

1 AN ACT concerning regulation.

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

4 Section 5. The Managed Care Reform and Patient Rights Act
5 is amended by changing Sections 15 and 90 as follows:

6 (215 ILCS 134/15)

7 Sec. 15. Provision of information.

8 (a) A health care plan shall provide annually to enrollees
9 and prospective enrollees, upon request, a complete list of
10 participating health care providers in the health care plan's
11 service area and a description of the following terms of
12 coverage:

13 (1) the service area;

14 (2) the covered benefits and services with all
15 exclusions, exceptions, and limitations;

16 (3) the pre-certification and other utilization review
17 procedures and requirements;

18 (4) a description of the process for the selection of
19 a primary care physician, any limitation on access to
20 specialists, and the plan's standing referral policy;

21 (5) the emergency coverage and benefits, including any
22 restrictions on emergency care services;

23 (6) the out-of-area coverage and benefits, if any;

1 (7) the enrollee's financial responsibility for
2 copayments, deductibles, premiums, and any other
3 out-of-pocket expenses;

4 (8) the provisions for continuity of treatment in the
5 event a health care provider's participation terminates
6 during the course of an enrollee's treatment by that
7 provider;

8 (9) the appeals process, forms, and time frames for
9 health care services appeals, complaints, and external
10 independent reviews, administrative complaints, and
11 utilization review complaints, including a phone number to
12 call to receive more information from the health care plan
13 concerning the appeals process; and

14 (10) a statement of all basic health care services and
15 all specific benefits and services mandated to be provided
16 to enrollees by any State law or administrative rule,
17 highlighting any newly enacted State law or administrative
18 rule, must be provided annually to enrollees. This
19 requirement can be fulfilled by providing enrollees the
20 most up-to-date accident and health checklist submitted to
21 the Department, reflecting statutory health care coverage
22 compliance by the health care plan. The requirement to
23 highlight any newly enacted State laws or administrative
24 rules does not apply to plans for beneficiaries of
25 Medicaid.

26 (a-5) Without limiting the generality of subsection (a) of

1 this Section, no qualified health plans shall be offered for
2 sale directly to consumers through the health insurance
3 marketplace operating in the State in accordance with Sections
4 1311 and 1321 of the federal Patient Protection and Affordable
5 Care Act (Public Law 111-148), as amended by the federal
6 Health Care and Education Reconciliation Act of 2010 (Public
7 Law 111-152), and any amendments thereto, or regulations or
8 guidance issued thereunder (collectively, "the Federal Act"),
9 unless, in addition to the information required under
10 subsection (a) of this Section, the following information is
11 available to the consumer at the time he or she is comparing
12 health care plans and their premiums:

13 (1) With respect to prescription drug benefits, the
14 most recently published formulary where a consumer can
15 view in one location covered prescription drugs;
16 information on tiering and the cost-sharing structure for
17 each tier; and information about how a consumer can obtain
18 specific copayment amounts or coinsurance percentages for
19 a specific qualified health plan before enrolling in that
20 plan. This information shall clearly identify the
21 qualified health plan to which it applies.

22 (2) The most recently published provider directory
23 where a consumer can view the provider network that
24 applies to each qualified health plan and information
25 about each provider, including location, contact
26 information, specialty, medical group, if any, any

1 institutional affiliation, and whether the provider is
2 accepting new patients. The information shall clearly
3 identify the qualified health plan to which it applies.

4 In the event of an inconsistency between any separate
5 written disclosure statement and the enrollee contract or
6 certificate, the terms of the enrollee contract or certificate
7 shall control.

8 (b) Upon written request, a health care plan shall provide
9 to enrollees a description of the financial relationships
10 between the health care plan and any health care provider and,
11 if requested, the percentage of copayments, deductibles, and
12 total premiums spent on healthcare related expenses and the
13 percentage of copayments, deductibles, and total premiums
14 spent on other expenses, including administrative expenses,
15 except that no health care plan shall be required to disclose
16 specific provider reimbursement.

17 (c) A participating health care provider shall provide all
18 of the following, where applicable, to enrollees upon request:

19 (1) Information related to the health care provider's
20 educational background, experience, training, specialty,
21 and board certification, if applicable.

22 (2) The names of licensed facilities on the provider
23 panel where the health care provider presently has
24 privileges for the treatment, illness, or procedure that
25 is the subject of the request.

26 (3) Information regarding the health care provider's

1 participation in continuing education programs and
2 compliance with any licensure, certification, or
3 registration requirements, if applicable.

4 (d) A health care plan shall provide the information
5 required to be disclosed under this Act upon enrollment and
6 annually thereafter in a legible and understandable format.
7 The Department shall promulgate rules to establish the format
8 based, to the extent practical, on the standards developed for
9 supplemental insurance coverage under Title XVIII of the
10 federal Social Security Act as a guide, so that a person can
11 compare the attributes of the various health care plans.

12 (e) The written disclosure requirements of this Section
13 may be met by disclosure to one enrollee in a household.

14 (f) Each issuer of qualified health plans for sale
15 directly to consumers through the health insurance marketplace
16 operating in the State shall make the information described in
17 subsection (a) of this Section, for each qualified health plan
18 that it offers, available and accessible to the general public
19 on the company's Internet website and through other means for
20 individuals without access to the Internet.

21 (g) The Department shall ensure that State-operated
22 Internet websites, in addition to the Internet website for the
23 health insurance marketplace established in this State in
24 accordance with the Federal Act and its implementing
25 regulations, prominently provide links to Internet-based
26 materials and tools to help consumers be informed purchasers

1 of health care plans.

2 (h) Nothing in this Section shall be interpreted or
3 implemented in a manner not consistent with the Federal Act.
4 This Section shall apply to all qualified health plans offered
5 for sale directly to consumers through the health insurance
6 marketplace operating in this State for any coverage year
7 beginning on or after January 1, 2015.

8 (Source: P.A. 103-154, eff. 6-30-23.)

9 (215 ILCS 134/90)

10 Sec. 90. Office of Consumer Health Insurance.

11 (a) The Director of Insurance shall establish the Office
12 of Consumer Health Insurance within the Department of
13 Insurance to provide assistance and information to all health
14 care consumers within the State. Within the appropriation
15 allocated, the Office shall provide information and assistance
16 to all health care consumers by:

17 (1) assisting consumers in understanding health
18 insurance marketing materials and the coverage provisions
19 of individual plans;

20 (2) educating enrollees about their rights within
21 individual plans;

22 (3) assisting enrollees with the process of filing
23 formal grievances and appeals;

24 (4) establishing and operating a toll-free "800"
25 telephone number line to handle consumer inquiries;

1 (5) making related information available in languages
2 other than English that are spoken as a primary language
3 by a significant portion of the State's population, as
4 determined by the Department;

5 (6) analyzing, commenting on, monitoring, and making
6 publicly available an annual report, posted in a prominent
7 location on the Department's publicly accessible website,
8 ~~reports~~ on the development and implementation of federal,
9 State, and local laws, regulations, and other governmental
10 policies and actions that pertain to the adequacy of
11 health care plans, facilities, and services in the State
12 and summary of all State health insurance benefit related
13 legislation enacted in the prior calendar year that
14 includes, at minimum, a link to the Public Act, the
15 statutory citation, the subject, a brief summary, and the
16 effective date;

17 (7) filing an annual report with the Governor, the
18 Director, and the General Assembly, which shall contain
19 recommendations for improvement of the regulation of
20 health insurance plans, including recommendations on
21 improving health care consumer assistance and patterns,
22 abuses, and progress that it has identified from its
23 interaction with health care consumers; and

24 (8) performing all duties assigned to the Office by
25 the Director.

26 (a-5) The report required under paragraph (6) of

1 subsection (a) shall be posted by January 31, 2026 and each
2 January 31 thereafter on the Department's publicly accessible
3 website.

4 (b) The report required under paragraph (7) of subsection
5 (a) ~~subsection (a) (7)~~ shall be filed and posted by January 31,
6 2026 ~~January 31, 2001~~ and each January 31 thereafter on the
7 Department's publicly accessible website.

8 (c) Nothing in this Section shall be interpreted to
9 authorize access to or disclosure of individual patient or
10 health care professional or provider records.

11 (Source: P.A. 91-617, eff. 1-1-00.)

12 Section 10. The Uniform Health Care Service Benefits
13 Information Card Act is amended by changing Section 15 as
14 follows:

15 (215 ILCS 139/15)

16 Sec. 15. Uniform health care benefit information cards
17 required.

18 (a) A health benefit plan, health benefit plan offering
19 dental coverage, or ~~a~~ dental plan that issues a physical or
20 electronic card or other technology and provides coverage for
21 health care services including prescription drugs or devices
22 also referred to as health care benefits and an administrator
23 of such a plan including, but not limited to, third-party
24 administrators for self-insured plans and state-administered

1 plans shall issue to its insureds a card or other technology
2 containing uniform health care benefit information. The health
3 care benefit information physical card, electronic card, and
4 ~~or~~ other technology shall specifically identify and display
5 the following mandatory data elements on the physical and
6 electronic cards ~~card~~:

7 (1) processor control number, if required for claims
8 adjudication;

9 (2) group number;

10 (3) card issuer identifier;

11 (4) cardholder ID number;

12 (5) (blank); ~~except for dental plans, the regulatory~~
13 ~~entity that holds authority over the plan; for the purpose~~
14 ~~of this requirement, the Department of Healthcare and~~
15 ~~Family Services is the regulatory entity that holds~~
16 ~~authority over plans that the Department of Healthcare and~~
17 ~~Family Services has contracted with to provide services~~
18 ~~under the medical assistance program;~~

19 (6) except for dental plans, any deductible applicable
20 to the plan;

21 (7) except for dental plans, any out-of-pocket maximum
22 limitation applicable to the plan;

23 (8) a toll-free telephone number and Internet website
24 address through which the cardholder may seek consumer
25 assistance information, such as up-to-date lists of
26 preferred providers, including health care professionals,

1 hospitals, and other facilities, offices, or sites that
2 are contracted to furnish items or services under the
3 plan, and additional information about the plan; and

4 (9) cardholder name.

5 (b) The uniform health care benefit information physical
6 card, electronic card, and ~~or~~ other technology shall
7 specifically identify and display the following mandatory data
8 elements on the back of the card:

9 (1) claims submission names and addresses; ~~and~~

10 (2) help desk telephone numbers and names; ~~and.~~

11 (3) ~~(b-5) A uniform health care benefit information~~
12 ~~card or other technology for a health benefit plan~~
13 ~~offering dental coverage or dental plan shall include a~~
14 statement indicating whether the ~~health benefit~~ plan
15 ~~offering dental coverage or dental plan~~ is self-insured or
16 fully funded and if the plan is subject to regulation by
17 the Department of Insurance. For the purpose of this
18 requirement, the Department of Healthcare and Family
19 Services is the regulatory entity that holds authority
20 over plans that the Department of Healthcare and Family
21 Services has contracted with to provide services under the
22 medical assistance program.

23 (c) A new uniform health care benefit information physical
24 card, electronic card, and ~~or~~ other technology shall be issued
25 by a health benefit plan or dental plan upon enrollment and
26 reissued upon any change in the insured's coverage that

1 affects mandatory data elements contained on the card.

2 (d) Notwithstanding subsections (a), (b), and (c) of this
3 Section, a discounted health care services plan administrator
4 shall issue to its beneficiaries a card containing the
5 following mandatory data elements:

6 (1) an Internet website for beneficiaries to access
7 up-to-date lists of preferred providers;

8 (2) a toll-free help desk number for beneficiaries and
9 providers to access up-to-date lists of preferred
10 providers and additional information about the discounted
11 health care services plan;

12 (3) the name or logo of the provider network;

13 (4) a group number, if necessary for the processing of
14 benefits;

15 (5) a cardholder ID number;

16 (6) the cardholder's name or a space to permit the
17 cardholder to print his or her name, if the cardholder
18 pays a periodic charge for use of the card;

19 (7) a processor control number, if required for claims
20 adjudication; and

21 (8) a statement that the plan is not insurance.

22 (e) As used in this Section, "discounted health care
23 services plan administrator" means any person, partnership, or
24 corporation, other than an insurer, health service
25 corporation, limited health service organization holding a
26 certificate of authority under the Limited Health Service

1 Organization Act, or health maintenance organization holding a
2 certificate of authority under the Health Maintenance
3 Organization Act that arranges, contracts with, or administers
4 contracts with a provider whereby insureds or beneficiaries
5 are provided an incentive to use health care services provided
6 by health care services providers under a discounted health
7 care services plan in which there are no other incentives,
8 such as copayment, coinsurance, or any other reimbursement
9 differential, for beneficiaries to utilize the provider.
10 "Discounted health care services plan administrator" also
11 includes any person, partnership, or corporation, other than
12 an insurer, health service corporation, limited health service
13 organization holding a certificate of authority under the
14 Limited Health Service Organization Act, or health maintenance
15 organization holding a certificate of authority under the
16 Health Maintenance Organization Act that enters into a
17 contract with another administrator to enroll beneficiaries or
18 insureds in a preferred provider program marketed as an
19 independently identifiable program based on marketing
20 materials or member benefit identification cards.

21 (Source: P.A. 102-902, eff. 1-1-24.)