

Disability Rights Legal Center



Cancer Legal Resource Center

**Cancer Legal Resource Center**

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*The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School*

## Health Insurance in Illinois

### Types of Private Health Insurance

#### Group vs. Individual Insurance

*Group insurance* is usually offered through your employer or some form of a trade association (ex. a union, etc.). *Individual insurance* means that you are contracting directly with an insurance company (ex. when you purchase a plan from Blue Cross or Blue Shield, etc.). People who purchase group or individual health insurance plans are called “members” of that insurance company.

#### HMO, PPO, and POS Plans

There are three types of managed care plans. There are HMO, PPO, and POS plans.

*HMO* stands for a health maintenance organization. There are generally two forms: 1) independent physician associations (IPAs), and 2) stand alone facilities. IPAs have physicians that practice in their own offices and sometimes join with other providers to form a medical group.

*PPO* stands for Preferred Provider Organization. A PPO is a group of health care providers who have agreed to provide services to an insurance company’s members at a reduced rate.

*POS* stands for Point of Service Plan. A POS Plan is a cross between an HMO and a PPO. Members of a POS plan decide which type of service they want to use at the point when they are ready to use it.

HMO	PPO	POS
Participating doctors and hospitals. Generally have a primary care physician who coordinates care	Usually many health care provider and hospital choices	Can see providers in- or out-of-network
HMO	PPO	POS
Generally have to select doctors and hospitals from within the participating group	Can select from all participating providers	If selecting within network, generally have a minimal co-pay. If selecting from larger group, member will pay more
Limited choices	More choices in doctors, specialists, overall providers	More choice when needed
Usually less expensive	Usually more expensive	Cost is between that of a PPO and an HMO

### What to consider when choosing a health insurance plan

- 1) Look at the summary of *benefits*. What benefits are included? What benefits are excluded?
- 2) Look at *costs*. How much are the monthly premiums, annual deductibles, and co-payments?
- 3) When are the *enrollment periods*? Do they offer annual open enrollment periods to make changes to your policy?
- 4) How much *flexibility* do they offer? Can you change plans if you need to? How?

Health insurance companies are required to renew an individual's existing health coverage, but there is no cap on the rate increases companies may impose at the time of renewal. This is called guaranteed renewability. Guaranteed renewability is not portable, so you do not have the right to switch to another company or even another product offered by the same company.

### **Ways to Get and Keep Health Insurance**

#### Employment-Based Health Insurance

The most common way that people obtain health insurance coverage is through their own employment or a family member's employment. There are certain rights that are guaranteed to people who are insured through their own or a family member's employment. These rights have to do with the continuation of coverage during certain leaves of absence (under the Family and Medical Leave Act) or upon termination of employment (see COBRA, discussed below). Persons with employment-based health insurance are also protected from health insurance discrimination based on their pre-existing conditions under the Health Insurance Portability & Accountability Act (see HIPAA, discussed below).

#### COBRA

COBRA is a federal law that allows you to continue the same health insurance coverage that you had through your or your family member's employer. It's the same health insurance policy you had when you were employed, so you don't have to worry about changing providers.

COBRA is available to an employee or family member after an employee has terminated their employment or has reduced their work hours to a point that they are no longer eligible to receive coverage from their employer. This termination or reduction in hours is referred to as a "qualifying event." Other qualifying events for COBRA are divorce or death of a spouse (when the person seeking COBRA coverage was insured by a plan provided through the spouse's employment), or a child aging out of a parent's health insurance policy.

Federal law defines the terms of COBRA coverage and its availability as follows:

- COBRA applies to employers with 20 or more employees.
- COBRA coverage generally lasts for 18 months.<sup>1</sup>
- The cost of the monthly premium paid by the employee can be up to 102% of what the employer was paying for the same benefits.
- The person insured is responsible for the full premium for the coverage.

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<sup>1</sup> COBRA coverage can last up to 29 months if the person insured has a qualifying disability, or up to 36 months if the person became eligible for COBRA coverage because of certain qualifying events or a combination of qualifying events. For detailed coverage limits please visit: <http://www.idfpr.com/DOI/HealthInsurance/continueCobra.asp>

- Who is responsible for notifying the health plan of the qualifying event depends on which qualifying event has occurred.
- A health plan has 14 days after the plan administrator is notified of the qualifying event to notify the employee of the right to elect COBRA.
- An employee must elect COBRA within 60 days after being notified of their COBRA rights. The employee then has 45 days after electing coverage to pay the initial premium.

If you elect COBRA coverage, you will have to pay the premiums for each month since you became eligible. So, even if you wait until the last day of your eligibility to elect COBRA coverage, you will still have to back-pay the premiums to the date your eligibility began.

### Illinois State Continuation Coverage

The Illinois Continuation Law protects individuals who lose their group health insurance coverage with an employer group of any size due to termination of employment or a reduction in hours.

The continuation law does not apply to self-insured employers, self-insured health and welfare benefit plans, such as union plans and insurance policies or trusts written in other states. Nor does it apply to the following:

- You were terminated for committing a work-related felony and have admitted to or been convicted of such felony;
- You were terminated for a work-related theft for which your employer was in no way responsible and you have admitted to or been convicted of such theft;
- You are covered by Medicare;
- You are covered by any other insured or self-insured plan of group hospital, surgical or medical coverage.

Illinois state law defines the terms of their continuation coverage and its availability as follows:

- Illinois state continuation coverage applies to employers of any size.
- Continuation coverage generally lasts for 9 months.
- The cost of the monthly premium paid by the employee is 100% of what the employer was paying for the same benefits.

### Health Insurance Premium Payment Program (HIPP)

The Health Insurance Premium Payment (HIPP) Program pays health insurance premiums for qualifying individuals who have high medical expenses and private health insurance. This health insurance must be cost-effective. Individuals with high cost medical conditions must provide information for any health plan that they are currently enrolled in, are eligible to enroll in but currently are not, or may be able to enroll in due to loss of employment or retirement, such as COBRA coverage. The Third Party Liability Section of the Bureau of Collections runs HIPP and decides the cost-effectiveness of each health insurance policy on a case-by-case basis.

### Health Insurance Portability & Accountability Act (HIPAA)

HIPAA prohibits health insurance discrimination against individuals based on their pre-existing conditions, when going from a group health insurance plan to another group health insurance plan or from a group plan to a HIPAA guarantee issue plan.

HIPAA also: 1) provides a federal right to an individual health insurance plan (called a guarantee issue plan); 2) reduces the maximum pre-existing condition exclusion period to 12 months; and 3) gives you credit for the time that you had health insurance coverage in the past to eliminate or reduce a pre-existing condition exclusion period.

## *Guarantee Issue Plan*

Normally when you apply for an individual health insurance plan, you are required to go through a process called medical underwriting. During this process, the insurance company looks at your past and current medical condition in order to decide whether or not they want to issue you a health plan. If you currently have, or in the past have had, a serious medical condition, the insurance company will likely decide that it is not worth the risk to them to issue you a health plan, and they will deny you coverage.

A guarantee issue plan, also known as a “federally insured plan” or “HIPAA plan,” is an individual health insurance plan that you have a right to purchase under federal law. A HIPAA plan isn’t a specific plan – it’s just a right to purchase an individual plan.

If you lose your group coverage, including expiration of your COBRA or Illinois Continuation Coverage, and you have no other coverage available, you may apply to the Illinois Comprehensive Health Insurance Plan (ICHIP).<sup>2</sup> ICHIP offers the HIPAA CHIP plan for individuals who have lost their group coverage and cannot obtain other health insurance coverage through a group or individual policy. HIPAA CHIP has no preexisting condition exclusions.

To be eligible for HIPAA CHIP, you must:

- be a resident of Illinois;
- have at least 18 months of creditable coverage;
- have most recent creditable coverage provided under a group plan, governmental employee plan or church plan;
- not have a lapse in coverage of more than 90 days since you lost your group plan, governmental employee plan or church plan;
- not be eligible for coverage under a group plan, Medicare Part A or B, or Medicaid;
- not have committed or attempted to commit fraud in obtaining insurance or benefits;
- have exhausted continuation coverage under COBRA or Illinois continuation, if such coverage was available.

## *Pre-existing Condition Exclusion Period (PECEP)*

When you are going from one employer’s group health plan to another employer’s plan, the new plan is required to insure you, but they can impose a PECEP, which means that for a certain period of time, they will not cover any treatment or services related to a pre-existing medical condition. Before HIPAA, a two-year PECEP was the industry standard. HIPAA limited the maximum PECEP that may be imposed to one year. Illinois does not change the HIPAA maximum PECEP of one year.

## *Creditable Coverage*

Creditable coverage is any previous period of health insurance coverage that was not interrupted by a break in coverage of more than 63 days. HIPAA reduces any PECEP by the length of time that you previously had creditable coverage. Example: If you previously had coverage for four months, have not had a break in coverage of more than 63 days, and your new insurance plan has a PECEP of 12 months, then you get a credit for your 4 previous months of coverage, leaving you with only 8 months left on your PECEP. So, if you have 12 months or more of previous health insurance coverage, and you never have a break in coverage of more than 63 days, you will never face a PECEP.

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<sup>2</sup> For more information about ICHIP, call (866) 851-2751.

Almost all types of health insurance can qualify as creditable coverage. (Medicare, Medicaid, group, individual, COBRA, and HIPAA plans can all qualify.) One exception is student health insurance plans because they are not typically a full policy with catastrophic coverage. If a particular condition was not covered by the policy that you are claiming as creditable coverage, then your new health plan may still subject that condition to a PECEP.

To show that you have creditable coverage, call your insurance company to request a “certificate of creditable coverage,” which lists the dates that you have been insured by that company. If you have been insured by multiple companies, you need certificates of creditable coverage from each one.

### Illinois Major Risk Insurance Plan

Illinois maintains a state health benefits risk pool, called the Illinois Comprehensive Health Insurance Plan (CHIP) to provide insurance for eligible residents of Illinois. Eligibility requirements are the same as being HIPAA eligible. This is called HIPAA-CHIP. Individuals who are not HIPAA eligible may qualify if they have applied for individual health insurance and have been rejected because of a pre-existing condition; they have an individual policy that is substantially similar to CHIP which costs them more than they would pay for CHIP coverage; or they have a conditions presumed to be uninsurable by insurance companies.

Based on the amount of state money that is available to subsidize the CHIP program enrollment is limited.

Eligible Illinois residents can apply for any of the CHIP benefit plans that are available under one of the State's two CHIP pools directly through the Board office, or through any agent or producer licensed to sell health insurance in Illinois. Parents or legal guardians of the person may apply on behalf of resident dependents or legally incompetent individuals. Guardianship or power of attorney papers are required. Separate applications are required for each applicant.

### **Handling Health Insurance Disputes**

If you disagree with a decision that your health insurance provider has made regarding coverage, you have the right to appeal that decision. The appeals process varies depending on what state you live in.

In Illinois, you must first exhaust your health plan's internal appeals process, and then you can request an external review of the decision.

#### *Internal review*

This is the health plan's own review of its decision. There are state and federal laws and rules that apply to internal review processes. The internal review must be complete in whole within 20 working days.

#### *External or independent review*

This is a reconsideration of the health plan's determination by an outside, independent organization. In Illinois, reviews are conducted by the Illinois Office of Consumer Health Insurance.

### Before you begin an appeal, understand your coverage and applicable laws.

An *employer-sponsored* health plan is one that a person can get through their own employment or through a family member's employment. The employer usually makes a contribution toward the cost of the employee's coverage. An *individually purchased* plan is one that you purchase directly from a health plan. The person purchasing the insurance pays the entire premium. Different laws apply depending on whether your plan is employer-sponsored or individually-purchased.

If your plan is an employer-sponsored plan, you need to know whether it is a *self-insured* plan. A self-insured plan is one in which the employer does not contract with an insurance company to insure their employees. Instead, the employer does their own risk pooling like an insurance company would, and pays directly for their employees' health costs. Since self-insurance does not involve a contract between an insurance company and an employer, it is not subject to state insurance regulations. Federal laws still apply to self-insured plans.

Know *what is covered* and what is not covered by your plan. Also know what *procedures* and *deadlines* are required by your plan.

Next, exhaust your plan's internal complaint process.

If you have a problem with your health plan, you have the right to file a complaint with your health plan. A complaint can also be called a grievance or an appeal. You may be able to file your complaint by phone, mail, or on the internet.

You should exhaust your plan's internal grievance process before pursuing external review through the Illinois Department of Financial and Professional Regulation - Department of Insurance, but you may file a complaint at any time with the Illinois Division of Insurance.

If your problem is not urgent, your health plan must give you a decision within *15 working days*.

If your problem is urgent, meaning there is a serious threat to your health, your health plan must give you a decision within *24 hours*.

Then, you may request external review.

The external review may take up to *5 days* to complete. If you are not granted external review, you may file a written complaint with the Department of Insurance

The decision of the independent review entity is binding on the plan.

## **Additional Health Care Rights in Illinois**

### Second Medical Opinions

In Illinois you have the right to a second medical opinion from a participating health care provider and to have it paid for by your health plan. The patient is responsible only for any applicable co-payments or coinsurance amounts.

## **Resources**

For Assistance With Insurance Disputes or  
Questions About State Health Insurance  
Continuation Coverage

**Illinois Department of Insurance**

320 W. Washington Street  
Springfield, IL 62767-0001  
(217) 782-4515

<http://www.idfpr.com/doi/default2.asp>

For Questions About COBRA

**U.S. Department of Labor**

**Employee Benefits Security Administration**

Chicago Regional Office  
200 West Adams St, Ste 1600  
Chicago, IL 60606  
(866) 444-3272

<http://www.dol.gov/ebsa/>

**U.S. Department of Labor  
Employee Benefits Security Administration**  
City Center Square  
1100 Main, Suite 1200  
Kansas City, MO 64105-2112  
(816) 426-5131 or (866) 275-7922  
<http://www.dol.gov/ebsa/>  
(Southern Illinois)

For Questions About The Health Insurance  
Premium Assistance Programs (HIPP)

**Illinois Department of Public Aid**  
Bureau of Collections TPL Section  
P.O. Box 19149  
Springfield, IL 62794-9890  
(800) 457-6273

For Questions About HIPAA

**Illinois Department of Insurance**  
320 W. Washington Street  
Springfield, IL 62767-0001  
(217) 782-4515  
<http://www.idfpr.com/doi/default2.asp>

For Questions About CHIP

**Illinois Comprehensive Health Insurance  
Plan**  
320 West Washington Street, Suite 700  
Springfield, Illinois 62701-1150  
(866) 851-2751 (toll-free in Illinois)  
[www.chip.state.il.us](http://www.chip.state.il.us)

For Assistance for Children

**Illinois All Kids**  
(866) 255-5437

For Questions About Medicaid

**Illinois Department of Healthcare and  
Family Services**  
201 South Grand Avenue East  
Springfield, IL 62763-0001  
(217) 782-1200

**Illinois Department of Human Services**  
401 South Clinton Street  
Chicago, Illinois 60607  
(800) 843-6154

For Questions About Medicare

**U.S. Department of Health & Human  
Services**  
Centers for Medicare & Medicaid Services  
(CMS)  
(800) 633-4227

**Senior Health Insurance Program**

320 W. Washington St.  
Springfield, IL 62767  
(800) 548-9034 or (217) 785-9021

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