for coverage of specialty care, adding further confusion for consumers (see Table 4 above).

### **Disputes regarding a plan’s reimbursement of a non-participating provider**

Complaints about reimbursement rates for services received from non-participating providers generally come from consumers who are members of HMO-POS or PPO plans. These consumers complain that their plan paid the provider too little, leaving them with a large balance to pay. Most plans pay a set percentage of what is called the “usual and customary rate” (UCR) charged for a particular service when a consumer receives services from an out of network provider.<sup>47</sup> The member is liable for the remainder of the UCR plus whatever balance the provider charges. Health plans determine the UCR rate and pay a percentage of that charge. In-network providers accept UCR as payment in full.

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<sup>46</sup> Complaints categorized as “Other Specialty Care Access Problems” in Table 4 involve:

- Access to Care: Inability to access specialty care physicians in certain geographic areas;
- Continuity of Care: Inability to continue treatments with the same physician; and
- Unintentional transfer from a specialty hospital.

<sup>47</sup> Health plans may use other names for this concept, such as “reasonable and customary charge,” “reasonable and customary rate,” or “allowed amount.”

**Example: Health plan payment to out-of-network provider (80% of UCR) and the amount left for HMO-POS or PPO member to pay**

Amount charged by out-of-network surgeon	\$10,000
Health plan's "usual and customary rate" for this procedure	\$ 5,500
Health plan pays provider 80% of UCR	\$ 4,400
Balance owed by member	\$ 5,600

To determine the UCR for a specific medical procedure or service in a given geographic area, insurers often analyze statistics from a national study of fees charged by medical providers, such as the data base profile set up by the Health Insurance Association of America (HIAA). Some insurers accumulate their own data using their own claim information. The insurers use these statistics to chart a range of fees for each geographical area in which services are provided. Then, when a claim for a specific treatment or procedure is submitted, the insurer pays all or part of the claim, depending on whether the amount of the claim is within the UCR allowance.

Currently in Illinois, there are no laws or rules regulating the compilation and use of UCR fee schedules. Insurers are allowed to develop UCR fee schedules and determine the percentile that they will use to process claims. Your policy should contain a definition of Usual and Customary and explain how claims will be paid. However, policies rarely state the percentage of UCR upon which your claims will be calculated.

Example:

The HCB received a complaint concerning a consumer's bill for heart surgery. The consumer had heart surgery to insert a stent. The total cost for the surgery was \$30,604.30. According to the consumer's health insurance policy, the plan is required to pay 80% of the UCR. However, the insurance plan only paid 60% of UCR, leaving the consumer with a higher balance than he was legally obligated to pay. After a HCB mediator contacted the health plan, the health plan admitted that they improperly paid only 60% of UCR. The health plan issued a check to the provider in the amount of \$5,129.00 to cover the additional 20% that they did not pay.

## **Consumer Tips**

### **How to appeal UCR determinations:**

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- Ask the treating provider to write a letter to the insurer explaining any mitigating conditions or medical complications, and to provide copies of all applicable medical records and operative reports. Often a health plan will adjust the benefit after receiving additional information that justifies the higher charge.
- Contact other health care providers in your geographic area and ask what they charge for the exact same procedure. If the fee charged by your provider is equal to or less than what other area providers charge, the health plan *may* review that information and make a favorable adjustment, depending upon the percentile they use for Usual and Customary fee determinations.
- Contact the HCB Hotline for assistance in filing your appeal.

### **Plan wrongly issued a “No pre-authorization” or “No referral” denial**

Pre-authorizations and referrals issued by one division in a health plan are sometimes not logged into the health plan’s computer system, resulting in a denial of care or coverage for care.

### **Plan refused to authorize a referral to an out-of-network provider**

Illinois law provides HMO members with the right to full coverage for out-of-network care from a health care provider if their health plan does not have a participating provider with experience and expertise in the treatment or specialty needed.<sup>48</sup> An out-of-network referral is usually sought when (1) the member’s condition is rare or unusually serious and (2) the member’s condition calls for either an uncommon medical service or a provider with unusual training and expertise that cannot be found within the health plan’s network.

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<sup>48</sup> 215 ILCS 134/40(d).

Example:

A Consumer called the HCB and explained that she was being sued for approximately \$136,000 in medical bills. She had been taken to an in-network community hospital with a bleeding intra cranial aneurysm. She was subsequently transferred to an out-of-network university hospital for surgery. The insurance plan denied payment to the university hospital because there was no referral and the provider was out-of-network.

The HCB did a comparative analysis of both hospitals and physicians to show that the patient would not have received adequate care in the community hospital. The university hospital had 763 neurosurgical cases: 192 of these were for intra cranial bleeding. The hospital had 40 neurosurgeons on staff. The community hospital had 274 neurosurgical cases: only five cases involved any type of aneurism at all. That hospital had 3 neurosurgeons on staff.

With these statistics, a support letter from our office and the community hospital, the insurance plan reversed its decision and paid \$136,000 to the hospital and doctor.

**Consumer received a surprise bill from a non-participating provider**

A health plan member, who goes to a participating provider or facility for covered services, is sometimes surprised by receiving a bill weeks later from a non-participating provider who was “brought in” during the procedure or service.

Illinois law requires that these services must be paid by the member’s health plan at the in-network rate if the services were rendered during an emergency<sup>49</sup> or if the consumer received a referral from his/her primary care physician. However, generally, if the situation is not an emergency or if no referral was given, the consumer is responsible for the bill.

Example:

The HCB received a complaint raising concerns about a bill for emergency services. A consumer went to the emergency room at an in-network hospital for chest pains. Ultimately, the consumer received a bill for \$827 from the emergency room physician who was not a participating provider in the consumer’s HMO network. However, because the emergency room services were rendered during an emergency, the \$827 bill should have been paid by the consumer’s HMO. The HCB contacted the HMO and it issued full payment.

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<sup>49</sup> 215 ILCS 134/65(a).

### **Consumer received an in-network service without pre-authorization**

As previously explained, specialty care referrals and pre-authorizations are common in HMOs. Members who want to receive certain specialized health services must first obtain a referral from their primary care physicians or a pre-authorization directly from the health plan. HMOs have the right to deny coverage for in-network services when a member fails to obtain a necessary referral or pre-authorization. The few consumer complaints received on this issue suggest that most HMO members understand the requirements necessary for referrals and pre-authorizations.

Example:

A consumer suffered from a gynecological disorder. The consumer sought the advice and care of an ob/gyn after a referral from her primary care physician. During the visit, a blood sample was taken and sent to a laboratory for processing. The health plan denied payment stating that the referral did not authorize a blood test. The consumer contacted the HCB for help. The HCB wrote an appeal letter to the health plan which included a statement from the ob/gyn that the blood test was a standard procedure the examination of the disorder involved. The health plan overruled the denial and covered the procedure resulting in a savings of \$857.

## 5. OBTAINING AND KEEPING HEALTH COVERAGE

Obtaining and keeping health insurance coverage is an important issue that prompts residents of Illinois to contact the Hotline. For 2004, 3% of complaint issues concerned access to and the affordability of health insurance coverage. However, in 2005, this percentage increased to 5.4% of all complaint issues. This increase is not surprising given that there are approximately 1.7 million uninsured people in Illinois and many other Illinois residents with employer-provided insurance who are seriously concerned about the permanence of such coverage.

Consumer complaints about obtaining and keeping health coverage break down into the eight categories listed in Table 5 below.

<b>Table 5</b>	<b>2004</b>	<b>2005</b>
<b>Complaint Issues:</b>		
<b>Problems obtaining and keeping coverage</b>		
Policy Terminated	26	39
By Employer	3	3
By health plan due to employer premium default	11	7
Other eligibility problems <sup>50</sup>	19	16
Enrollment prevented or policy terminated – consumer error	9	4
Enrollment prevented or policy terminated – health plan error	8	15
Health plan computer glitches causing eligibility problems	7	2
Affordability of Insurance <sup>51</sup>	0	16
Reduction in Policy Benefits <sup>52</sup>	0	17
No insurance <sup>53</sup>	0	15
COBRA – problems getting enrolled, employer mistakes <sup>54</sup>	0	8
<b>TOTAL</b>	<b>83</b>	<b>142</b>

Many Illinois residents have health insurance through their employers and face the possibility of losing coverage or having to change health plans whenever they lose a job or move to a new job, and whenever their employers terminate coverage. It is extremely

<sup>50</sup> Table 5 includes complaints of other eligibility complaints. These include claims that:

- Insurance companies are raising premiums, resulting in a reduction to care;
- Lack of insurance;
- Riders on the insurance policy are reducing coverage; and
- Consumers are unable to access coverage because they have not received their insurance card.

<sup>51</sup> Affordability of Insurance is a new issue type added in 2005.

<sup>52</sup> Reduction in policy benefits is a new issue type added in 2005.

<sup>53</sup> No insurance is a new issue type added in 2005.

<sup>54</sup> COBRA – problems getting enrolled, employer mistakes is a new issue type added in 2005.

difficult for consumers to understand that they might lose health coverage while still working at the same job. Judging from complaint patterns, this is a crisis many Illinois residents confront.

### **Policy termination**

The 26 complaints classified in this sub-section either arose from an employer’s deliberate termination of its group health insurance policy or its failure to make premium payments to the health plan, as well as from consumer errors regarding the payment of their premium or the health plan terminating the consumer’s policy after post-claim underwriting. In many of these cases, the employer was collecting premium payments from the employees’ paychecks – and allowing the employees to continue to believe that they had health coverage – but was failing to forward the premiums to the health plan. Many of these premium non-payment cases involved businesses that were in serious financial difficulty or in bankruptcy. Employees frequently discovered, after they had already received care, that their plan had been terminated.

### **COBRA – Problems getting enrolled, employer mistakes**

Both federal and state law require employers to offer most terminated employees and their dependents continued health coverage for either 18, 29 or 36 months, if employees

#### **Consumer Tips**

##### Protecting your COBRA rights

- When you lose or leave your job, ask your employer for information and forms to enroll in COBRA continuation coverage. If possible, do so in advance.
- Always comply with all COBRA enrollment and premium payment deadlines.
- For more information, go to <http://www.ins.state.il.us/healthInsurance/continueCobra.htm>
- If your employer refuses to comply, contact the Attorney General’s Health Care Hotline at 1-877-305-5145.

pay the premiums. This continuation coverage is commonly referred to as “COBRA”.<sup>55</sup> However, few people take advantage of their COBRA rights because the cost is relatively expensive.

Many of the Hotline’s COBRA-related complaints came from employees facing the possibility of losing their jobs who wanted to make sure they understood in advance how

<sup>55</sup> COBRA is an acronym for the federal *Consolidated Omnibus Budget Reconciliation Act of 1985*, 29 U.S.C.A. §1161 *et. seq.* This law applies to employees and their dependents who would otherwise lose their insurance coverage as a result of a “qualifying event”. The length of additional coverage they receive (18, 29 or 36 months) depends on the qualifying event. Illinois state law provides similar “continuation coverage” to employees not covered by federal COBRA – specifically, those working for employers with under 20 employees. For Illinois state law, see 215 ILCS 5/367(e) and 215 ILCS 125/4-9.2.

to enroll in COBRA. Many others, however, were from consumers whose employers had failed in one way or another to fulfill their clear legal obligations, resulting in consumers, and often their families, losing coverage. The most common failures by employers include: (1) not informing employees in advance about COBRA; (2) not providing them with enrollment forms and other materials; and (3) not telling them about filing deadlines.

Example:

A consumer involved in one of the HCB complaints explained that she left her place of employment and wanted to continue her health insurance coverage. The employer believed he was not obligated to offer continuation coverage because it had less than 20 employees and because federal law only requires employers to offer continuation of coverage for groups of 20 or more people. The HCB contacted the employer and informed the company that Illinois law requires employers with less than 20 employees to offer continued coverage.

Employers' failures often leave consumers without health insurance coverage at a time when they are most vulnerable financially. Unfortunately, consumers are often the last to learn that their coverage has been terminated, receiving denial notices and even collection notices when they thought they would be fully covered.

**Affordability of Insurance**

An increasing number of consumers called the Hotline in 2004 and 2005 to request information regarding advertised insurance plans and medical or prescription drug discount cards. Discount cards offer consumers a percentage off the average price of medical treatment or prescription drugs.

These plans can be an attractive alternative to those without insurance, or with high deductible insurance plans, because these plans do not involve medical underwriting and do not exclude people because of preexisting conditions. While some discount plans are provided legitimately by insurers or other businesses, the HCB received numerous complaints from consumers who had purchased plans from discount card companies

**Enforcement Actions**

Protecting the Uninsured

- The HCB investigated entities which sell discount health plans to Illinois consumers. The HCB developed a checklist for consumers to determine whether the company is legitimate, and has drafted sample legislation to amend Illinois law requiring additional disclosures and financial obligations for discount health plans.
- The HCB filed a lawsuit against IAB, which sells discount health care cards to consumers. The lawsuit alleges that IAB misleads consumers to believe that they are purchasing health insurance when, in fact, they are only purchasing a discount card.
- The HCB settled a lawsuit against Argus Health Plans which sold reduced fee dental plans to consumers. The settlement included \$12,949.35 in restitution for consumers and a permanent injunction.

which were not registered with the Division of Insurance as is required in Illinois. Additionally, the discount card companies were engaging in deceptive business practices and false advertising. The HCB has developed a checklist about discount cards to help consumers purchase such cards wisely. You can obtain the checklist on our website at [www.illinoisattorneygeneral.gov/consumers/health\\_care\\_discount\\_plan.pdf](http://www.illinoisattorneygeneral.gov/consumers/health_care_discount_plan.pdf) or by calling the HCB Hotline.

**Consumer Tip**  
**Unlicensed Health Plans**

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Before purchasing a health insurance policy, always check with the Illinois Division of Insurance at 1-877-527-9431 to confirm that the health plan is licensed to do business in the State of Illinois.

## 6. CONSUMER ACCESS TO PRESCRIPTION DRUGS

Many of the issues already discussed – whether they relate to denials of coverage, access to specialty care, problems obtaining or losing coverage, or other issues – involved prescriptions in some manner. In a number of cases, however, the real issue is the prescription itself – whether, for example, it is medically necessary or covered under the member’s plan. These cases are summarized here for separate discussion (see Table 6 below).

Table 6 Complaint Issues: Consumer access to prescription drugs	2004	2005
Mail orders – return/reimbursement	20	36
Other prescription issues <sup>56</sup>	17	10
Inquiries re: Prescription Benefits & Formularies	11	0
Plan / pharmacist cuts the number of pills dispensed per visit	4	4
Plan denies pre-authorization for medication	3	2
Formulary Issues	2	10
Adverse reaction/side effect <sup>57</sup>	0	5
Price <sup>58</sup>	0	16
<b>TOTAL</b>	<b>57</b>	<b>83</b>

<sup>56</sup> Table 6 includes complaints about “Other Prescription Issues”. These include claims such as:

- Price Gouging; and
- Adverse reactions.

<sup>57</sup> Adverse reaction/side effect is a new issue type added in 2005.

<sup>58</sup> Price is a new issue type added in 2005.

## Formulary Issues: preferred drugs, generics, substitution

With drug costs rising faster than the rate of overall health expenditures,<sup>59</sup> health plans are devoting more resources to containing the cost of prescription benefits, primarily through the use of formularies. A formulary is a list of prescription medications and, sometimes, non-prescription medications covered by a health plan. If a medication is on the formulary, it is covered; any other medication is not covered, or is covered only partially. Formularies are usually managed on behalf of health plans by companies known as pharmacy benefit managers (PBMs).

Formularies are increasingly structured in tiers, with lower co-payments for “preferred” drugs and higher co-payments for others. Preferred drugs are those a health plan would prefer its members use, in contrast to other, usually more expensive, drugs. Preferred drugs are usually brand-name drugs that are cheaper for the health plan than other brand-name drugs due to bulk discounts or manufacturer rebates, but may also be generic<sup>60</sup> versions of brand-name drugs. Health plans encourage the substitution of generics for brand-name drugs whenever possible. Pharmacists are allowed to substitute a generic for a name-brand drug at the time the prescription is filled unless the prescribing physician has written “do not substitute” on the prescription.<sup>61</sup>

### Enforcement Actions

#### Consumer Access to Prescription Drugs

- The Illinois Attorney General, along with 19 other state Attorneys General, sued Medco Health Solutions, Inc., the world’s largest PBM. The suit alleged that although Medco claimed to save patients and health plans money by encouraging physicians to switch patients to different prescription drugs, the drug switches generally benefited Medco. The suit also alleged that the drug switches resulted in increased costs to consumers. The case resulted in a settlement whereby Medco agreed to disclose cost savings and financial incentives, and pay up to \$2.5 million in reimbursement to patients and \$20.2 million in *cy pres* payments.

<sup>59</sup> The Centers for Medicare and Medicaid Services (CMS) predicted that prescription drug spending growth between 2001 and 2011 will exceed total health spending growth by almost 5 percentage points per year on average, so that by 2011 prescription drug spending will account for 14.7% of total health expenditures, compared with its 2000 level of 9.4%. Stephen Heffler *et. al.*, “Health Spending Projections for 2001 – 2011: The Latest Outlook,” *Health Affairs*, March/April 2002, p. 215.

<sup>60</sup> A generic drug is defined by the Food and Drug Administration as “a copy [of a brand name drug] that is the same as a brand-name drug in dosage, safety, strength, how it is taken, quality, performance and intended use.” See [www.fda.gov/cder/consumerinfo/generics\\_q&a.htm](http://www.fda.gov/cder/consumerinfo/generics_q&a.htm).

<sup>61</sup> 225 ILCS 85/25.

The HCB received some consumer complaints involving formulary issues. Most commonly, a consumer was unable to fill a prescription for a drug because it was not on the health plan formulary. In some cases, the health plan told the consumer that it would only pay for the generic version of a drug – i.e., it was insisting on substituting a generic for the brand – when the consumer believed there was no generic equivalent to the brand-name drug.

### **Mail order – return/reimbursement**

In 2004 and 2005, the HCB received complaint issues about prescriptions filled through mail orders. Many employers now require that consumers obtain certain prescription drugs through a mail order pharmacy to help reduce the cost of insurance. The most common complaint involved problems canceling prescription orders before the pharmacy benefit manager sent all or part of orders and billed the consumer.

Example:

A consumer called the HCB to complain that his mail order prescription service charged him too much for his medication co-payment. The consumer's usual co-payment fee for the specific drug was \$58.77. However, the consumer was charged \$158.77. The Health Care Bureau contacted the mail order prescription service to inquire as to the reason for the large increase. The mail order prescription service checked its records and verified that the consumer's prescription was processed at an incorrect usual and customary price per tablet which resulted in an overpayment of \$100. The consumer was credited \$100.

### **Plan/Pharmacist cuts the number of pills dispensed per visit**

Consumers experience another restriction on their access to health services when a plan refuses to fill an entire prescription and insists that the consumer return to the pharmacy another day for the remainder of the prescription medication. While such requests are occasionally imposed by a policy of the member's health plan or the Pharmacy Benefit Manager hired by the plan to administer the prescription benefit, the pharmacy often explains the practice to the member as being the result of a limited supply on the shelf or as being required by the Food and Drug Administration. At other times, pharmacies do not offer any explanation. The practical effect of this practice, aside from causing the consumer the inconvenience of additional travel, is that the consumer often has to make an additional co-payment to receive the remainder of the prescription. This can create an unexpected financial burden for those who maintain their health with prescription medications.

The Illinois Attorney General's Office, along with 20 other state attorneys general, entered into a settlement with CVS Pharmacy regarding this issue in 2002. CVS agreed to pay \$1.1 million and implement policies to address the partial-fill issue by not

collecting money until the entire prescription is delivered to the consumer, and disclosing the reason why the prescription will only be partially filled.

Example:  
 A consumer contacted the Health Care Bureau stating that his insurance company had recently cut the number of pills that may be dispensed for his daughter’s prescription. The consumer wanted additional information as to why this occurred. The Health Care Bureau contacted the insurance company and discovered that the insurance company had recently amended the insured’s certificate of benefits to limit the amount of drugs dispensed per visit. The Health Care Bureau informed the consumer of this new benefit change.

**7. ADVERTISING**

The HCB received complaints from consumers regarding advertisements by health care providers, dietary supplements/herbal remedies, discount health plans and other health care entities. Generally, these complaints allege that the consumers were not fully informed by the advertisement or that the advertisement may have included false or misleading information regarding the product or service being provided.

Table 7 Complaint Issues: Advertising	2004	2005
Advertising	176	155
<b>TOTAL</b>	<b>176</b>	<b>155</b>

**Enforcement Actions**  
 Advertising

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- The HCB investigated 7 entities for complaints of false advertising. These entities all sold dietary or herbal supplements and used advertisements containing outrageous claims regarding their efficacy. The HCB sent cease and desist letters to these entities advising them that their claims were unsubstantiated and illegal. Additionally, the HCB referred some of these entities to the Federal Trade Commission.
- The HCB filed a lawsuit against Diet Patch, Inc. under the Illinois Consumer Fraud Act for unsubstantiated scientific and health claims regarding the Amazing Diet Patch. Diet Patch, Inc. sold the Amazing Diet Patch and made claims on its website that consumers could lose 3 – 7 pounds per week without diet or exercise. The HCB permanently enjoined Diet Patch from engaging in this conduct and obtained consumer restitution and a civil penalty in the amount of \$25,000.

## 8. QUALITY OF CARE

Complaints regarding quality of care fall into two main categories: (1) quality of care by a provider and (2) quality of care regarding durable medical equipment, glasses, or dentures. In the context of quality of care by a

<b>Table 8 Complaint Issues:</b>	<b>2004</b>	<b>2005</b>
<b>Quality of Care</b>		
Quality of Care <sup>62</sup>	158	0
Quality of Care: Provider	0	172
Quality of Care: DME	0	20
<b>TOTAL</b>	<b>158</b>	<b>192</b>

provider, consumers tend to express dissatisfaction with the manner in which the services or medical treatment were provided or the general demeanor of the health care professional. The HCB usually refers quality of care complaints regarding providers to the Illinois Department of Financial and Professional Regulation because that agency licenses and disciplines medical providers. Complaints regarding quality of care for durable medical equipment, glasses or dentures usually involve claims that the equipment is faulty, does not fit properly or is not the proper prescription.

## 9. MISINFORMATION

Misinformation complaints cover a wide variety of topics. However, the two most common types of complaints regarding misinformation include: (1) claims that a provider incorrectly told a

<b>Table 9</b>	<b>2004</b>	<b>2005</b>
<b>Complaint Issue</b>		
<b>Misinformation</b>		
Misinformation	105	178
<b>TOTAL</b>	<b>105</b>	<b>178</b>

consumer that he is an in-network provider for the consumer's health plan and (2) claims that a provider quoted a price for a medical treatment or service but then charged a higher price. Generally, these problems are the result of a mistake by the provider or consumer, and do not involve fraud or intentionally deceptive practices

<sup>62</sup> Quality of Care was changed in 2005 into 2 new specific issues: Quality of care for providers and quality of care for durable medical equipment.

## 10. MISCELLANEOUS ISSUES

This section includes calls to the HCB that do not directly relate to payment or processing errors, billing errors, eligibility problems, or access to prescription drugs. Table 10 lists the issues which are unrelated to health plan, provider or pharmacy mistakes. The largest category, request for information, includes calls to the HCB with legal inquiries regarding health care laws, how to access specific health services, or informational requests about the HCB. The

<b>Table 10</b>	<b>2004</b>	<b>2005</b>
<b>Complaint Issues:</b>		
<b>Miscellaneous Issues</b>		
Request for Information	122	140
Other	94	74
No Jurisdiction	84	69
For Your Information	81	141
Medical Records: Non-release	41	30
Telemarketing	11	6
Policy Refuse to Issue	2	3
Medical Records: HIPAA Violation <sup>63</sup>	0	8
Medical Records: Copying Fees <sup>64</sup>	0	5
Legal Inquiry <sup>65</sup>	0	23
<b>TOTAL</b>	<b>435</b>	<b>499</b>

For Your Information category includes informational materials sent by consumers to the HCB to inform the office about relevant health care issues, topics and organizations.

<sup>63</sup> Medical records: HIPAA violation is a new issue type added in 2005.

<sup>64</sup> Medical records: Copying fees is a new issue type added in 2005.

<sup>65</sup> Legal inquiry is a new issue type added in 2005.

**APPENDIX A**  
**DETAILED SUMMARY OF 2004**  
**HEALTH CARE BUREAU COMPLAINT ISSUES**

The following is a detailed summary of the complaints received by the HCB for the year 2004.

<b>IMPROPER BILLING BY PROVIDERS (547)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>
<b>None</b>	<ul style="list-style-type: none"> <li>• 189</li> <li>• 181</li> <li>• 92</li> <li>• 43</li> <li>• 24</li> <li>• 18</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Wrong amount/wrong code</b></li> <li>• <b>Other billing problems</b></li> <li>• <b>Bill already paid</b></li> <li>• <b>Wrong person billed</b></li> <li>• <b>Balance billing</b></li> <li>• <b>Usual and customary billing issues</b></li> </ul>

<b>CLAIM PROCESSING AND PAYMENT PROBLEMS BY HEALTH PLANS &amp; PROVIDERS(459)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>
<b>Due to Health Plan Errors (271)</b>	<ul style="list-style-type: none"> <li>• 161</li> <li>• 64</li> <li>• 18</li> <li>• 15</li> <li>• 11</li> <li>• 2</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Health plan not processing/paying claims</b></li> <li>• <b>Health plan paid wrong amount</b></li> <li>• <b>Other Health plan processing/payment problems</b></li> <li>• <b>Health plan error regarding deductible/co-payment</b></li> <li>• <b>Health plan overpaid provider</b></li> <li>• <b>Health plan paid wrong party</b></li> </ul>
<b>Due to Provider Errors (188)</b>	<ul style="list-style-type: none"> <li>• 83</li> <li>• 68</li> <li>• 30</li> <li>• 7</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Other provider error</b></li> <li>• <b>Provider used wrong diagnostic/procedure code</b></li> <li>• <b>Provider filed claim late</b></li> <li>• <b>Provider did not provide sufficient clinical</b></li> </ul>

		<b>information to plan</b>
<b>HEALTH PLAN DENIALS OF CARE OR COVERAGE (291)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>
<b>Denials Due to Health Plan Errors</b>	<ul style="list-style-type: none"> <li>• 144</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Coordination of Benefits</b></li> <li>• <b>Late Filing of Claim</b></li> <li>• <b>Lack of Information</b></li> <li>• <b>Not a Covered Benefit Denial</b></li> <li>• <b>Other Health Plan Denial Errors</b></li> </ul>
<b>Medical Necessity Denials</b>	<ul style="list-style-type: none"> <li>• 114</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Preauthorization Denials</b></li> <li>• <b>Retrospective Denials</b></li> <li>• <b>Concurrent Denials</b></li> <li>• <b>Care is Experimental or Investigational</b></li> <li>• <b>Care is Cosmetic</b></li> <li>• <b>Care is Custodial</b></li> <li>• <b>Other Medical Necessity Denials</b></li> </ul>
<b>Covered Benefit Denials</b>	<ul style="list-style-type: none"> <li>• 33</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Pre-existing Condition</b></li> <li>• <b>Consumer has reached their policy benefit maximum</b></li> <li>• <b>Other covered benefit denials</b></li> </ul>

<b>ADVERTISING (176)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Complaint Examples</b>
<b>None</b>	<ul style="list-style-type: none"> <li>• 176</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Fax Advertisements by Discount Health Cards</b></li> <li>• <b>Internet Advertisements by Dietary Supplements or Herbal Remedies</b></li> <li>• <b>Newspaper Advertisements by Providers for Clinics or Offices</b></li> </ul>

<b>QUALITY OF CARE (158)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Complaint Examples</b>
<b>None</b>	<ul style="list-style-type: none"> <li>• <b>158</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Dissatisfaction with Dental Work</b></li> <li>• <b>Dissatisfaction with Provider's Medical Treatment/Services</b></li> <li>• <b>Glasses Wrong Prescription</b></li> <li>• <b>Durable Medical Equipment Faulty</b></li> </ul>

<b>PROBLEMS ACCESSING SPECIALTY CARE (149)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>
<b>None</b>	<ul style="list-style-type: none"> <li>• <b>68</b></li> <li>• <b>19</b></li> <li>• <b>16</b></li> <li>• <b>14</b></li> <li>• <b>12</b></li> <li>• <b>7</b></li> <li>• <b>7</b></li> <li>• <b>6</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Consumer received Out-of-Network Services</b></li> <li>• <b>Consumer Disputes Balance Owed to Non-Participating Provider</b></li> <li>• <b>Health Plan Issued a "No Pre-authorization/No Referral Denial"</b></li> <li>• <b>Other Specialty Care Access Problem</b></li> <li>• <b>Health Plan Refused Referral to an Out-of-Network Provider</b></li> <li>• <b>Health Plan Gave Wrong Information on Participating Provider Status</b></li> <li>• <b>Consumer Received In-Network Service Without Pre-Authorization</b></li> <li>• <b>Consumer Received a Surprise Bill from a Non-Participating Provider</b></li> </ul>

<b>MISINFORMATION (105)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Complaint Examples</b>
<b>None</b>	<ul style="list-style-type: none"> <li>• <b>105</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Provider Tells Consumer He is an In-Network Provider When He is Not</b></li> </ul>

		<ul style="list-style-type: none"> <li>• <b>Provider Quotes Wrong Price</b></li> </ul>
<b>PROBLEMS WITH OBTAINING AND KEEPING COVERAGE (83)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>
None	<ul style="list-style-type: none"> <li>• 26</li> <li>• 19</li> <li>• 11</li> <li>• 9</li> <li>• 8</li> <li>• 7</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Policy Terminated</b></li> <li>• <b>Other Eligibility Problems</b></li> <li>• <b>Policy Terminated by Health Plan Due to Employer Premium Default</b></li> <li>• <b>Consumer Error Regarding Enrollment or Termination of Policy</b></li> <li>• <b>Health Plan Error Regarding Enrollment or Termination of Policy</b></li> <li>• <b>Health Plan Computer Glitches Caused Eligibility Problems</b></li> </ul>

<b>ACCESS TO PRESCRIPTION DRUGS (57)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>
None	<ul style="list-style-type: none"> <li>• 20</li> <li>• 17</li> <li>• 11</li> <li>• 4</li> <li>• 3</li> <li>• 2</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Mail Order Pharmacy</b></li> <li>• <b>Other Prescription Drug Issues</b></li> <li>• <b>Inquiries Regarding Prescription Benefits and Formularies</b></li> <li>• <b>Health Plan Cut Number of Drugs Dispensed Per Visit</b></li> <li>• <b>Health Plan Denies Pre-Authorization for Medication</b></li> <li>• <b>Formulary Issues</b></li> </ul>

<b>MISCELLANEOUS ISSUES (435)</b>	
<b>NUMBER OF COMPLAINTS</b>	<b>ISSUES</b>
<ul style="list-style-type: none"> <li>• 122</li> <li>• 84</li> <li>• 81</li> <li>• 41</li> <li>• 11</li> <li>• 2</li> <li>• 94</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Request for Information</b></li> <li>• <b>No jurisdiction</b></li> <li>• <b>For Your Information</b></li> <li>• <b>Non-release of Medical Records</b></li> <li>• <b>Telemarketing</b></li> <li>• <b>Refuse to issue policy</b></li> <li>• <b>Other</b></li> </ul>

**APPENDIX B**  
**DETAILED SUMMARY OF 2005**  
**HEALTH CARE BUREAU COMPLAINT ISSUES**

The following is a detailed summary of the complaints received by the HCB for the year 2005.

<b>IMPROPER BILLING BY PROVIDERS (706)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>
<b>None</b>	<ul style="list-style-type: none"> <li>• 195</li> <li>• 109</li> <li>• 92</li> <li>• 63</li> <li>• 55</li> <li>• 43</li> <li>• 26</li> <li>• 25</li> <li>• 25</li> <li>• 18</li> <li>• 18</li> <li>• 13</li> <li>• 12</li> <li>• 12</li> </ul>	<ul style="list-style-type: none"> <li>• Wrong amount/wrong code</li> <li>• Consumer requests refund</li> <li>• Bill already paid</li> <li>• Other billing problems</li> <li>• Fraudulent billing</li> <li>• Services never received</li> <li>• Usual and customary</li> <li>• Balance billing</li> <li>• Wrong person billed</li> <li>• Refuse to issue itemized bill</li> <li>• Unknown bill</li> <li>• Bill never received</li> <li>• Will not remove from credit bureau</li> <li>• Late fees/Interest charges</li> </ul>

<b>CLAIM PROCESSING AND PAYMENT PROBLEMS BY HEALTH PLANS &amp; PROVIDERS (296)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>
<b>Due to Health Plan Errors (152)</b>	<ul style="list-style-type: none"> <li>• 84</li> <li>• 46</li> <li>• 11</li> <li>• 6</li> <li>• 5</li> </ul>	<ul style="list-style-type: none"> <li>• Health plan not processing/paying claims</li> <li>• Health plan paid wrong amount</li> <li>• Other Health plan processing/payment problems</li> <li>• Health plan overpaid provider</li> <li>• Health plan error regarding deductible/co-</li> </ul>

	<ul style="list-style-type: none"> <li>• 0</li> </ul>	<p>payment</p> <ul style="list-style-type: none"> <li>• Health plan paid wrong party</li> </ul>
<b>Due to Provider Errors (132)</b>	<ul style="list-style-type: none"> <li>• 40</li> <li>• 34</li> <li>• 27</li> <li>• 23</li> <li>• 8</li> </ul>	<ul style="list-style-type: none"> <li>• Provider used wrong diagnostic/procedure code</li> <li>• Other provider error</li> <li>• Provider filed claim late</li> <li>• Provider failed to bill plan</li> <li>• Provider did not provide sufficient clinical information to plan</li> </ul>
<b>Due to Contract Dispute</b>	<ul style="list-style-type: none"> <li>• 12</li> </ul>	<ul style="list-style-type: none"> <li>• Health plan not paying and provider charging higher amount to consumer due to contractual dispute</li> </ul>

<b>HEALTH PLAN DENIALS OF CARE OR COVERAGE (235)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>
<b>Medical Necessity Denials</b>	<ul style="list-style-type: none"> <li>• 114</li> </ul>	<ul style="list-style-type: none"> <li>• Preauthorization Denials</li> <li>• Retrospective Denials</li> <li>• Concurrent Denials</li> <li>• Care is Experimental or Investigational</li> <li>• Care is Cosmetic</li> <li>• Care is Custodial</li> <li>• Other Medical Necessity</li> </ul>
<b>Denials Due to Health Plan Errors</b>	<ul style="list-style-type: none"> <li>• 61</li> </ul>	<ul style="list-style-type: none"> <li>• Denials Coordination of Benefits</li> <li>• Late Filing of Claim</li> <li>• Lack of Information</li> <li>• Not a Covered Benefit Denial</li> <li>• Other Health Plan Denial Errors</li> </ul>

<b>Covered Benefit Denials</b>	<ul style="list-style-type: none"> <li>• 60</li> </ul>	<ul style="list-style-type: none"> <li>• Pre-existing Condition</li> <li>• Consumer has reached their policy benefit maximum</li> <li>• Other covered benefit denials</li> </ul>
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<b>QUALITY OF CARE (192)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Complaint Examples</b>
<ul style="list-style-type: none"> <li>• Provider</li> <li>• DME</li> </ul>	<ul style="list-style-type: none"> <li>• 172</li> <li>• 20</li> </ul>	<ul style="list-style-type: none"> <li>• Dissatisfaction with Dental Work</li> <li>• Dissatisfaction with Provider's Medical Treatment/Services</li> <li>• Glasses Wrong Prescription</li> <li>• Durable Medical Equipment Faulty</li> </ul>

<b>MISINFORMATION (178)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Complaint Examples</b>
None	<ul style="list-style-type: none"> <li>• 178</li> </ul>	<ul style="list-style-type: none"> <li>• Provider Tells Consumer He is an In-Network Provider When He is Not</li> <li>• Provider Quotes Wrong Price</li> </ul>

<b>ADVERTISING (155)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Complaint Examples</b>
None	<ul style="list-style-type: none"> <li>• 176</li> </ul>	<ul style="list-style-type: none"> <li>• Fax Advertisements by Discount Health Cards</li> <li>• Internet Advertisements by Dietary Supplements or Herbal Remedies</li> <li>• Newspaper Advertisements by Providers for Clinics or Offices</li> </ul>

<b>PROBLEMS WITH OBTAINING AND KEEPING COVERAGE (142)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>

None	<ul style="list-style-type: none"> <li>• 49</li> <li>• 17</li> <li>• 16</li> <li>• 16</li> <li>• 15</li>   <li>• 15</li> <li>• 8</li>   <li>• 4</li>   <li>• 2</li> </ul>	<ul style="list-style-type: none"> <li>• Policy Terminated</li> <li>• Benefit Reduction</li> <li>• Other Eligibility Problems</li> <li>• Affordability of Insurance</li> <li>• Health Plan Error Regarding Enrollment or Termination of Policy</li>   <li>• No Insurance</li> <li>• COBRA: Problems getting enrolled; employer mistakes</li> <li>• Consumer Error Regarding Enrollment or Termination of Policy</li>   <li>• Health Plan Computer Glitches Caused Eligibility Problems</li> </ul>
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<b>PROBLEMS ACCESSING SPECIALTY CARE (122)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>
None	<ul style="list-style-type: none"> <li>• 52</li> <li>• 21</li> <li>• 17</li> <li>• 9</li> <li>• 9</li> <li>• 7</li> <li>• 6</li> <li>• 6</li> <li>• 1</li> </ul>	<ul style="list-style-type: none"> <li>• Consumer received Out-of-Network Services</li> <li>• Consumer Disputes Balance Owed to Non-Participating Provider</li> <li>• Other Specialty Care Access Problem</li> <li>• Consumer Received a Surprise Bill from a Non-Participating Provider</li> <li>• Health Plan Gave Wrong Information on Participating Provider Status</li> <li>• Health Plan Issued a “No Pre-authorization/No Referral Denial”</li> <li>• Consumer Received In-Network Service Without Pre-Authorization</li> <li>• Other Specialty Care Access Problem</li> <li>• Health Plan Refused Referral to an Out-of-Network Provider</li> </ul>

<b>ACCESS TO PRESCRIPTION DRUGS (83)</b>		
<b>Sub-Categories</b>	<b>Number of Complaints</b>	<b>Issues</b>
None	<ul style="list-style-type: none"> <li>• 36</li> <li>• 16</li> <li>• 10</li> <li>• 10</li> <li>• 5</li> <li>• 4</li> <li>• 2</li> </ul>	<ul style="list-style-type: none"> <li>• Mail Order Pharmacy</li> <li>• Price</li> <li>• Other Prescription Drug Issues</li> <li>• Formulary Issues</li> <li>• Adverse Reaction/Side Effect</li> <li>• Health Plan Cut Number of Drugs Dispensed Per Visit</li> <li>• Health Plan Denies Pre-Authorization for Medication</li> </ul>

<b>MISCELLANEOUS ISSUES (499)</b>	
<b>NUMBER OF COMPLAINTS</b>	<b>ISSUES</b>
<ul style="list-style-type: none"> <li>• 141</li> <li>• 140</li> <li>• 74</li> <li>• 69</li> <li>• 43</li> <li>• 23</li> <li>• 6</li> <li>• 3</li> </ul>	<ul style="list-style-type: none"> <li>• For Your Information</li> <li>• Request for Information</li> <li>• Other</li> <li>• No jurisdiction</li> <li>• Medical Record Issues</li> <li>• Legal Inquiry</li> <li>• Telemarketing</li> <li>• Refuse to issue policy</li> </ul>