HB2652

LRB09610389RPM20559b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB2652

Introduced 2/20/2009, by Rep. Kevin Joyce

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.15 new	
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2
215 ILCS 165/10	from Ch. 32, par. 604

Amends the Illinois Insurance Code, Health Maintenance Organization Act, and Voluntary Health Services Plans Act to provide coverage for prosthetic and customized orthotic devices that are no less favorable than the terms and conditions applicable to substantially all medical and surgical benefits provided under the plan or coverage. Provides that a policy or plan may require prior authorization. Provides that repairs and replacements of prosthetic and orthotic devices are also covered. Provides that a policy or plan may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to the Act shall be covered only if the prosthetic or orthotic devices are provided by a licensed provider employed by a provider service who contracts with or is designated by the carrier. Sets forth provisions concerning (i) patient access and (ii) in-network and out of network standards. Makes other changes. Contains a nonacceleration clause. Effective immediately.

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A BILL FOR

AN ACT concerning insurance.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by adding Section 356z.15 as follows:

(215 ILCS 5/356z.15 new)

Sec. 356z.15. Prosthetic and customized orthotic devices.

(a) For the purposes of this Section:

"Customized orthotic device", as defined in the Illinois Orthotic, Prosthetic, Pedorthic practice act of 2001, means a supportive device for the body or a part of the body, the head, neck, or extremities, and includes the replacement or repair of the device based on the patient's physical condition as medically necessary. This Act shall provide benefits to any person covered thereunder for expenses incurred in obtaining a prosthetic or orthotic device from any Illinois licensed prosthetist, licensed orthotist or licensed pedorthist.

"Licensed provider" means a prosthetist, orthotist or pedorthist licensed to practice in this State.

"Prosthetic device", as defined in the Illinois Orthotic, Prosthetic, Pedorthic Practice Act of 2001, means an artificial device to replace, in whole or in part, an arm or leg and includes accessories essential to the effective use of the

device and the replacement or repair of the device based on the patient's physical condition as medically necessary.

(b) A group or individual policy of accident or health insurance or managed care plan or medical/health/hospital service corporation contract amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 96th General Assembly must provide coverage for prosthetic and orthotic devices under terms and conditions that are no less favorable than the terms and conditions applicable to substantially all medical and surgical benefits provided under the plan or coverage.

(c) The policy or plan or contract may require prior authorization for the prosthetic or orthotic devices in the same manner that prior authorization is required for any other covered benefit. Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the patient as determined by the insured's treating physician.

(d) Repairs and replacements of prosthetic and orthotic devices are also covered, subject to the co-payments and deductibles, unless necessitated by misuse or loss. Such benefits for prosthetic and orthotic devices and components under the plan or coverage may not be subject to separate financial requirements that are applicable only with respect to such benefits; any financial requirements applicable to such benefits may be no more restrictive than the financial requirements applicable to substantially all medical and

surgical benefits provided under the plan or coverage.

(e) A policy or plan or contract may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to this Section shall be covered benefits only if the prosthetic or orthotic devices are provided by a licensed provider employed by a provider service who contracts with or is designated by the carrier, to the extent that the carrier provides in-network and out of network service, the coverage for the prosthetic or orthotic device shall be offered no less extensively. All policies, plans, and contracts require a minimum rate of reimbursement and coverage for such devices as under the Illinois State Medicaid reimbursement schedule as directed by the federal Medicare program.

No insurer corporation or health maintenance organization shall impose upon any person receiving benefits pursuant to this Section, any annual lifetime dollar maximum on coverage for prosthetic and orthotic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy or plan. The coverage may be made subject to, and no more restrictive than the provisions of a health insurance policy that applies to other benefits under the policy or plan.

(f) The following provisions apply to patient access:

(1) The health plan shall have available, either directly or though arrangements, appropriate and sufficient licensed providers of prosthetic care and

custom fabricated orthotic devices for people with severe permanent physical disabilities to meet the projected needs of its enrollees within a reasonable travel distance.

(2) Any health plan that does not provide coverage for benefits outside of the network shall ensure that its network contains a sufficient number of licensed providers for prosthetic care and custom fabricated orthotic devices for people with severe permanent physical disabilities to ensure that enrollees may obtain such services from a network provider located within a reasonable travel distance.

(3) Within the health plan's service area, the reasonable travel distance or time to the nearest licensed provider of prosthetic care or custom fabricated orthotics must be designated and the method used must be defined as the lesser of either travel distance or time. Reasonable travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest licensed provider.

(4) A request for an exception to the requirements of item 3 of this subsection (f) shall be considered. The health plan shall submit specific data in support of its request.

(g) The following provisions apply to in-network and out of network standards:

(1) In the case of a group health plan or health insurance coverage that provides both medical and surgical

benefits and benefits for prosthetic and custom fabricated orthotic devices for severe permanent physical disabilities and components and that provides both in-network benefits for prosthetic and custom orthotic devices for people with disabilities and out of network benefits for prosthetic and custom orthotic devices for people with disabilities, the requirements of this Section shall apply separately with respect to the benefits provided under the plan on an in-network basis and benefits provided under the plan on an out of network basis.

(2) Nothing in item (1) of this subsection (f) shall be construed as requiring that a group health plan or health insurance coverage offered in connection with such a plan eliminate an out-of-network provider option from such plan or coverage pursuant to the terms of the plan or coverage.

Section 10. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

(Text of Section before amendment by P.A. 95-958)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x,

356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.13 ~~356z.11~~, 356z.14, 356z.15, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial

conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with

respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's

profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

(Text of Section after amendment by P.A. 95-958)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13 ~~356z.11~~, 356z.14, 356z.15, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles

IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not

apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its

enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or

enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

Section 15. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

(Text of Section before amendment by P.A. 95-958)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c, 149, 155.37, 354, 355.2, 356g.5, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.13 ~~356z.11~~, 356z.14, 356z.15, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07;

95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

(Text of Section after amendment by P.A. 95-958)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c, 149, 155.37, 354, 355.2, 356g.5, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13 ~~356z.11~~, 356z.14, 356z.15, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07; 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

Section 95. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other

Public Act.

Section 99. Effective date. This Act takes effect upon becoming law.