



## 104TH GENERAL ASSEMBLY

### State of Illinois

2025 and 2026

SB3815

Introduced 2/6/2026, by Sen. Laura Ellman

#### SYNOPSIS AS INTRODUCED:

215 ILCS 97/5  
215 ILCS 97/65 new

Amends the Illinois Health Insurance Portability and Accountability Act. Defines "grandfathered health plan". Provides that, except for grandfathered health plans, a health insurance issuer in the individual, small group, or large group market shall not deny coverage to an individual or employer due to the individual's or employer's failure to pay premiums owed under a prior policy, certificate, or contract of insurance. Specifies that nothing in the provisions concerning past-due premiums prohibits a health insurance issuer from pursuing the collection of past-due premiums from an individual or employer by any other means permitted by law. Effective immediately.

LRB104 19900 BAB 33350 b

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 Illinois Health Insurance Portability and  
5 Accountability Act is amended by changing Section 5 and by  
6 adding Section 65 as follows:

7 (215 ILCS 97/5)

8 Sec. 5. Definitions.

9 "Affiliate" means a person that directly, or indirectly  
10 through one or more intermediaries, controls, is controlled  
11 by, or is under common control with the person specified.

12 "Beneficiary" has the meaning given such term under  
13 Section 3(8) of the Employee Retirement Income Security Act of  
14 1974.

15 "Bona fide association" means, with respect to health  
16 insurance coverage offered in a State, an association which:

17 (1) has been actively in existence for at least 5  
18 years;

19 (2) has been formed and maintained in good faith for  
20 purposes other than obtaining insurance;

21 (3) does not condition membership in the association  
22 on any health status-related factor relating to an  
23 individual (including an employee of an employer or a

1 dependent of an employee);

2 (4) makes health insurance coverage offered through  
3 the association available to all members regardless of any  
4 health status-related factor relating to such members (or  
5 individuals eligible for coverage through a member);

6 (5) does not make health insurance coverage offered  
7 through the association available other than in connection  
8 with a member of the association; and

9 (6) meets such additional requirements as may be  
10 imposed under State law.

11 "Church plan" has the meaning given that term under  
12 Section 3(33) of the Employee Retirement Income Security Act  
13 of 1974.

14 "COBRA continuation provision" means any of the following:

15 (1) Section 4980B of the Internal Revenue Code of  
16 1986, other than subsection (f)(1) of that Section insofar  
17 as it relates to pediatric vaccines.

18 (2) Part 6 of subtitle B of title I of the Employee  
19 Retirement Income Security Act of 1974, other than Section  
20 609 of that Act.

21 (3) Title XXII of federal Public Health Service Act.

22 "Control" means the possession, direct or indirect, of the  
23 power to direct or cause the direction of the management and  
24 policies of a person, whether through the ownership of voting  
25 securities, the holding of policyholders' proxies by contract  
26 other than a commercial contract for goods or non-management

1 services, or otherwise, unless the power is solely the result  
2 of an official position with or corporate office held by the  
3 person. Control is presumed to exist if any person, directly  
4 or indirectly, owns, controls, holds with the power to vote,  
5 or holds shareholders' proxies representing 10% or more of the  
6 voting securities of any other person or holds or controls  
7 sufficient policyholders' proxies to elect the majority of the  
8 board of directors of the domestic company. This presumption  
9 may be rebutted by a showing made in a manner as the Secretary  
10 may provide by rule. The Secretary may determine, after  
11 furnishing all persons in interest notice and opportunity to  
12 be heard and making specific findings of fact to support such  
13 determination, that control exists in fact, notwithstanding  
14 the absence of a presumption to that effect.

15 "Department" means the Department of Insurance.

16 "Employee" has the meaning given that term under Section  
17 3(6) of the Employee Retirement Income Security Act of 1974.

18 "Employer" has the meaning given that term under Section  
19 3(5) of the Employee Retirement Income Security Act of 1974,  
20 except that the term shall include only employers of 2 or more  
21 employees.

22 "Enrollment date" means, with respect to an individual  
23 covered under a group health plan or group health insurance  
24 coverage, the date of enrollment of the individual in the plan  
25 or coverage, or if earlier, the first day of the waiting period  
26 for enrollment.

1 "Federal governmental plan" means a governmental plan  
2 established or maintained for its employees by the government  
3 of the United States or by any agency or instrumentality of  
4 that government.

5 "Governmental plan" has the meaning given that term under  
6 Section 3(32) of the Employee Retirement Income Security Act  
7 of 1974 and any federal governmental plan.

8 "Grandfathered health plan" means coverage provided by a  
9 group health plan, or a group or individual health insurance  
10 issuer, in which an individual was enrolled on March 23, 2010  
11 for as long as the coverage maintains that status under 45 CFR  
12 147.140. This definition applies separately to each benefit  
13 package made available under a group health plan or health  
14 insurance coverage. Accordingly, if any benefit package  
15 relinquishes grandfather status, it shall not affect the  
16 grandfather status of the other benefit packages.

17 "Group health insurance coverage" means, in connection  
18 with a group health plan, health insurance coverage offered in  
19 connection with the plan.

20 "Group health plan" means an employee welfare benefit plan  
21 (as defined in Section 3(1) of the Employee Retirement Income  
22 Security Act of 1974) to the extent that the plan provides  
23 medical care (as defined in paragraph (2) of that Section and  
24 including items and services paid for as medical care) to  
25 employees or their dependents (as defined under the terms of  
26 the plan) directly or through insurance, reimbursement, or

1 otherwise.

2 "Health insurance coverage" means benefits consisting of  
3 medical care (provided directly, through insurance or  
4 reimbursement, or otherwise and including items and services  
5 paid for as medical care) under any hospital or medical  
6 service policy or certificate, hospital or medical service  
7 plan contract, or health maintenance organization contract  
8 offered by a health insurance issuer.

9 "Health insurance issuer" means an insurance company,  
10 insurance service, or insurance organization (including a  
11 health maintenance organization, as defined herein) which is  
12 licensed to engage in the business of insurance in a state and  
13 which is subject to Illinois law which regulates insurance  
14 (within the meaning of Section 514(b)(2) of the Employee  
15 Retirement Income Security Act of 1974). The term does not  
16 include a group health plan.

17 "Health maintenance organization (HMO)" means:

18 (1) a Federally qualified health maintenance  
19 organization (as defined in Section 1301(a) of the Public  
20 Health Service Act.);

21 (2) an organization recognized under State law as a  
22 health maintenance organization; or

23 (3) a similar organization regulated under State law  
24 for solvency in the same manner and to the same extent as  
25 such a health maintenance organization.

26 "Individual health insurance coverage" means health

1 insurance coverage offered to individuals in the individual  
2 market, but does not include short-term limited duration  
3 insurance.

4 "Individual market" means the market for health insurance  
5 coverage offered to individuals other than in connection with  
6 a group health plan.

7 "Large employer" means, in connection with a group health  
8 plan with respect to a calendar year and a plan year, an  
9 employer who employed an average of at least 51 employees on  
10 business days during the preceding calendar year and who  
11 employs at least 2 employees on the first day of the plan year.

12 (1) Application of aggregation rule for large  
13 employers. All persons treated as a single employer under  
14 subsection (b), (c), (m), or (o) of Section 414 of the  
15 Internal Revenue Code of 1986 shall be treated as one  
16 employer.

17 (2) Employers not in existence in preceding year. In  
18 the case of an employer which was not in existence  
19 throughout the preceding calendar year, the determination  
20 of whether the employer is a large employer shall be based  
21 on the average number of employees that it is reasonably  
22 expected the employer will employ on business days in the  
23 current calendar year.

24 (3) Predecessors. Any reference in this Act to an  
25 employer shall include a reference to any predecessor of  
26 such employer.

1 "Large group market" means the health insurance market  
2 under which individuals obtain health insurance coverage  
3 (directly or through any arrangement) on behalf of themselves  
4 (and their dependents) through a group health plan maintained  
5 by a large employer.

6 "Late enrollee" means with respect to coverage under a  
7 group health plan, a participant or beneficiary who enrolls  
8 under the plan other than during:

9 (1) the first period in which the individual is  
10 eligible to enroll under the plan; or

11 (2) a special enrollment period under subsection (F)  
12 of Section 20.

13 "Medical care" means amounts paid for:

14 (1) the diagnosis, cure, mitigation, treatment, or  
15 prevention of disease, or amounts paid for the purpose of  
16 affecting any structure or function of the body;

17 (2) amounts paid for transportation primarily for and  
18 essential to medical care referred to in item (1); and

19 (3) amounts paid for insurance covering medical care  
20 referred to in items (1) and (2).

21 "Nonfederal governmental plan" means a governmental plan  
22 that is not a federal governmental plan.

23 "Network plan" means health insurance coverage of a health  
24 insurance issuer under which the financing and delivery of  
25 medical care (including items and services paid for as medical  
26 care) are provided, in whole or in part, through a defined set

1 of providers under contract with the issuer.

2 "Participant" has the meaning given that term under  
3 Section 3(7) of the Employee Retirement Income Security Act of  
4 1974.

5 "Person" means an individual, a corporation, a  
6 partnership, an association, a joint stock company, a trust,  
7 an unincorporated organization, any similar entity, or any  
8 combination of the foregoing acting in concert, but does not  
9 include any securities broker performing no more than the  
10 usual and customary broker's function or joint venture  
11 partnership exclusively engaged in owning, managing, leasing,  
12 or developing real or tangible personal property other than  
13 capital stock.

14 "Placement" or being "placed" for adoption, in connection  
15 with any placement for adoption of a child with any person,  
16 means the assumption and retention by the person of a legal  
17 obligation for total or partial support of the child in  
18 anticipation of adoption of the child. The child's placement  
19 with the person terminates upon the termination of the legal  
20 obligation.

21 "Plan sponsor" has the meaning given that term under  
22 Section 3(16)(B) of the Employee Retirement Income Security  
23 Act of 1974.

24 "Preexisting condition exclusion" means, with respect to  
25 coverage, a limitation or exclusion of benefits relating to a  
26 condition based on the fact that the condition was present

1 before the date of enrollment for such coverage, whether or  
2 not any medical advice, diagnosis, care, or treatment was  
3 recommended or received before such date.

4 "Small employer" means, in connection with a group health  
5 plan with respect to a calendar year and a plan year, an  
6 employer who employed an average of at least 2 but not more  
7 than 50 employees on business days during the preceding  
8 calendar year and who employs at least 2 employees on the first  
9 day of the plan year.

10 (1) Application of aggregation rule for small  
11 employers. All persons treated as a single employer under  
12 subsection (b), (c), (m), or (o) of Section 414 of the  
13 Internal Revenue Code of 1986 shall be treated as one  
14 employer.

15 (2) Employers not in existence in preceding year. In  
16 the case of an employer which was not in existence  
17 throughout the preceding calendar year, the determination  
18 of whether the employer is a small employer shall be based  
19 on the average number of employees that it is reasonably  
20 expected the employer will employ on business days in the  
21 current calendar year.

22 (3) Predecessors. Any reference in this Act to a small  
23 employer shall include a reference to any predecessor of  
24 that employer.

25 "Small group market" means the health insurance market  
26 under which individuals obtain health insurance coverage

1 (directly or through any arrangement) on behalf of themselves  
2 (and their dependents) through a group health plan maintained  
3 by a small employer.

4 "State" means each of the several States, the District of  
5 Columbia, Puerto Rico, the Virgin Islands, Guam, American  
6 Samoa, and the Northern Mariana Islands.

7 "Waiting period" means with respect to a group health plan  
8 and an individual who is a potential participant or  
9 beneficiary in the plan, the period of time that must pass with  
10 respect to the individual before the individual is eligible to  
11 be covered for benefits under the terms of the plan.

12 (Source: P.A. 94-502, eff. 8-8-05.)

13 (215 ILCS 97/65 new)

14 Sec. 65. Past-due premiums.

15 (a) A health insurance issuer in the individual, small  
16 group, or large group market shall not deny coverage to an  
17 individual or employer due to the individual's or employer's  
18 failure to pay premiums owed under a prior policy,  
19 certificate, or contract of insurance, including by  
20 attributing payment of premiums for a new policy, certificate,  
21 or contract of insurance to the prior policy, certificate, or  
22 contract of insurance. This Section does not apply to a  
23 grandfathered health plan.

24 (b) Nothing in this Section prohibits a health insurance  
25 issuer from pursuing the collection of past-due premiums from

1 an individual or employer by any other means permitted by law.

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