SB1812

LRB09709496RPM49633b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

SB1812

Introduced 2/9/2011, by Sen. Terry Link

SYNOPSIS AS INTRODUCED:

215 ILCS 5/352b new
215 ILCS 5/356r
215 ILCS 5/356r.1 new
215 ILCS 5/356z.12
215 ILCS 5/356z.19 new
215 ILCS 5/356z.20 new
215 ILCS 5/356z.21 new
215 ILCS 5/356z.23 new
215 ILCS 5/356z.24 new
215 ILCS 5/356z.25 new
215 ILCS 5/359c
215 ILCS 5/359f new
215 ILCS 125/5-3 from Ch. 111 1/2, par. 1411.2

Amends the Illinois Insurance Code. Adds definitions. Makes changes in the provisions concerning woman's principal health care provider and dependent coverage. Sets forth provisions concerning woman's health care providers; coverage of preventative services; annual and lifetime limits; reinstatement of coverage; patient protections; choice of health care professional; access to pediatric care; patient protections; coverage of emergency services; coverage for children with preexisting conditions; and health insurance rescissions and notice and hearing. Makes changes to the provision concerning accident and health reporting (now, accident and health expense reporting). Amends the Health Maintenance Organization Act to comport with the Illinois Insurance Code. Effective immediately.

LRB097 09496 RPM 49633 b

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 Sections 352b, 356r.1, 356z.19, 356z.20, 356z.21, 356z.23, 356z.24, 356z.25, and 359f and by changing Sections 356r, 356z.12, and 359c as follows:

(215 ILCS 5/352b new)

Sec. 352b. Definitions. Unless otherwise provided, as used in this Article the terms listed in this Section have the following meanings:

"Grandfathered health plan" has the same meaning given the term in Section 1251 of the Patient Protection and Affordable Care Act and applicable regulations.

"Health insurance issuer" has the same meaning given the term in the Illinois Health Insurance Portability and Accountability Act.

"Health insurance coverage" has the same meaning given the term in the Illinois Health Insurance Portability and Accountability Act.

"Group health insurance" has the same meaning given the term in the Illinois Health Insurance Portability and Accountability Act.

"Individual health insurance" has the same meaning given the term in the Illinois Health Insurance Portability and Accountability Act.

(215 ILCS 5/356r)

Sec. 356r. Woman's principal health care provider.

(a) An individual or group policy of accident and health insurance or a managed care plan not subject to Section 356r.1 of this Code ~~amended, delivered, issued, or renewed in this State after November 14, 1996~~ that requires an insured or enrollee to designate an individual to coordinate care or to control access to health care services shall also permit a female insured or enrollee to designate a participating woman's principal health care provider, and the insurer or managed care plan shall provide the following written notice ~~to all female insureds or enrollees no later than 120 days after the effective date of this amendatory Act of 1998;~~ to all new enrollees at the time of enrollment; and thereafter to all existing enrollees at least annually, as a part of a regular publication or informational mailing:

"NOTICE TO ALL FEMALE PLAN MEMBERS:

YOUR RIGHT TO SELECT A WOMAN'S PRINCIPAL

HEALTH CARE PROVIDER.

Illinois law allows you to select "a woman's principal health care provider" in addition to your selection of a primary care physician. A woman's principal health care

provider is a physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice. A woman's principal health care provider may be seen for care without referrals from your primary care physician. If you have not already selected a woman's principal health care provider, you may do so now or at any other time. You are not required to have or to select a woman's principal health care provider.

Your woman's principal health care provider must be a part of your plan. You may get the list of participating obstetricians, gynecologists, and family practice specialists from your employer's employee benefits coordinator, or for your own copy of the current list, you may call [insert plan's toll free number]. The list will be sent to you within 10 days after your call. To designate a woman's principal health care provider from the list, call [insert plan's toll free number] and tell our staff the name of the physician you have selected.".

If the insurer or managed care plan exercises the option set forth in subsection (a-5), the notice shall also state:

"Your plan requires that your primary care physician and your woman's principal health care provider have a referral arrangement with one another. If the woman's principal health care provider that you select does not have a referral arrangement with your primary care physician, you will have to select a new primary care

physician who has a referral arrangement with your woman's principal health care provider or you may select a woman's principal health care provider who has a referral arrangement with your primary care physician. The list of woman's principal health care providers will also have the names of the primary care physicians and their referral arrangements.".

No later than 120 days after the effective date of this amendatory Act of 1998, the insurer or managed care plan shall provide each employer who has a policy of insurance or a managed care plan with the insurer or managed care plan with a list of physicians licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice who have contracted with the plan. At the time of enrollment and thereafter within 10 days after a request by an insured or enrollee, the insurer or managed care plan also shall provide this list directly to the insured or enrollee. The list shall include each physician's address, telephone number, and specialty. No insurer or plan formal or informal policy may restrict a female insured's or enrollee's right to designate a woman's principal health care provider, except as set forth in subsection (a-5). If the female enrollee is an enrollee of a managed care plan under contract with the Department of Healthcare and Family Services, the physician chosen by the enrollee as her woman's principal health care provider must be a Medicaid-enrolled provider. This

requirement does not require a female insured or enrollee to make a selection of a woman's principal health care provider. The female insured or enrollee may designate a physician licensed to practice medicine in all its branches specializing in family practice as her woman's principal health care provider.

(a-5) The insured or enrollee may be required by the insurer or managed care plan to select a woman's principal health care provider who has a referral arrangement with the insured's or enrollee's individual who coordinates care or controls access to health care services if such referral arrangement exists or to select a new individual to coordinate care or to control access to health care services who has a referral arrangement with the woman's principal health care provider chosen by the insured or enrollee, if such referral arrangement exists. If an insurer or a managed care plan requires an insured or enrollee to select a new physician under this subsection (a-5), the insurer or managed care plan must provide the insured or enrollee with both options to select a new physician provided in this subsection (a-5).

Notwithstanding a plan's restrictions of the frequency or timing of making designations of primary care providers, a female enrollee or insured who is subject to the selection requirements of this subsection, may, at any time, effect a change in primary care physicians in order to make a selection of a woman's principal health care provider.

(a-6) If an insurer or managed care plan exercises the option in subsection (a-5), the list to be provided under subsection (a) shall identify the referral arrangements that exist between the individual who coordinates care or controls access to health care services and the woman's principal health care provider in order to assist the female insured or enrollee to make a selection within the insurer's or managed care plan's requirement.

(b) If a female insured or enrollee has designated a woman's principal health care provider, then the insured or enrollee must be given direct access to the woman's principal health care provider for services covered by the policy or plan without the need for a referral or prior approval. Nothing shall prohibit the insurer or managed care plan from requiring prior authorization or approval from either a primary care provider or the woman's principal health care provider for referrals for additional care or services.

(c) For the purposes of this Section the following terms are defined:

(1) "Woman's principal health care provider" means a physician licensed to practice medicine in all of its branches specializing in obstetrics or gynecology or specializing in family practice.

(2) "Managed care entity" means any entity including a licensed insurance company, hospital or medical service plan, health maintenance organization, limited health

service organization, preferred provider organization, third party administrator, an employer or employee organization, or any person or entity that establishes, operates, or maintains a network of participating providers.

(3) "Managed care plan" means a plan operated by a managed care entity that provides for the financing of health care services to persons enrolled in the plan through:

(A) organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution; or

(B) financial incentives for persons enrolled in the plan to use the participating providers and procedures covered by the plan.

(4) "Participating provider" means a physician who has contracted with an insurer or managed care plan to provide services to insureds or enrollees as defined by the contract.

(d) The original provisions of this Section became law on July 17, 1996 and took effect November 14, 1996, which is 120 days after becoming law.

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 5/356r.1 new)

Sec. 356r.1. Woman's health care provider.

(a) A health insurance issuer offering group or individual health insurance coverage described in subsection (c) of this Section may not require authorization or referral by the plan, issuer, or any person, including a primary care provider described in paragraph (2) of subsection (c) of this Section, in the case of a female insured who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. The issuer may require such a professional to agree to otherwise adhere to such issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the issuer.

(b) A health insurance issuer described in subsection (c) of this Section shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subsection (a) of this Section, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(c) A health insurance issuer offering group or individual health insurance coverage described in this Subsection is a group health plan or coverage that:

(1) provides coverage for obstetric or gynecologic care; and

(2) requires the designation by an insured or enrollee of a participating primary care provider.

(d) Nothing in subsection (a) of this Section shall be construed to:

(1) waive any exclusions of coverage under the terms and conditions of the health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or issuer of treatment decisions.

(e) A health insurance issuer subject to this Section shall provide the following written notice to all new insureds at the time of enrollment and to all insureds at the time such insured's insurance coverage is amended or renewed; thereafter, to all existing insureds at least annually, as a part of a regular publication or informational mailing:

"NOTICE TO ALL FEMALE PLAN MEMBERS:

YOUR RIGHT TO A WOMAN'S

HEALTH CARE PROVIDER.

Illinois law allows you to visit "a woman's health care provider" without obtaining authorization or referral from your primary care physician, insurer, or any other person or entity. A woman's health care provider is a physician licensed to practice medicine in all its branches

specializing in obstetrics or gynecology or specializing in family practice.

Your woman's health care provider must be a part of your plan. You may get the list of participating obstetricians, gynecologists, and family practice specialists from your employer's employee benefits coordinator, or for your own copy of the current list, you may call [insert plan's toll free number] . The list will be sent to you within 10 days after your call.".

No later than 120 days after the effective date of this amendatory Act of the 97th General Assembly, the health insurance issuer shall provide each employer who has a policy of health insurance coverage with the insurer with a list of physicians licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice who have contracted with the plan. At the time of enrollment and thereafter within 10 days after a request by an insured, the health insurance issuer also shall provide this list directly to the insured. The list shall include each physician's address, telephone number, and specialty.

(f) For the purposes of this Section.

(1) "Woman's health care provider" means a physician licensed to practice medicine in all of its branches specializing in obstetrics or gynecology or specializing in family practice.

(2) "Participating provider" means a physician who has

contracted with a health insurance issuer to provide services to insureds or enrollees as defined by the contract.

(g) This Section shall not apply to grandfathered health plans.

(h) This Section shall apply to any health insurance coverage amended, delivered, issued, or renewed on and after the effective date of this amendatory Act of the 97th General Assembly.

(215 ILCS 5/356z.12)

Sec. 356z.12. Dependent coverage.

(a) A group or individual policy of accident and health insurance or managed care plan that provides coverage for dependents and that is amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly shall not terminate coverage or deny the election of coverage for a ~~an unmarried~~ dependent by reason of the dependent's age before the dependent's 26th birthday.

(b) A policy or plan subject to this Section shall, upon amendment, delivery, issuance, or renewal, establish an initial enrollment period of not less than 90 days during which an insured may make a written election for coverage of a ~~an unmarried~~ person as a dependent under this Section. After the initial enrollment period, enrollment by a dependent pursuant to this Section shall be consistent with the enrollment terms

of the plan or policy.

(c) A policy or plan subject to this Section shall allow for dependent coverage during the annual open enrollment date or the annual renewal date if the dependent, as of the date on which the insured elects dependent coverage under this subsection, has:

(1) a period of continuous creditable coverage of 90 days or more; and

(2) not been without creditable coverage for more than 63 days.

An insured may elect coverage for a dependent who does not meet the continuous creditable coverage requirements of this subsection (c) and that dependent shall not be denied coverage due to age.

For purposes of this subsection (c), "creditable coverage" shall have the meaning provided under subsection (C)(1) of Section 20 of the Illinois Health Insurance Portability and Accountability Act.

(d) Military personnel. A group or individual policy of accident and health insurance or managed care plan that provides coverage for dependents and that is amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly shall not terminate coverage or deny the election of coverage for <u>a</u> ~~an unmarried~~ dependent by reason of the dependent's age before the dependent's 30th birthday if the dependent (i) is an Illinois

resident, (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release or discharge other than a dishonorable discharge. To be eligible for coverage under this subsection (d), the eligible dependent shall submit to the insurer a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.

(e) Calculation of the cost of coverage provided to a ~~an unmarried~~ dependent under this Section shall be identical.

(f) Nothing in this Section shall prohibit an employer from requiring an employee to pay all or part of the cost of coverage provided under this Section.

(g) No exclusions or limitations may be applied to coverage elected pursuant to this Section that do not apply to all dependents covered under the policy.

(h) A policy or plan subject to this Section shall not condition eligibility for dependent coverage provided pursuant to this Section on enrollment in any educational institution, the presence or absence of financial dependency upon the insured or any other person, residency with the insured or with any other person, marital status, employment, or any combination of these factors.

(i) Notice regarding coverage for a dependent as provided pursuant to this Section shall be provided to an insured by the insurer:

(1) upon application or enrollment;

(2) in the certificate of coverage or equivalent document prepared for an insured and delivered on or about the date on which the coverage commences; and

(3) in a notice delivered to an insured on a semi-annual basis.

(j) The requirements of this amendatory Act of the 97th General Assembly shall apply to any health insurance coverage amended, delivered, issued, or renewed on and after the effective date of this amendatory Act of the 97th General Assembly.

(Source: P.A. 95-958, eff. 6-1-09.)

(215 ILCS 5/356z.19 new)

Sec. 356z.19. Coverage of preventative services.

(a) Notwithstanding any other provision of law, except as provided in subsection (f) of this Section, a health insurance issuer offering group or individual health insurance coverage shall, at a minimum, provide coverage for and shall not impose any cost sharing requirements, such as a copayment, coinsurance, or deductible, for the following items and services:

(1) except as provided in subsection (b) of this Section, evidence-based items or services that have in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force as of

September 23, 2010, with respect to the individual involved;

(2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; for purposes of this paragraph (2), a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

(4) with respect to women, to the extent not described in paragraph (1) of this subsection (a), such additional evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(b) Unless otherwise required by law, a health insurance

issuer is not required to provide coverage for any items or services specified in any recommendation or guideline described in subsection (a) after the recommendation or guideline is no longer described in subsection (a).

(c) For the purposes of this Section, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

(d) A recommendation described in paragraphs (1) or (2) of subsection (a) of this Section or a guideline described under paragraphs (3) or (4) of subsection (a) of this Section that is issued after September 23, 2010, shall be effective with respect to a plan amended, delivered, issued, or renewed one year after such recommendation or guideline is issued.

(e) A health insurance issuer offering group or individual health insurance coverage may utilize value-based insurance designs to the extent such designs are permitted by guidelines issued by the Secretary of the United States Department of Health and Human Service.

(f) At least annually, a health insurance issuer shall visit the website maintained by the U.S. Department of Health and Human Services to determine whether any additional items or services must be covered without cost-sharing requirements and shall incorporate changes to coverage and cost-sharing requirements based on any new recommendations or guidelines as

set forth in subsection (d) of this Section.

(g) The following provisions shall apply concerning office visits:

(1) A health insurance issuer may impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this Section is billed separately or is tracked as individual encounter data separately from the office visit.

(2) A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this Section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

(3) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in subsection (a) of this Section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

(h) Nothing in this Section requires a health carrier that has a network of providers to provide benefits for items and services described in subsection (a) of this Section that are delivered by an out-of-network provider or precludes a health

carrier that has a network of providers from imposing cost-sharing requirements for items or services described in subsection (a) of this Section that are delivered by an out-of-network provider.

(i) Nothing in this Section prohibits a health carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee or under those guidelines. A health carrier may impose cost-sharing requirements for a treatment not described in this Section even if the treatments result from an item or service described in this Section.

(j) This Section shall not apply to grandfathered health plans.

(k) The requirements of this Section shall apply to any health insurance coverage amended, delivered, issued, or renewed on and after the effective date of the amendatory Act of the 97th General Assembly.

(215 ILCS 5/356z.20 new)

Sec. 356z.20. Annual and lifetime limits.

(a) Notwithstanding any other provision of law, except as

provided in subsection (d) of this Section, a health insurance issuer offering group or individual health insurance coverage shall not establish a lifetime limit on the dollar amount of essential health benefits for any insured.

(b) Notwithstanding any other provision of law, except as provided in subsection (c) of this Section, a health insurance issuer offering group or individual health insurance coverage shall not establish any annual limit on the dollar amount of essential health benefits for any insured.

(c) With respect to a plan amended, delivered, issued, or renewed before January 1, 2014, a health insurance issuer offering group or individual health insurance coverage may establish an annual limit on the dollar amount of essential health benefits provided the limit is no less than the following:

(1) for a plan amended, delivered, issued, or renewed beginning after September 22, 2010, but before September 23, 2011, $750,000;

(2) for a plan amended, delivered, issued, or renewed beginning after September 22, 2011, but before September 23, 2012, $1,250,000; and

(3) for a plan amended, delivered, issued, or renewed beginning after September 22, 2012, but before January 1, 2014, $2,000,000.

In determining whether an insured has received benefits that meet or exceed the allowable limits as provided in this

subsection, a health carrier shall take into account only essential health benefits.

A plan amended, delivered, issued, or renewed prior to January 1, 2014, is exempt from the annual limit requirements if the plan is approved for a waiver from such requirements by the U.S. Department of Health and Human Services, but such exemption only applies for the specified period of time that the waiver from the U.S. Department of Health and Human Services is applicable.

At the time a plan receives a waiver from the U.S. Department of Health and Human Services, the plan shall notify the Department, prospective applicants, and affected policyholders in each state where prospective applicants and any affected insured are known to reside.

At the time the waiver expires or is otherwise no longer in effect, the plan shall notify the Department and affected policyholders in each state where any affected insured is known to reside.

(d) Subsections (a) and (b) of this Section shall not be construed to prevent a health insurance issuer offering group or individual health insurance coverage from placing annual or lifetime dollar limits for any insured on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under federal or State law.

(e) Nothing in this Section prohibits a health insurance

issuer from excluding all benefits for a given condition.

(f) Subsection (b) of this Section shall not apply to grandfathered health plans that are individual health plans, a health flexible spending arrangement as defined in Section 106(a)(2)(i) of the federal Internal Revenue Code, a medical savings account as defined in Section 220 of the federal Internal Revenue Code, and a health savings account as defined in Section 223 of the federal Internal Revenue Code.

(g) The requirements of this Section shall apply to any health insurance coverage amended, delivered, issued, or renewed on and after September 23, 2010.

(h) For purposes of this Section, "essential health benefits" has the same meaning given the term in Section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations.

(215 ILCS 5/356z.21 new)

Sec. 356z.21. Reinstatement of coverage.

(a) This Section applies to any individual:

(1) whose coverage or benefits under a health plan ended by reason of reaching a lifetime limit on the dollar value of all benefits for the individual; and

(2) who, due to the provisions of Section 356z.20 of this Code, becomes eligible or is required to become eligible for benefits not subject to a lifetime limit on the dollar value of all benefits under the health plan:

(A) for group health insurance coverage, on the first day of the first plan year beginning on or after September 23, 2010; or

(B) for individual health insurance coverage, on the first day of the first policy year beginning on or after September 23, 2010.

(b) For individual health insurance coverage, an individual is not entitled to reinstatement under the health plan under this Section if the individual reached his or her lifetime limit and the contract is not renewed or is otherwise no longer in effect. However, this Section applies to a family member who reached his or her lifetime limit in a family plan and other family members remain covered under the plan.

(c) If an individual described in subsection (a) of this Section is eligible for benefits or is required to become eligible for benefits under the health plan, then the health carrier shall provide the individual written notice that:

(1) the lifetime limit on the dollar value of all benefits no longer applies; and

(2) the individual, if still covered under the plan is again eligible to receive benefits under the plan.

(d) If the individual is not enrolled in the plan or if an enrolled individual is eligible for, but not enrolled in, any benefit package under the plan, then the health plan shall provide an opportunity for the individual to enroll in the plan for a period of at least 30 days.

(e) The notices and enrollment opportunity under this Section shall be provided beginning no later than the following time frames:

(1) for group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or

(2) for individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.

(f) The notices required under this Section may be provided according to the following provisions:

(1) for group health insurance coverage, to an employee on behalf of the employee's dependent; or

(2) for individual health insurance coverage, to the primary subscriber on behalf of the primary subscriber's dependent.

(g) For group health insurance coverage, the notices may be included with other enrollment materials that a health benefit plan distributes to employees, provided the statement is prominent. If a notice satisfying the requirements of this subsection is provided to an individual, then a health carrier's requirement to provide the notice with respect to that individual is satisfied.

(h) For any individual who enrolls in a health benefit plan in accordance with this Section, coverage under the plan shall take effect no later than the following time frames:

(1) for group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or

(2) for individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.

(i) An individual enrolling in a health plan for group health insurance coverage in accordance with this Section shall be treated as if the individual were a special enrollee in the plan, as provided under federal regulations 45 CFR §146.117(d). In such instances, the following provisions shall apply:

(1) the individual shall be offered all of the benefit packages available to similarly situated individuals who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value of all benefits; and

(2) the individual shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

(j) For purposes of paragraph (1) of subsection (i) of this Section, any difference in benefits or cost-sharing constitutes a different benefit package.

(k) For purposes of this Section:

"Essential health benefits" has the same meaning given the term in Section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations.

"Policy year" means, in the individual health insurance market, the 12-month period that is designated as the policy year in the policy documents of the individual health insurance coverage. If there is no designation of a policy year in the policy document or no such policy document is available, then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, then the policy year is the calendar year.

(215 ILCS 5/356z.23 new)

Sec. 356z.23. Patient protections; choice of health care professional; access to pediatric care.

(a) Notwithstanding any other provision of law, a health insurance issuer offering group or individual health insurance coverage that requires or provides for designation by an insured of a participating primary care provider shall permit each participant or beneficiary to designate any participating primary care provider who is available to accept such individual.

(b) Notwithstanding any other provision of law, in the case of a person who has a child who is a participant or beneficiary under health insurance coverage offered by a health insurance issuer in the group or individual market, if the issuer requires or provides for the designation of a participating primary care provider for the child, the issuer shall permit such person to designate any participating physician who

specializes in pediatrics as the child's primary care provider if such provider is available to accept the child. Nothing in this subsection shall be construed to waive any exclusions of coverage under the terms and conditions of the health insurance coverage with respect to coverage of pediatric care.

(c) A health insurance issuer subject to this Section shall provide the following written notice to all new insureds at the time of enrollment and to all insureds at the time such insured's insurance coverage is amended or renewed; thereafter, to all existing insureds at least annually, as a part of a regular publication or informational mailing:

"YOUR RIGHT TO DESIGNATE A

HEALTH CARE PROVIDER.

[Name of health carrier] generally [requires/allows] the designation of a primary care health care professional. You have the right to designate any primary care health care professional who participates in our network and who is available to accept you or your family members. [If the health carrier designates a primary care health care professional automatically, insert:] Until you make this designation, [name of health carrier] designates one for you. [For health carriers that require or allow for the designation or a primary care health care professional for a child, add:] For children, you may designate a pediatrician as the primary care health care professional. For information on how to select a primary care health care

professional, and for a list of participating primary care health care professionals, contact the [health carrier] at [insert toll-free number] .".

(d) This Section shall not apply to grandfathered health plans.

(e) The requirements of this Section shall apply to any health insurance coverage amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 97th General Assembly.

(215 ILCS 5/356z.24 new)

Sec. 356z.24. Patient protections; coverage of emergency services.

(a) Notwithstanding any other provision of law, a health insurance issuer offering group or individual health insurance that provides or covers any benefits with respect to services in an emergency department of a hospital shall cover emergency services:

(1) without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;

(2) without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to such services;

(3) in a manner so that, if the emergency services are provided out of network:

(A) without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers; and

(B) the emergency services are provided at no greater cost to the insured than if the services were provided in network;

(4) without regard to any other term or condition of such coverage, other than exclusion or coordination of benefits, or an affiliation or waiting period permitted under part 7 of the Employee Retirement Income Security Act of 1974, part A of title XXVII of the Public Health Service Act, or chapter 100 of the Internal Revenue Code of 1986.

(b) As used in this Section:

"Emergency medical condition" has the same meaning as in the Managed Care Reform and Patient Rights Act.

"Emergency services" has the same meaning as in the Managed Care Reform and Patient Rights Act.

"Stabilize" has the same meaning as in the Managed Care Reform and Patient Rights Act.

(c) This Section shall not apply to grandfathered health plans.

(d) The requirements of this Section shall apply to any health insurance coverage amended, delivered, issued, or renewed on and after the effective date of this amendatory Act

of the 97th General Assembly.

(215 ILCS 5/356z.25 new)

Sec. 356z.25. Coverage for children with preexisting conditions.

(a) A health insurance issuer offering group or individual health insurance shall not limit or exclude coverage for an individual under the age of 19 by imposing a preexisting condition exclusion on that individual.

(b) Notwithstanding any other provision of law, a health insurance issuer offering individual health insurance must offer a child-only plan and shall accept applications for child-only plans and offer coverage without any limitations or riders based on health status according to the following provisions:

(1) during the open enrollment periods outlined in subsection (c) of this Section; and

(2) within 30 days after a qualifying event.

(c) Beginning July 1, 2011, and each January and July thereafter, a health insurance issuer offering a child only plan shall hold an open enrollment period for child-only plan applicants for the duration of the entire month. During these open enrollment periods, all child-only plan applicants under the age of 19 shall be offered coverage without any limitations or riders based on health status.

(d) Notice of the open enrollment opportunity and open

enrollment dates for new applicants, as well as the opportunity to enroll due to a qualifying event, must be displayed prominently on the health insurance issuer's web site throughout the year.

(e) Applications for coverage during a January open enrollment period shall become effective no later than March 1 following the open enrollment during which the application is received. Applications for coverage during a July open enrollment period shall become effective no later than September 1 following the open enrollment during which the application is received.

(f) To encourage continuous coverage, a child enrolling in an individual market child-only plan may be subject to a surcharge of up to 50% of the standard rate for up to 12 months if the child has a lapse in a child only plan within the past 12 months. The 50% surcharge may be on top of the rate that would be charged for the same child demonstrating continuous coverage.

(g) To ensure parents cannot temporarily obtain family coverage at any point in the year only to subsequently drop coverage to make the child a child-only subscriber, health insurance issuers are allowed to cancel coverage for dependents in the individual market if the parent subscriber drops coverage. The health insurance issuer must allow the child to enroll on a child-only basis during the next open enrollment period without assessing a surcharge for lapse in coverage.

(h) For the purposes of this Section:

"Child-only plan" means renewable individual health insurance coverage (as defined in 42 U.S.C. 300gg-91) issued with an effective date on or after September 23, 2010, that provides coverage to an individual under the age of 19. This shall not include individual health insurance coverage that covers children under age 19 as dependents.

"Qualifying event" includes the following:

(1) For individuals under age 19 covered as a dependent under the plan of another (the insured), and for individuals under age 19 with their own coverage:

(A) loss of the insured's or the individual's employer-sponsored insurance, including termination of employment or reduction in the number of hours of employment;

(B) involuntary loss of the insured's or the individual's other existing coverage for any reason other than fraud, misrepresentation or failure to pay premium so long as the individual is under age 19 when the qualifying event occurs;

(C) exhaustion of the insured's or the individual's COBRA continuation coverage;

(D) a situation in which a claim is incurred that would meet or exceed a lifetime or annual limit on all benefits;

(E) termination of employer contributions towards

the insured's or the individual's coverage, including any current or former employers;

(F) legal separation or divorce of the insured or the individual; and

(G) in the case of coverage offered through an HMO or other arrangement that does not provide benefits to persons who no longer reside, live, or work in a service area, loss of the insured's or the individual's coverage because a person no longer resides in the service area (whether or not within the choice of the person).

(2) For individuals under age 19 who have been covered as a dependent under the plan of another (the insured).

(3) For individuals under age 19 with their own coverage:

(A) birth, adoption, or placement for adoption of an individual; and

(B) a person under age 19 becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(4) Birth, adoption, or placement for adoption.

"Preexisting condition" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition was present before the effective date of coverage, or if the coverage is denied, the date of denial, under a health benefit plan whether or not any medical advice,

diagnosis, care or treatment was recommended or received before the effective date of coverage.

"Preexisting condition exclusion" includes any limitation or exclusion of benefits, including a denial of coverage, applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage or, if the coverage is denied, the date of denial under the health benefit plan, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual or review of medical records relating to the pre-enrollment period.

(215 ILCS 5/359c)

Sec. 359c. Accident and health ~~expense~~ reporting.

(a) Beginning January 1, 2011 and every 6 months thereafter, any health insurance issuer offering group or individual health insurance coverage ~~carrier providing a group or individual major medical policy of accident or health insurance~~ shall prepare and provide to the Department of Insurance a statement of the aggregate administrative expenses of the health insurance issuer ~~carrier~~, based on the premiums earned in the immediately preceding 6-month period on the health insurance coverage ~~accident or health insurance~~ business of the issuer ~~carrier~~. The semi-annual statements shall be filed on or before July 31 for the preceding 6-month

period ending June 30 and on or before February 1 for the preceding 6-month period ending December 31. The statements shall itemize and separately detail all of the following information with respect to the health insurance issuer's health insurance coverage ~~carrier's accident or health insurance~~ business:

(1) the amount of premiums earned by the health insurance issuer ~~carrier~~ both before and after any costs related to the issuer's ~~carrier's~~ purchase of reinsurance coverage;

(2) the total amount of claims for losses paid by the health insurance issuer ~~carrier~~ both before and after any reimbursement from reinsurance coverage including any costs incurred related to:

(A) disease, case, or chronic care management programs;

(B) wellness and health education programs;

(C) fraud prevention;

(D) maintaining provider networks and provider credentialing;

(E) health information technology for personal electronic health records; and

(F) utilization review and utilization management;

(3) the amount of any losses incurred by the health insurance issuer ~~carrier~~ but not reported to the issuer ~~carrier~~ in the current or prior reporting period;

(4) the amount of costs incurred by the carrier for State fees and federal and State taxes including:

(A) any high risk pool and guaranty fund assessments levied on the health insurance issuer ~~carrier~~ by the State; and

(B) any regulatory compliance costs including State fees for form and rate filings, licensures, market conduct exams, and financial reports;

(5) the amount of costs incurred by the health insurance issuer ~~carrier~~ for reinsurance coverage;

(6) the amount of costs incurred by the health insurance issuer ~~carrier~~ that are related to the issuer's ~~carrier's~~ payment of marketing expenses including commissions; ~~and~~

(7) any other administrative expenses incurred by the health insurance issuer ~~carrier~~.

(b) The information provided pursuant to subsection (a) of this Section shall be separately aggregated for the following lines of health insurance coverage ~~major medical insurance~~:

(1) individual health insurance ~~individually underwritten~~;

(2) group health insurance covering groups of 2 to 25 members;

(3) group health insurance covering groups of 26 to 50 members;

(4) group health insurance covering groups of 51 or

more members.

(b-5) Beginning January 1, 2011, any health insurance issuer offering group or individual health insurance coverage shall provide to the Department of Insurance any information required to be submitted to the Secretary of the U.S. Department of Health and Human Services under Section 2718 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act, or under regulations promulgated pursuant thereto.

(b-10) Any health insurance issuer offering group or individual health insurance coverage shall provide to the Department of Insurance and make available to the public any information required under Section 2715A of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act, or under regulations promulgated pursuant thereto.

(c) The Department shall make the submitted information publicly available on the Department's website or such other media as appropriate in a form useful for consumers.

(Source: P.A. 96-857, eff. 1-5-10.)

(215 ILCS 5/359f new)

Sec. 359f. Health insurance rescissions; notice and hearing.

(a) Notwithstanding any other provision of law, no health insurance issuer shall rescind any health insurance coverage

unless:

(1) as set forth in Section 2712 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act, the insured or someone seeking coverage on behalf of the insured has performed an act, practice, or omission that constitutes fraud or has made an intentional misrepresentation of material fact as prohibited by the terms of the health insurance coverage;

(2) the health insurance issuer provides a notice of rescission to the named insured pursuant to subsection (b) of this Section;

(3) the proposed effective date of such rescission is no more than 9 months after the date of issuance of the policy, certificate, or contract of health insurance coverage; and

(4) if such rescission is initiated after a claim is submitted under the policy, certificate, or contract of health insurance coverage, then the condition that relates to the submitted claim bears a direct relationship to the condition which is the subject of the act or practice described in paragraph (1) of subsection (a) of this Section.

(b) No rescission shall be effective unless, at least 60 days prior to the effective date of such rescission, a notice of rescission is mailed by the health insurance issuer to the named insured at the last mailing address known by the health

insurance issuer. The health insurance issuer shall maintain proof of mailing of such notice on a recognized U.S. Post Office form or a form acceptable to the U.S. Post Office or other commercial mail delivery service. A copy of all such notices shall be sent to the insured's broker, if known, or the agent of record, if known, at the last mailing address known to the health insurance issuer. All notices of rescission shall include a specific explanation of the reason or reasons for rescission and shall advise the named insured of his right to appeal the rescission under the Health Carrier Grievance Procedure Act and the Health Carrier External Review Act. The health insurance issuer must provide continued coverage pending the outcome of any appeal of a rescission.

(c) The requirements of this Section shall apply to any health insurance coverage amended, delivered, issued, or renewed on and after the effective date of this amendatory Act of the 97th General Assembly.

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)

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, 352b, 355.2, 356g.5-1, 356m, 356r, 356r.1, 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.14, 356z.12, 356z.19, 356z.20, 356z.21, 356z.23, 356z.24, 356z.25, 359c, 359f, 356z.15, 356z.17, 356z.18, 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.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 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; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; 96-833, eff. 6-1-10; 96-1000, eff. 7-2-10.)

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