Illinois Department of Insurance

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Governor

DANA POPISH SEVERINGHAUS
Director

TO: All Health Insurance Issuers

FROM: Dana Popish Severinghaus, Director dps

DATE: August 23, 2022

RE: Company Bulletin 2022-15 – Guidance related to Coverage of Reproductive Health Care Services, including Abortion and Contraceptives

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The Department of Insurance ("Department") issues this Bulletin to make Illinois-licensed health insurance issuers aware of recent federal guidance and remind them that Illinois law remains unaffected with respect to abortion coverage and nondiscrimination.

Nothing in this Bulletin, nor state or federal law prohibits companies from providing greater protections than the minimum requirements described below.

Questions about this Company Bulletin should be directed to DOI.InfoDesk@Illinois.gov.

I. Discrimination Prohibited

The Reproductive Health Act ("RHA"), Pub. Act 101-0013 (eff. Jun. 12, 2019), requires health insurance policies, health maintenance organization health care plans, and voluntary health services plans that provide pregnancy-related benefits to include coverage for abortion services at no greater cost-sharing than required for other pregnancy-related benefits covered by the policy and with no restrictions or delays. Additionally, issuers are reminded that they must comply with State and Federal laws and regulations related to nondiscrimination in healthcare services.

As previously outlined in Company Bulletin 2020-16, the following Illinois laws and regulations prohibit discrimination based on actual or perceived gender identity or sexual orientation: the Illinois Human Rights Act (IHRA), 775 ILCs 5/1-103(O-1) and (Q); the Illinois Insurance Code, 215 ILCS 5/236, 5/364, and 5/424; the Illinois Mental Health Parity Act, 215 ILCS 5/370c.1; and the Illinois Administrative Code, 50 Ill. Adm. Code 2603. See also the Nondiscrimination Guidance issued in conjunction with the Office of the Governor, Illinois Department of Human Rights, and Illinois Department of Healthcare and Family Services.

Illinois law remains unchanged. The Department will continue to enforce Illinois law through market conduct exams and otherwise address issues as they may arise through consumer complaints, external reviews, and other sources of information. The Department will take action against a health insurance issuer for any failure to adhere to all statutory and regulatory requirements related to abortion coverage.

II. Protections in Case of Inadvertent Receipt Out-of-Network Abortion Services

This section affirms the protection afforded under the federal No Surprises Act ("NSA") (Pub. L. 116-260, div. BB, tit. 1) to covered individuals who inadvertently obtain out-of-network care, including covered abortion services, based on a good faith belief that the provider was in-network because the current provider directory for their health insurance coverage had listed the provider as in-network. This NSA protection applies to plan years beginning on or after January 1, 2022 for all group health plans and all group or individual health insurance coverage.

As summarized in guidance from the Centers for Medicare and Medicaid Services:

> "Under the No Surprises Act, if an individual relies on incorrect provider directory information and, as a result, receives items or services from an out-of-network provider or out-of-network health care facility:
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> 1. Their plan or issuer must:
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> • Limit cost-sharing to in-network terms that would apply had items or services been furnished by an in-network provider;
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> • Apply the deductible or out-of-pocket maximums as if the provider or health care facility were in-network.
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> 2. Their provider or health care facility must:
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> • Not bill an individual [for costs above that required for] in-network cost-sharing."
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> "If 1) an individual relies on incorrect provider directory information, 2) the provider submits a bill to the individual that is more than the in-network cost-sharing amount, and 3) the individual pays the bill:
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> • The provider must reimburse the individual for the full amount paid by the individual in excess of the in-network cost-sharing amount, plus interest. The interest rate will be determined by the Secretary of HHS through rulemaking."

Please see 42 U.S.C. §§ 300gg-15(b) and 300gg-139(b) for details. The U.S. Department of Health and Human Services ("HHS") has indicated it anticipates undertaking a rulemaking to implement these provisions.

Additionally, there may be instances when a consumer needs to obtain abortion services from an out-of-network provider because of barriers to accessing care from an in-network provider. For consumers with PPO coverage, if a covered individual "has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to insufficient number, type, or unreasonable travel distance or delay," the PPO must cover that service for the covered individual from an out-of-network provider at no greater cost to the individual than if the service had been received from a preferred provider. 215 ILCS 124/10(b)(6).

For all PPO and HMO plans, emergency services must be covered at the in-network benefit level without prior authorization whenever they are received from an out-of-network provider, even when the covered individual knew the provider was out-of-network and did not try to find an in-network provider. 215 ILCS 5/356z.3a(b), 5/370o, 124/10(b)(7), 134/65(a), and 134/70(a-5). Protections against balance billing apply to emergency services under the federal NSA and 215 ILCS 5/356z.3a. When an abortion is performed as part of furnishing emergency services to a covered individual, these coverage requirements and protections apply.

III. Separate Premium Billing Related to Non-Hyde Abortion Services

This section supersedes and replaces the guidance in Company Bulletin 2020-03 related to separate billing requirements for consumers enrolled through the Exchange in a QHP that covers non-Hyde abortion services.

Pursuant to amendments published in 86 Fed. Reg. 53412 (Sep. 27, 2021), federal regulations no longer require QHP issuers to send a physically separate paper bill or a separate billing email to Exchange enrollees exclusively for the portion of their premium attributable to non-Hyde abortion services, which must be at least $1 per enrollee per month.

The currently allowed methods for QHP issuers to satisfy the separate billing requirement on the Exchange are set forth at 45 C.F.R. § 156.280(e)(2)(ii) as follows:

> An issuer will be considered to satisfy the obligation in paragraph (e)(2)(i) of this section if it sends the policy holder a single monthly invoice or bill that separately itemizes the premium amount for coverage of abortion services described in paragraph (d)(1) of this section; sends the policy holder a separate monthly bill for these services; or sends the policy holder a notice at or soon after the time of enrollment that the monthly invoice or bill will include a separate charge for such services, and specifies the charge.

The Department strongly recommends that issuers not send separate paper bills or separate billing emails for the non-Hyde abortion component. As indicated in CB 2020-03, such billing practices increase the risk of enrollees inadvertently triggering the termination of their entire coverage because they neglected to pay a separate bill for $1.

The Department also emphasizes that the federal requirements for separate billing and segregation of funds related to non-Hyde abortion services do not apply to any coverage regulated by the Department other than QHPs with respect to their Exchange enrollees.

IV. Coverage for Contraceptives

On January 24, 2022, the Department issued Company Bulletin 2022-02 to notify issuers of the Part 51 FAQs on the implementation of the Affordable Care Act (ACA), which includes requirements for coverage of contraceptives. Issuers should review the previous Bulletin and ensure compliance.

On June 27, 2022, U.S. Departments of Health and Human Services, Labor, and the Treasury published a letter to plans and issuers that reiterated the ACA requirement to cover contraceptive counseling and the full range of contraceptive products approved, cleared, or granted by the FDA without cost-sharing. The letter noted with concern the fact that complaints of noncompliance with this mandate continue to be received more than a decade after it took effect. The Department enforces this mandate and the State

mandate at 215 ILCS 5/356z.4 and will thoroughly investigate complaints of any failure to cover contraceptive services as provided by law.

On July 28, 2022, HHS, Labor, and the Treasury published Part 54 FAQs on the implementation of the ACA to address additional concerns about contraceptive coverage under Section 2713 of the Public Health Service Act. The FAQs cover a range of issues, from the requirement to cover, without cost-sharing, all health care services that are integral to a preventive service; coverage of contraceptive items and services not included in the HRSA-Supported Guidelines; various issues with reasonable medical management techniques; coverage of over-the-counter contraception with a prescription and the use of certain tax-advantaged accounts to pay for such products when obtained without a prescription; coverage for a 12-month supply of contraceptives; the prohibition on using an appeals process as a medical exception; preemption of state law; federal enforcement; and resources for consumers experiencing difficulty accessing contraceptive coverage.

Please note, however, that in some instances Illinois law offers greater consumer protections than federal law. For example, whereas Part 54 merely encourages issuers to cover a 12-month supply of contraceptives dispensed at one time, Illinois law requires it. 215 ILCS 5/356z.4(a)(3)(A)(iv). Issuers should also take note of the provision in both the Illinois contraceptive and abortion coverage mandates that, "[e]xcept as otherwise authorized" within those statutes, "a policy shall not impose any restrictions or delays on the coverage required…" 215 ILCS 5/356z.4(a)(5) and 5/356z.4a(c). The Department will enforce the federal contraceptive coverage mandate in accordance with federal guidance except where Illinois law imposes more stringent standards that do not prevent the application of federal law.

V. Telehealth Services

On July 22, 2021, Governor Pritzker signed PA 102-0104 into law. Under PA 102-0104 an individual or group policy of health insurance coverage, other than a dental service plan, must provide coverage for telehealth services. For purposes of health insurance coverage requirements, telehealth services include the delivery of covered health care services by way of an interactive telecommunications system. Interactive telecommunications systems include an audio and video or an audio-only system permitting 2-way, live interactive communication between the patient and the provider. Coverage for telehealth services must not impose cost-sharing for telehealth that exceeds what the insurance carrier requires for the same services provided in person.

Issuers may not:

- Require that in-person contact occur between a health care provider and a patient before the provision of a telehealth service;
- Require the patient or health care provider to document a barrier to an in-person consultation for coverage of services to be provided through telehealth;
- Require the use of telehealth when the health care provider has determined that it is not appropriate;
- Require a health care professional to be physically present in the same room as the patient during a telehealth visit;
- Create geographic or facility restrictions for telehealth services;
- Require patients to use telehealth services or a separate panel of telehealth providers;
- Impose unnecessary, duplicative, or unwarranted utilization review requirements or impose treatment limitations, prior authorization, documentation, or recordkeeping requirements that are more stringent than for the same health care service when rendered in-person.

Complete telehealth coverage requirements are provided at 215 ILCS 5/356z.22. To the extent that covered health care services related to abortion are medically necessary and clinically appropriate to deliver via telehealth, coverage for such telehealth services is required in accordance with that section.

VI. Travel and Lodging Coverage for Out-of-State Covered Individuals

The Department has favorably taken note of some issuers' efforts to assist covered individuals residing or located in states that restrict or prohibit abortion services by filing updated policy contracts or a rider or endorsement to cover travel and lodging expenses to obtain abortion services in a state, such as Illinois, that does not burden reproductive health care. Such provisions are consistent with State law and public policy, and the Department encourages issuers to move forward with these provisions where appropriate to make health care services more accessible.

VII. Federal Guidance and Resources

On July 8, 2022, President Biden signed Executive Order 14076 to protect access to reproductive health care services. The order affirmed the Biden Administration's policy to support women's right to choose and to protect and defend reproductive rights. The order further directed federal agencies to identify potential ways to protect access to reproductive healthcare services, to convene stakeholders in furtherance of that effort, to protect privacy, safety, and security in the provision and seeking of reproductive healthcare services, and to establish an Interagency Task Force on Reproductive Healthcare Access to coordinate agencies' activities, policymaking, program development, and outreach efforts. No direct obligation is imposed on health insurance issuers or health care providers, but the Department will monitor the impact of this order as it unfolds.

The HHS Office for Civil Rights has issued guidance with examples of situations when a pharmacy or pharmacist may be deemed to engage in federally prohibited discrimination based on sex or disability by refusing to fill a prescription medication because abortion or contraception is one of the medication's potential uses. Issuers, utilization review organizations, third party administrators, pharmacy benefit managers, and other entities involved in paying for or administering pharmacy benefits should ensure that clinical guidelines, utilization review practices, provider contracts, and business policies and procedures do not require or facilitate any prohibited discrimination by pharmacy providers.

HHS also has issued guidance about the application of the HIPAA Privacy Rule to covered entities, including insurers and providers, on disclosures of protected health information (PHI) without the individual's authorization. This guidance reminds covered entities that, although the Privacy Rule allows them to turn over PHI without the individual's authorization when another law requires the disclosure, enforceable by a court, and the covered entity's disclosure complies with that other law, the Privacy Rule does not require the covered entity to do so. Likewise, the Privacy Rule permits, but does not require, disclosure for law enforcement purposes, such as a court order, court-ordered warrant, subpoena, or summons, as long as only the requested PHI is disclosed and all other conditions specified in the Privacy Rule for permissible law enforcement disclosures are met. The HHS guidance also identifies circumstances in which the Privacy Rule prohibits a covered entity or business associate, on its own initiative or in response to a request that is not judicially enforceable, from reporting an actual or intended abortion to law enforcement even when the law enforcement officer's state would prohibit the abortion.

Finally, the Department notes HHS' July 25, 2022 release of its draft notice of proposed rulemaking to restore or strengthen nondiscrimination rules under Section 1557 of the Patient Protection and Affordable Care Act. Among other aspects, and consistent with federal case law, the proposed rules would more

explicitly recognize discrimination on the basis of sex to include discrimination based on sex stereotypes, sex characteristics, pregnancy or related conditions, sexual orientation, and gender identity. The notice elaborates on the ways that these forms of sex discrimination intersect with one another and with other categories of discrimination. The rulemaking also proposes to restore the applicability of these nondiscrimination provisions to a substantial number of health insurance issuers in relation to their health insurance coverage. The Department supports federal efforts to protect consumers' equitable access to affordable healthcare and, consistent with Illinois law and public policy, stands ready to coordinate with our federal partners when the rulemaking is finalized.