Illinois Department of Insurance

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Governor

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Acting Director

TO: All Companies Writing Accident and Health Insurance and Managed Care Plans in Illinois
FROM: Dana Popish Severinghaus, Director dps
DATE: May 2, 2022
RE: Company Bulletin 2022-06
Comprehensive Update on High-Deductible Health Plans (HDHPs)

In Company Bulletin 2021-11, the Illinois Department of Insurance ("Department") cautioned that state-regulated, private health insurance coverage would not satisfy the criteria for a high-deductible health plan pursuant to 26 U.S.C. § 223 if it contained policy language in compliance with 215 ILCS 134/30(d) as in effect in 2021. Per 26 U.S.C. § 223, an individual is not eligible to contribute to a health savings account ("HSA") or to have an employer make contributions on their behalf unless the individual is enrolled in an HDHP. To protect consumers from misleading information about their coverage, the Department instructed health insurance issuers that intended to market a plan as an HDHP or for use with an HSA to remove language compliant with 215 ILCS 134/30(d), and to remove any indicia that a plan is an HDHP or HSA-intended if the plan fully complied with 215 ILCS 134/30(d).

Subsequently, Company Bulletin 2021-13 (revised) announced that, in 2022, the Department temporarily would not enforce the provisions of 215 ILCS 134/30(d) with respect to policies satisfying the definition of a high-deductible health plan under 26 U.S.C. § 223 until the minimum deductible provided under that statute had been met. For 2022, those minimum deductible amounts are $1,400 for self-only coverage and $2,800 for family coverage. The Department also stated that, in the absence of a change in federal or state law prior to the submission deadlines for the 2023 Plan Year, the Department would begin to enforce the provisions of 215 ILCS 134/30(d).

Pursuant to [Pub. Act 102-0704], effective April 22, 2022, to the extent that application of 215 ILCS 134/30(d) would result in HSA ineligibility under 26 U.S.C. § 223, the Illinois requirement to apply the amount of any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses toward a covered individual's cost-sharing responsibility will not apply with respect to the deductible of an HDHP until the covered individual has satisfied the minimum deductible under 26 U.S.C. § 223. However, with respect to items or services that are preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), the Illinois requirement will apply at all times regardless of whether the minimum deductible has been satisfied. Based on this change to 215 ILCS 134/30(d), HDHPs may be filed and marketed in Illinois for Plan Year 2023 and for the foreseeable future. HDHPs already in effect for the 2022 Plan Year must continue to comply with 215 ILCS 134/30(d) after the enrollee meets the statutory minimum deductible of $1,400 for self-only coverage or $2,800 for family coverage.

Issuers should continue to ensure that plans marketed to individuals and employers as HDHPs or as HSA-Eligible satisfy both 26 U.S.C. § 223 and Illinois state benefit requirements. To ensure the efficient navigation of all applicable requirements, the Department offers the following:

- To ensure that the Department properly recognizes an issuer's basis for using a statutory exemption, SERFF form filings should clearly identify in the cover letter which forms are intended to be used for plans marketed as an HDHP or for use with an HSA. For large group plans, if the policy form includes variable language dependent on whether the policy will be issued as an HDHP, the changes in policy language should be explained in the statement of variability.

- If a plan pays partially or completely for any covered health care service, other than preventive care, before the statutory minimum deductible set under 26 U.S.C. § 223 has been met, the plan does not satisfy the definition of an HDHP and should not be marketed to consumers as an HDHP or for use with an HSA. For purposes of the definition of an HDHP, "preventive care" is not limited to "preventive health services" under Section 2713 of the Public Health Service Act but includes additional services described by the U.S. Department of the Treasury in guidance.

- Under 215 ILCS 134/30(d), plans marketed as HDHPs or for use with an HSA must not apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of such insured for prescription drugs to the insured's deductible until the statutory minimum deductible set under 26 U.S.C. § 223 has been met. Thereafter, such reductions in out-of-pocket expenses must apply toward all cost-sharing requirements for the covered prescription drug.

- Some Illinois statutes prohibit or limit cost-sharing for a health care service that is not preventive care under 26 U.S.C. § 223 but contain an exemption for HDHPs to the extent that compliance with the statute would prevent HSA eligibility. Policy language for plans marketed as HDHPs or for use with an HSA must incorporate all such exemptions when the health care service is not preventive care in order to satisfy the definition of a high-deductible health plan, but the exemptions only apply until the statutory minimum deductible under 26 U.S.C. § 223 has been met. Besides 215 ILCS 134/30(d), the following provisions exempt HDHPs , which apply to non-preventive care as listed below:

    - 215 ILCS 5/356g(a) and 125/4-6.1(a) - diagnostic mammograms.

    - 215 ILCS 5/356z.4(a)(4) - voluntary male sterilization.

    - 215 ILCS 5/356z.23(a-5) (for policies amended, delivered, issued, or renewed after January 1, 2024 per HB 4408) - naloxone hydrochloride. Please note that subsection (a-5) only prohibits the use of copayments, not deductibles, for this benefit. Any plan that imposes a pre-deductible copayment for prescription drugs as a class (rather than only for specific prescription drugs) would never satisfy the definition of a high-deductible health plan in 26 U.S.C. § 223 because, even if the plan did not pay for the naloxone hydrocholoride before the statutory minimum deductible had been met, the plan would pay for some expenses on other drugs that are not preventive care before passing that threshold. As a result, the exemption in subsection (a-5) would never apply to such plans.

    - 215 ILCS 5/356u(c) (for policies amended, delivered, issued, or renewed after January 1, 2024 per HB 5318) - follow-up tests to initial prostate cancer screenings. Because IRS Notice 2004-23 expressly recognizes prostate cancer screenings, such as a prostate-specific antigen test, as preventive care under 26 U.S.C. § 223, this exemption cannot apply to prostate cancer screening tests that are initial tests, such as prostate-specific antigen tests and digital rectal

exams. Subsequent follow-up tests that are diagnostic in nature, such as urinary analysis, serum biomarkers, and medical imaging, may be subject to the exemption.

- The following Illinois statutes prohibit or limit cost-sharing for certain health care services that are considered preventive care within the meaning of 26 U.S.C. § 223 but exempt HDHPs to the extent that compliance with the statute would prevent HSA eligibility. . Because these health care services are preventive care, compliance with the statutes would not prevent HSA eligibility. Therefore, no exemption will be allowed for HDHPs under the following statutes:

  - 215 ILCS 5/356z.37 - annual office visits for whole body skin examinations. IRS Notice 2004-23 specifically recognizes skin cancer screenings as preventive care. Whole body skin examinations are the only skin cancer screening test to be evaluated by the United States Preventive Services Task Force. *See* https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/skin-cancer-screening. The U.S. Department of the Treasury has affirmed in IRS Notice 2013-57 that preventive care for purposes of 26 U.S.C. § 223 includes "anything that is preventive care under Notice 2004-23 and Notice 2004-50 without regard to whether it would constitute preventive care for purposes of section 2713 of the PHS Act." Subsequent IRS guidance has affirmed IRS Notice 2013-57.

  - 215 ILCS 5/356z.43 - colonoscopies that are a follow-up to an initial screen. *See* Company Bulletin 2022-02.

- With respect to 215 ILCS 134/45.3, no HDHP may be counted towards an insurance carrier's obligation to ensure that a minimum percentage or number of its plans have a flat-dollar copayment structure for the entire drug benefit. The drug benefits for plans that comply with this statute will include pre-deductible coverage for at least some drugs that are not preventive care. Therefore, the pre-deductible application of a copayment will prevent these plans from satisfying the federal definition of a high-deductible health plan.

- The U.S. Department of the Treasury has several publications with guidance on the requirements for HDHPs. To the extent that issuers may wish to offer plan designs with more generous or innovative cost-sharing provisions than Illinois law requires, the following publications assist in determining whether a plan qualifies as an HDHP:

  - Publication 969
  - IRS Notice 2004-23
  - IRS Notice 2004-50
  - IRS Notice 2013-57
  - IRS Notice 2018-12
  - IRS Notice 2019-45
  - FAQS About Affordable Care Act Implementation Part 40 (Aug. 26, 2019)

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