AN ACT concerning regulation.

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

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

(215 ILCS 97/5)

Sec. 5. Definitions.

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

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

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

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

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

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

dependent of an employee);

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

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

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

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

"COBRA continuation provision" means any of the following:

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

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

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

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

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

"Department" means the Department of Insurance.

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

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

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

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

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

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

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

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

otherwise.

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

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

"Health maintenance organization (HMO)" means:

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

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

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

"Individual health insurance coverage" means health

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

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

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

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

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

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

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

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

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

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

"Medical care" means amounts paid for:

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

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

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

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

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

of providers under contract with the issuer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(215 ILCS 97/65 new)

Sec. 65. Past-due premiums.

(a) Except as provided in subsection (b) for a third plan or policy year, 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 a premium owed under a prior policy, certificate, or contract of health insurance coverage, including by attributing payment of premium for a new policy, certificate, or contract of health insurance coverage to the prior policy, certificate, or contract. The use of "one," "first," "second," and "third" in this Section does not limit its applicability to situations when terminations or

cancellations occur in consecutive plan or policy years.

(b) If a health insurance issuer terminates or cancels an individual or employer's coverage for nonpayment of premium in one plan or policy year and if the individual or employer enrolls in or purchases a new policy, certificate, or contract of health insurance coverage from the same issuer in a second plan or policy year, the issuer shall comply with subsection (a) if the individual or employer again enrolls in or purchases a new policy, certificate, or contract of health insurance coverage from the same issuer in a third plan or policy year unless:

(1) the individual or employer had past-due premiums from the first plan or policy year and all past-due amounts from the first and second years have not been paid; and

(2) during the second plan or policy year, the issuer offered a payment plan to the individual or employer under which all past-due premiums from the first plan or policy year would be spread out over 12 monthly billing periods starting with the bill for the first month of coverage in the second plan or policy year and the individual or employer failed to fulfill the requirements of the payment plan through the end of the 12-month period. As required by subsection (a), the issuer shall not attribute payments of premium for the new policy, certificate, or contract to amounts due under the payment plan.

(c) Except to the extent that a health insurance issuer must adhere to the terms of a payment plan it offers under paragraph (2) of subsection (b), nothing in this Section 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.

(d) Nothing in this Section shall supersede the requirements of Sections 30 or 50 of this Act. Nothing in this Section shall supersede any requirements related to grace periods or binder payments under applicable law. Subsection (b) shall be inoperative if a court or the United States Department of Health and Human Services interprets any exception to a provision substantially similar to subsection (a) to violate 42 U.S.C. 300gg-1 or federal regulations thereunder.

(e) For purposes of this Section, amounts are not considered past due with respect to any portion of a plan or policy year falling after the effective date of a termination, cancellation, or rescission or after the issuer declines to effectuate coverage due to the individual or employer's failure to make a timely binder payment.

(f) This Section does not apply to a grandfathered health plan.

(g) For the purposes of this subsection, "renewal" means the continuation in force of an existing policy, certificate, or contract of health insurance coverage with the same issuer

for a subsequent plan or policy year. This Section applies only to an individual or employer enrolling in or purchasing a new policy, certificate, or contract of health insurance coverage and shall not be construed to establish requirements or prohibitions for the renewal of an existing policy, certificate, or contract of health insurance coverage.

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