National Health Reform—Comparison to Current Illinois Law

Illinois Department of Insurance
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Note: This information was developed to provide consumers with general information and guidance about insurance coverage and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

Issue	**Current Illinois Law**	**PPACA Section**	**Patient Protection and Affordable Care Act of 2010 ("PPACA")**
IMMEDIATE INSURANCE MARKET REFORMS -- Effective for Plan Years beginning on or after September 23, 2010 (unless indicated otherwise below) --			
Lifetime/Annual Limits	Insurers • In general, Illinois law does not restrict the use of annual or lifetime dollar limits by health insurers. HMOs • Illinois law does not specifically prohibit annual or lifetime dollar limits for HMO plans. o However, HMO plans must provide for a certain minimum level of basic health care services, regardless of the dollar value of claims incurred within a given year or during the lifetime of the enrollee. Individual or group HMO plans containing an annual or lifetime dollar limit are not approved for sale by the Department. *(215 ILCS 125/5-7; 50 Ill. Adm. Code 5421.130)*	Sec. 1001 (as amended by Sec. 10101(a)) Public Health Service Act Sec. 2711	• PPACA prohibits the use of lifetime dollar limits on "essential health benefits" for all individual and group plans, including self-insured plans.[1] • Prior to 2014, PPACA allows insurance companies and self-insured plans to establish "restricted" annual limits.[2] Beginning in 2014, annual limits will be prohibited entirely. o *Does not apply to grandfathered individual plans*.[3]

[1] See page 13 below for categories of essential health benefits. See here for the Department's fact sheet explaining self-insured health plans.
[2] The definition of "restricted annual limit" will be determined by the U.S. Department of Health and Human Services (HHS) in a manner that ensures "that access to needed services is made available with a minimal impact on premiums."
[3] In general, a grandfathered plan refers to any coverage in which an individual was enrolled as of March 23, 2010, the date on which PPACA was signed into law. See here for more information on grandfathered plans under PPACA.

Rescissions	• Illinois law allows an insurance company to "rescind" (terminate the policy back to the original effective date) a health insurance policy any time within the first 2 years after the policy is issued if the company finds an omission or incorrect response on an application—whether intentional or not. *(50 Ill. Adm. Code 2005.40(d))* o After 2 years, an insurance company can rescind a health insurance policy only in cases of fraud. *(215 ILCS 5/357.3)* • A recent survey by the National Association of Insurance Commissioners (NAIC) revealed that Illinois has more rescissions by volume than any state in the entire country—almost fifty percent (50%) more than California. o In one instance, an insurer attempted to rescind a teenager's coverage on her family policy because her parents failed to disclose her congenital deformity—she wore braces.	Sec. 1001 PHSA Sec. 2712	• PPACA prohibits rescissions, except in cases where an individual "has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage."
Preventive Benefits	• Illinois law requires insurers and HMOs to provide certain mandated benefits, including preventive benefits such as mammograms and other cancer screenings. See here for a comprehensive list of mandated benefits. • Many other preventive benefits may not be included in a health insurance policy. Those benefits that are included may be subject to significant cost-sharing requirements (including deductibles and co-payments).	Sec. 1001 PHSA Sec. 2713 *(Does not apply to grandfathered plans)*	• PPACA requires all individual and group plans, including self-insured plans, to provide first-dollar coverage for a defined list of preventive health services. • In other words, insurers will be required to include wellness and prevention benefits such as immunizations and screenings, without cost to the policyholder.

Coverage of Young Adult Children	• Illinois law requires individual and group health insurance policies that offer dependent coverage to allow unmarried young adults up to age 26, or up to age 30 for military veterans, to remain covered under a parent's health insurance plan. *(215 ILCS 5/356z.12)* • Under the Illinois law, insurance companies are allowed to establish additional eligibility requirements (for example, that a young adult have the same permanent mailing address as the parent), provided that such requirements do not act as a substitute for age or student status. • Like other state insurance laws, the Illinois law does not apply to self-insured employer policies. See here for the Department's fact sheet on Young Adult Dependent Coverage.	Sec. 1001 (as amended by Section 2301(b) of the Health Care and Education Reconciliation Act of 2010) PHSA Sec. 2714	• PPACA requires all individual and group plans that offer dependent coverage—including self-insured employer plans—to allow young adults up to age 26 to remain covered on a parent's plan. o For grandfathered self-insured plans, the plan may exclude coverage for a dependent who has access to another group plan (*e.g.*, through the dependent's own employer). • PPACA does not allow insurance companies or employers to establish eligibility requirements for dependent coverage other than age and relationship to the insured (*e.g.*, child, adopted child, grandchild, *etc.*). See here for regulations and guidance from HHS.
Uniform Explanation of Coverage Documents and Standardization of Terms	• Illinois law provides a standard definition for certain insurance terms (for example, "preexisting condition") that must be used by insurance companies in the application or policy documents. • HMOs, but not insurers, are required to adhere to uniform standards for providing explanation of coverage documents (*i.e.*, a summary of coverage provided under a health insurance policy). *(50 Ill. Adm. Code 5420.40)*	Sec. 1001 PHSA Sec. 2715	• PPACA requires HHS to develop, in consultation with the NAIC, standards for a summary of benefits and coverage document, not to exceed 4 pages in length, to be used by all health insurance companies and employer health plans. The standards will include uniform definitions of insurance terms. o HHS will develop standards not later than 12 months after enactment (March 23, 2011). o The summary of benefits document must be provided by insurance companies and employer plans beginning not later than 24 months after enactment (March 23, 2012).

Additional Insurer Reporting Requirements	• Insurers and HMOs in Illinois are required to submit annual and/or quarterly financial statements. *(215 ILCS 5/136; 215 ILCS 125/2-7)* • HMOs must report additional information to the Department, including data on enrollment and complaints involving denied claims. *(215 ILCS 134/55)* Click here to see a list of reports published by the Department.	Sec. 10101(c) PHSA Sec. 2715A	• PPACA requires all insurance companies to report to the Department and HHS information regarding: o Claims payment policies and practices; o Data on enrollment, disenrollment, number of denied claims, and rating practices; and o Information on cost sharing and payments for out-of-network coverage. • The data must also be made available to the public.
Prohibition of Discrimination Based on Salary	No applicable Illinois law.	Sec. 1001 (as amended by Sec. 10101(d)) PHSA Sec. 2716 *(Does not apply to grandfathered plans)*	• PPACA requires group health insurance plans to comply with certain requirements relating to the prohibition on discrimination in favor of highly compensated individuals. *(Section 105(h)(2) of the Internal Revenue Code of 1986)*
Quality Reporting Requirements	No applicable Illinois law.	Sec. 1001 (as amended by Sec. 10101(e)) PHSA Sec. 2717 *(Does not apply to grandfathered plans)*	• PPACA requires insurance companies and employer plans to report information regarding benefit and reimbursement structures that: improve health outcomes (*e.g.*, through the use of case management or medical homes); prevent hospital readmissions; reduce medical errors; and implement wellness and health promotion activities.

Minimum Medical Loss Ratios	• Illinois law does not require health insurance companies to spend a minimum percentage of premium dollars on providing health care to policyholders (known as a "medical loss ratio").[4] • Pursuant to Public Act 96-857, signed by Governor Quinn on January 5, 2010, health insurance companies will be required to submit to the Department semi-annual statements with detailed information regarding premiums and expenditures for major medical health insurance plans. o The information will be publicly available on the Department's website. o This reporting requirement will be effective January 1, 2011. *(215 ILCS 5/359c)*	Sec. 1001 (as amended by Sec. 10101(f)) PHSA Sec. 2718	• PPACA requires minimum medical loss ratios of <u>85% in the large group</u> market and <u>80% in the individual and small group</u> markets. o Insurers who do not meet the applicable minimum medical loss ratio will be required to issue rebates to policyholders. *(Effective beginning January 1, 2011)* • PPACA requires insurance companies to report detailed loss ratio data, which will be posted on the HHS and DOI websites. • Hospitals will also be required to establish and publicize a list of standard charges for items and services provided by the hospital. See here for the HHS Request for Comments.
Appeal Rights	• Pursuant to Public Act 96-857, signed by Governor Quinn on January 5, 2010, all Illinois residents covered by an individual or group health insurance policy have the right to an internal appeal and an independent, external review of denied health insurance claims. o The law is effective beginning July 1, 2010. *(215 ILCS 180)* • Like other state insurance laws, the Illinois law does not apply to self-insured plans.	Sec. 1001 (as amended by Sec. 10101(g)) PHSA Sec. 2719 *(Does not apply to grandfathered plans)*	• PPACA requires all individual and group plans—including self-insured employer plans—to provide internal appeal and external review processes that meet minimum consumer protection standards.
Provider Network Provisions	<u>Direct Access to OB/GYNs</u> • Illinois law requires all individual and group insurance policies and HMO	Sec. 10101(h) PHSA Sec. 2719A	<u>Direct Access to OB/GYNs</u> • PPACA requires all individual and group plans that provide coverage for obstetric or gynecologic

[4] Individual and group Medicare Supplement policies must meet certain minimum loss ratio requirements (50 Ill. Adm. Code 2008.80).

	contracts to allow women to designate a "woman's principal health care provider," or a participating provider specializing in obstetrics or gynecology whom the woman may visit without the need for a referral. *(215 ILCS 5/356r)* Emergency Services • HMOs must cover emergency services without regard to prior authorization *(215 ILCS 134/65)* • Insurers and HMOs must provide coverage for out-of-network emergency services at no greater cost to the insured than if the emergency service or treatment was provided by an in-network provider. *(50 Ill. Adm. Code 2051.310(a)(6)(J))*	*(Does not apply to grandfathered plans)*	care to allow women "direct access" (*i.e.*, without referral or authorization requirements) to ANY participating OB/GYN. Choice of Providers • PPACA requires all individual and group plans to allow enrollees to select from any participating primary care provider (including pediatricians for children). Emergency Services • PPACA prohibits all individual and group plans from imposing preauthorization requirements for emergency services. • The cost-sharing requirements (*i.e.*, copayment or coinsurance rate) imposed by a plan for emergency services provided by an out-of-network provider must be the same as those that apply with respect to an in-network provider. • Benefit limitations and other terms or conditions for emergency services provided by an out-of-network provider must not be more restrictive than those that apply with respect to an in-network provider.
Pre-Existing Condition Exclusions	**Insurers** Individual/Family Health Insurance: • Illinois law allows health insurers to deny or reduce a claim, within the first 2 years after the policy's effective date, based on the presence of a "preexisting condition." *(215 ILCS 5/357.3)* o Illinois law establishes a minimum definition of "preexisting condition." In general, a condition can be considered preexisting if it was	Sec. 1201; Sec. 1255 (as amended by Sec. 10103(e)) PHSA Sec. 2704 *(Does not apply to grandfathered individual plans)*	• PPACA prohibits all preexisting condition exclusions for children under age 19. • PPACA prohibits preexisting condition exclusions for all persons beginning January 1, 2014. • The Obama administration has indicated that it will interpret this provision to require that insurers and HMOs provide coverage without pre-existing condition exclusions to children if

	diagnosed or treated by a licensed physician within 24 months prior to the policy's effective date. A condition that was not diagnosed or treated could also be considered a preexisting condition if there were symptoms evident within 12 months before the policy's effective date that would have caused "an ordinarily prudent person to seek diagnosis, care or treatment." *(50 Ill. Adm. Code 2005.30)* <u>Group (Employer-Based) Health Insurance</u>: • State and federal laws limit the maximum preexisting condition exclusion period to 12 months (or 18 months in the case of a late enrollee) for persons covered by employer-based health insurance policies. • The maximum exclusion period must be reduced by a person's prior health insurance coverage. • A condition cannot be considered preexisting unless medical care was recommended or received within the 6 months prior to the date of enrollment. *(215 ILCS 97/20)* **HMOs** • HMOs may not deny or reduce a claim for preexisting conditions. HMOs may, however, impose higher cost-sharing requirements for the treatment of preexisting conditions. *(50 Ill. Adm. Code 5421.110(j))*		they cover the parents, and the health insurance industry has signaled its intention to comply with this interpretation. More detailed guidance will be forthcoming from HHS.

Health Insurance Consumer Information	• The Department maintains an Office of Consumer Health Insurance (OHCI) to answer questions, provide information, and assist Illinois consumers with all health insurance inquiries. • OCHI was established pursuant to the Managed Care Reform and Patient Rights Act *(215 ILCS 134)* • OCHI's toll-free telephone number is (877) 527-9431.	Sec. 1002 *(Effective upon enactment)*	• PPACA appropriates $30 million for states to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs.
Premium Review	• In general, Illinois law does not vest the Department with authority to approve or deny any health insurance premium rate or rate increase.[5] *(215 ILCS 5/355; 215 ILCS 125/2-1(12); 50 Ill. Adm. Code 5421.60)* o The Individual Major Medical Health Policy Rate Filing Report posted on the Department's website reveals annual rate increases of up to 80%. • For non-HMO group plans, insurers do not even file premium rates or rate increases with the Department.[6]	Sec. 1003 (as amended by Sec. 10101(i)) PHSA Sec. 2794 *(Effective upon enactment)*	• PPACA establishes a process for the annual review, beginning with the 2010 plan year, of "unreasonable" increases in premiums. o Insurers are required to submit, to the Department of Insurance and the U.S. Department of Health and Human Services (HHS), the justification for an unreasonable premium increase prior to implementing the increase, and to post such information on the company websites. See here for the HHS Request for Comments.
High Risk Pool Coverage	• The Illinois Comprehensive Health Insurance Plan (ICHIP) provides coverage to individuals denied by health insurers and those losing group health insurance. *(215 ILCS 105)*	Sec. 1101 *(Effective upon enactment)*	• PPACA appropriates $5 billion for states to establish a temporary high risk pool program to provide health insurance coverage to uninsured individuals with preexisting conditions. o The federally funded high risk pools will serve as a coverage link until January 1, 2014, when insurers will be prohibited

[5] Premium rates and rating schedules for individual and group Medicare Supplement policies must be filed with and approved by the Department (50 Ill. Adm. Code 2008.81).
[6] Premium rates for small employers must comply with the Small Employer Health Insurance Rating Act ("SEHIRA"; 215 ILCS 93). When the Department receives complaints from a small employers or its employees, the Department verifies that the premiums charged to the small employer are in compliance with SEHIRA.

	• ICHIP premiums are unaffordable for many. o By law, premium rates for ICHIP plans must be between 125% and 150% of the "standard risk rate," or the average premium for comparable coverage sold by the five largest health insurance companies in the state. *(215 ILCS 105/7.1)* Click here for more information about ICHIP.		from basing coverage or pricing decisions on health status. o HHS estimates Illinois will receive approximately $196 million. o The federally funded high risk pools must be established within 90 days after enactment. • Premiums for the federally funded high risk pools must equal 100% of the standard premium rate. See here for more information from HHS on the federally funded high risk pool.
Reinsurance for Early Retirees	No applicable Illinois program.	Sec. 1102 *(Effective upon enactment)*	• PPACA appropriates $5 billion for the establishment of a temporary reinsurance program for early retirees (age 55 years or older and ineligible for Medicare). • Participating employers, including State and local governments, will be reimbursed for 80% of medical claims between $15,000 and $90,000 incurred by retired employees. • The reinsurance program will be established within 90 days of enactment. See here for regulations and guidance from HHS.
Internet Portal	No applicable Illinois program.	Sec. 1103 *(Effective upon enactment)*	• PPACA requires the establishment of an Internet portal allowing small businesses and individuals to identify affordable coverage options, including private major medical insurance, Medicaid, and State high-risk pools. • The internet portal will be established by July 1, 2010. See here for regulations and guidance from HHS.

Administrative Simplification	No applicable Illinois law.	Sec. 1104 *(Effective upon enactment)*	• PPACA requires HHS to develop operating rules for the electronic exchange of health information, transaction standards for electronic funds transfers and requirements for financial and administrative transactions. • Rules to be adopted by July 1, 2011 and to become effective by January 1, 2013
2014 INSURANCE REFORMS -- Effective for plan years beginning on or after January 1, 2014 --			
Health Insurance Premiums	Individual/Family Health Insurance • Illinois law does not limit the amount a health insurance company can charge based on an individual's health status or other rating factors such as age or gender. o For example, if a woman and man are of the same age, live in the same house, have the same health status, and see doctors in the same hospital, the woman can be charged much more than the man (up to 57% by some insurance companies)—independent of maternity benefits. o See the Individual Major Medical Health Policy Rate Filing Guide posted on the Department's website for an explanation of the different factors that may affect your premium under current Illinois law. Group (Employer-Based) Health Insurance • Small employers (50 or fewer employees) benefit from limited rating protections established by State law, but these small businesses are vulnerable to dramatic,	Sec. 1201 PHSA 2701 *(Does not apply to grandfathered plans)*	• PPACA prohibits insurance companies from varying premiums based on health status, gender, and other factors. Premiums may vary only by: o Age (3:1 maximum) o Tobacco use (1.5:1 maximum) o Geographic area o Whether coverage is for an individual or a family.

	unpredictable, and unaffordable rate increases upon renewal. *(215 ILCS 93)* • Individual employees or their family members receiving coverage through an employer group (of any size) may not be charged more for coverage based on health status. *(215 ILCS 97/25)*		
Guaranteed availability of coverage	<u>Individual/Family Health Insurance</u> • Illinois law does not require insurance companies to accept every individual that applies for coverage. o Insurers can deny coverage for any reason other than an applicant's "race, color, religion, or national origin." *(215 ILCS 5/424)* <u>Group (Employer-Based) Health Insurance</u> • State and federal laws require insurance companies to accept every small employer (2-50 employees) that applies for coverage. o Employers with 51 or more employees do not benefit from the same protection. • Individual employees or their family members may not be denied coverage based on health status. *(215 ILCS 97/25)*	Sec. 1201 PHSA Sec. 2702 *(Does not apply to grandfathered plans)*	• PPACA requires insurance companies to accept every employer—regardless of size—and every individual that applies for coverage. o An insurer may restrict enrollment based upon open or special enrollment periods.

Preexisting Condition Exclusions	**Insurers** Individual/Family Health Insurance: • Illinois law allows health insurers to deny or reduce a claim, within the first 2 years after the policy's effective date, based on the presence of a "preexisting condition." *(215 ILCS 5/357.3)* o In general, a condition can be considered preexisting if it was diagnosed or treated by a licensed physician within 24 months prior to the policy's effective date. A condition that was not diagnosed or treated could also be considered a preexisting condition if there were symptoms evident within 12 months before the policy's effective date that would have caused "an ordinarily prudent person to seek diagnosis, care or treatment." *(50 Ill. Adm. Code 2005.30).* Group (Employer-Based) Health Insurance: • State and federal laws limit the maximum preexisting condition exclusion period to 12 months (or 18 months in the case of a late enrollee) for persons covered by employer-based health insurance policies. • The maximum exclusion period must be reduced by a person's prior health insurance coverage. • A condition cannot be considered preexisting unless medical care was recommended or received within the 6 months prior to the date of enrollment. *(215 ILCS 97/20)*	Sec. 1201 PHSA Sec. 2704 *(Does not apply to grandfathered individual plans)*	• PPACA prohibits all preexisting condition exclusions.

	HMOs • HMOs may not deny or reduce a claim for preexisting conditions. HMOs may, however, impose higher cost-sharing requirements for the treatment of preexisting conditions. *(50 Ill. Adm. Code 5421.110(j))*		
Covered Benefits	• Illinois law requires insurers and HMOs to provide certain mandated benefits, including coverage for the treatment of autism and preventive benefits such as mammograms and other cancer screenings. See here for a comprehensive list of mandated benefits. • Many other benefits—such as maternity benefits and mental health services—may not be covered by a health insurance policy.	Sec. 1201 PHSA Sec. 2707 *(Does not apply to grandfathered plans)*	• PPACA requires all individual and small group health insurance policies to provide coverage for a minimum package of "essential health benefits," which will include benefits in at least the following categories: [7] o Ambulatory patient services; o Emergency services; o Hospitalization; o Maternity and newborn care; o Mental health and substance use disorder services, including behavioral health treatment; o Prescription drugs; o Rehabilitative and habilitative services and devices; o Laboratory services; and o Pediatric services, including oral and vision care.

[7] The small group market in Illinois is defined as the market for health insurance sold to employers with 2-50 employees. Beginning in 2016, employers with 1-100 employees will be considered "small employers" for the purpose of the PPACA reforms.

Cost-Sharing Limits	<u>Insurers</u>: • Illinois law does not limit the cost-sharing requirements (including deductibles, co-payments and coinsurance rates) that may apply under a group or individual health insurance policy. <u>HMOs</u>: • Deductibles and copayments for HMO enrollees in a year may not exceed $3000 per individual or $6000 per family. (50 Ill. Adm. Code 5421.110(i))	Sec. 1201 PHSA Sec. 2707 *(Does not apply to grandfathered plans)*	• PPACA requires all individual and group plans (including self-insured plans) to ensure that annual cost-sharing requirements—including co-pays, deductibles, and coinsurance amounts—do not exceed the dollar amounts applicable to Health Savings Accounts, adjusted annually (currently $5,950 for individuals and $11,900 for families). • For group plans, PPACA prohibits deductibles greater than $2,000 for single coverage and $4,000 for family coverage.