Sen. Michael E. Hastings

Filed: 4/16/2015

1 AMENDMENT TO SENATE BILL 750

2 AMENDMENT NO. ______. Amend Senate Bill 750, AS AMENDED, by
3 replacing everything after the enacting clause with:

4 "Section 5. The Illinois Insurance Code is amended by
5 changing Section 355a as follows:

6 (215 ILCS 5/355a) (from Ch. 73, par. 967a)
7 Sec. 355a. Standardization of terms and coverage.
8 (1) The purpose of this Section shall be (a) to provide
9 reasonable standardization and simplification of terms and
10 coverages of individual accident and health insurance policies
11 to facilitate public understanding and comparisons; (b) to
12 eliminate provisions contained in individual accident and
13 health insurance policies which may be misleading or
14 unreasonably confusing in connection either with the purchase
15 of such coverages or with the settlement of claims; and (c) to
16 provide for reasonable disclosure in the sale of accident and

1 health coverages.

2 (2) Definitions applicable to this Section are as follows:

3 (a) "Policy" means all or any part of the forms
4 constituting the contract between the insurer and the
5 insured, including the policy, certificate, subscriber
6 contract, riders, endorsements, and the application if
7 attached, which are subject to filing with and approval by
8 the Director.

9 (b) "Service corporations" means voluntary health and
10 dental corporations organized and operating respectively
11 under the Voluntary Health Services Plans Act and the
12 Dental Service Plan Act.

13 (c) "Accident and health insurance" means insurance
14 written under Article XX of the Insurance Code, other than
15 credit accident and health insurance, and coverages
16 provided in subscriber contracts issued by service
17 corporations. For purposes of this Section such service
18 corporations shall be deemed to be insurers engaged in the
19 business of insurance.

20 (3) The Director shall issue such rules as he shall deem
21 necessary or desirable to establish specific standards,
22 including standards of full and fair disclosure that set forth
23 the form and content and required disclosure for sale, of
24 individual policies of accident and health insurance, which
25 rules and regulations shall be in addition to and in accordance
26 with the applicable laws of this State, and which may cover but

1 shall not be limited to: (a) terms of renewability; (b) initial
2 and subsequent conditions of eligibility; (c) non-duplication
3 of coverage provisions; (d) coverage of dependents; (e)
4 pre-existing conditions; (f) termination of insurance; (g)
5 probationary periods; (h) limitation, exceptions, and
6 reductions; (i) elimination periods; (j) requirements
7 regarding replacements; (k) recurrent conditions; and (l) the
8 definition of terms including but not limited to the following:
9 hospital, accident, sickness, injury, physician, accidental
10 means, total disability, partial disability, nervous disorder,
11 guaranteed renewable, and non-cancellable.

12 The Director may issue rules that specify prohibited policy
13 provisions not otherwise specifically authorized by statute
14 which in the opinion of the Director are unjust, unfair or
15 unfairly discriminatory to the policyholder, any person
16 insured under the policy, or beneficiary.

17 (4) The Director shall issue such rules as he shall deem
18 necessary or desirable to establish minimum standards for
19 benefits under each category of coverage in individual accident
20 and health policies, other than conversion policies issued
21 pursuant to a contractual conversion privilege under a group
22 policy, including but not limited to the following categories:
23 (a) basic hospital expense coverage; (b) basic
24 medical-surgical expense coverage; (c) hospital confinement
25 indemnity coverage; (d) major medical expense coverage; (e)
26 disability income protection coverage; (f) accident only

1 coverage; and (g) specified disease or specified accident
2 coverage.
3 Nothing in this subsection (4) shall preclude the issuance
4 of any policy which combines two or more of the categories of
5 coverage enumerated in subparagraphs (a) through (f) of this
6 subsection.
7 No policy shall be delivered or issued for delivery in this
8 State which does not meet the prescribed minimum standards for
9 the categories of coverage listed in this subsection unless the
10 Director finds that such policy is necessary to meet specific
11 needs of individuals or groups and such individuals or groups
12 will be adequately informed that such policy does not meet the
13 prescribed minimum standards, and such policy meets the
14 requirement that the benefits provided therein are reasonable
15 in relation to the premium charged. The standards and criteria
16 to be used by the Director in approving such policies shall be
17 included in the rules required under this Section with as much
18 specificity as practicable.
19 The Director shall prescribe by rule the method of
20 identification of policies based upon coverages provided.
21 (5) (a) In order to provide for full and fair disclosure in
22 the sale of individual accident and health insurance policies,
23 no such policy shall be delivered or issued for delivery in
24 this State unless the outline of coverage described in
25 paragraph (b) of this subsection either accompanies the policy,
26 or is delivered to the applicant at the time the application is

1 made, and an acknowledgment signed by the insured, of receipt
2 of delivery of such outline, is provided to the insurer. In the
3 event the policy is issued on a basis other than that applied
4 for, the outline of coverage properly describing the policy
5 must accompany the policy when it is delivered and such outline
6 shall clearly state that the policy differs, and to what
7 extent, from that for which application was originally made.
8 All policies, except single premium nonrenewal policies, shall
9 have a notice prominently printed on the first page of the
10 policy or attached thereto stating in substance, that the
11 policyholder shall have the right to return the policy within
12 10 days of its delivery and to have the premium refunded if
13 after examination of the policy the policyholder is not
14 satisfied for any reason.

15 (b) The Director shall issue such rules as he shall deem
16 necessary or desirable to prescribe the format and content of
17 the outline of coverage required by paragraph (a) of this
18 subsection. "Format" means style, arrangement, and overall
19 appearance, including such items as the size, color, and
20 prominence of type and the arrangement of text and captions.
21 "Content" shall include without limitation thereto, statements
22 relating to the particular policy as to the applicable category
23 of coverage prescribed under subsection 4; principal benefits;
24 exceptions, reductions and limitations; and renewal
25 provisions, including any reservation by the insurer of a right
26 to change premiums. Such outline of coverage shall clearly

1 state that it constitutes a summary of the policy issued or
2 applied for and that the policy should be consulted to
3 determine governing contractual provisions.

4 (c) Without limiting the generality of paragraph (b) of
5 this subsection (5), no qualified health plans shall be offered
6 for sale directly to consumers through the health insurance
7 marketplace operating in the State in accordance with Sections
8 1311 and 1321 of the federal Patient Protection and Affordable
9 Care Act of 2010 (Public Law 111-148), as amended by the
10 federal Health Care and Education Reconciliation Act of 2010
11 (Public Law 111-152), and any amendments thereto, or
12 regulations or guidance issued thereunder (collectively, "the
13 Federal Act"), unless the following information is made
14 available to the consumer at the time he or she is comparing
15 policies and their premiums:

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

25 (ii) The most recently published provider directory
26 where a consumer can view the provider network that applies

1 to each qualified health plan and information about each
2 provider, including location, contact information,
3 specialty, medical group, if any, any institutional
4 affiliation, and whether the provider is accepting new
5 patients at each of the specific locations listing the
6 provider. Providers shall notify qualified health plans
7 electronically or in writing of any changes to their
8 information as listed in the provider directory. Qualified
9 health plans shall update their directories in a manner
10 consistent with the information provided by the provider
11 within 10 business days after being notified of the change
12 by the provider. Nothing in this paragraph (ii) shall void
13 any contractual relationship between the provider and the
14 plan. The information shall clearly identify the qualified
15 health plan to which it applies.
16 (d) Each company that offers qualified health plans for
17 sale directly to consumers through the health insurance
18 marketplace operating in the State shall make the information
19 in paragraph (c) of this subsection (5), for each qualified
20 health plan that it offers, available and accessible to the
21 general public on the company's Internet website and through
22 other means for individuals without access to the Internet.
23 (e) The Department shall ensure that State-operated
24 Internet websites, in addition to the Internet website for the
25 health insurance marketplace established in this State in
26 accordance with the Federal Act, prominently provide links to

1 Internet-based materials and tools to help consumers be
2 informed purchasers of health insurance.
3 (f) Nothing in this Section shall be interpreted or
4 implemented in a manner not consistent with the Federal Act.
5 This Section shall apply to all qualified health plans offered
6 for sale directly to consumers through the health insurance
7 marketplace operating in this State for any coverage year
8 beginning on or after January 1, 2015.
9 (6) Prior to the issuance of rules pursuant to this
10 Section, the Director shall afford the public, including the
11 companies affected thereby, reasonable opportunity for
12 comment. Such rulemaking is subject to the provisions of the
13 Illinois Administrative Procedure Act.
14 (7) When a rule has been adopted, pursuant to this Section,
15 all policies of insurance or subscriber contracts which are not
16 in compliance with such rule shall, when so provided in such
17 rule, be deemed to be disapproved as of a date specified in
18 such rule not less than 120 days following its effective date,
19 without any further or additional notice other than the
20 adoption of the rule.
21 (8) When a rule adopted pursuant to this Section so
22 provides, a policy of insurance or subscriber contract which
23 does not comply with the rule shall not less than 120 days from
24 the effective date of such rule, be construed, and the insurer
25 or service corporation shall be liable, as if the policy or
26 contract did comply with the rule.

1 (9) Violation of any rule adopted pursuant to this Section
2 shall be a violation of the insurance law for purposes of
3 Sections 370 and 446 of the Insurance Code.
4 (Source: P.A. 98-1035, eff. 8-25-14.)

5 Section 10. The Dental Care Patient Protection Act is
6 amended by changing Section 25 as follows:

7 (215 ILCS 109/25)
8 Sec. 25. Provision of information.
9 (a) A managed care dental plan shall provide upon request
10 to prospective enrollees a written summary description of all
11 of the following terms of coverage:
12 (1) Information about the dental plan, including how
13 the plan operates and what general types of financial
14 arrangements exist between dentists and the plan. Nothing
15 in this Section shall require disclosure of any specific
16 financial arrangements between providers and the plan.
17 (2) The service area.
18 (3) Covered benefits, exclusions, or limitations.
19 (4) Pre-certification requirements including any
20 requirements for referrals made by primary care dentists to
21 specialists, and other preauthorization requirements.
22 (5) A list of participating primary care dentists in
23 the plan's service area, including provider address and
24 phone number, for an enrollee to evaluate the managed care

1 dental plan's network access, as well as a phone number by
2 which the prospective enrollee may obtain additional
3 information regarding the provider network including
4 participating specialists. However, a managed care dental
5 plan offering a preferred provider organization ("PPO")
6 product that does not require the enrollee to select a
7 primary care dentist shall only be required to make
8 available for inspection to enrollees and prospective
9 enrollees a list of participating dentists in the plan's
10 service area, including whether the provider is accepting
11 new patients at each of the specific locations listing the
12 provider. Providers shall notify managed care dental plans
13 electronically or in writing of any changes to their
14 information as listed in the provider directory. Managed
15 care dental plans shall update their directories in a
16 manner consistent with the information provided by the
17 provider within 10 business days after being notified of
18 the change by the provider.
19 Nothing in this paragraph (5) shall void any
20 contractual relationship between the provider and the
21 plan.
22 (6) Emergency coverage and benefits.
23 (7) Out-of-area coverages and benefits, if any.
24 (8) The process about how participating dentists are
25 selected.
26 (9) The grievance process, including the telephone

number to call to receive information concerning grievance procedures.

An enrollee shall be provided with an evidence of coverage as required under the Illinois Insurance Code provisions applicable to the managed care dental plan.

(b) An enrollee or prospective enrollee has the right to the most current financial statement filed by the managed care dental plan by contacting the Department of Insurance. The Department may charge a reasonable fee for providing such information.

(c) The managed care dental plan shall provide to the Department, on an annual basis, a list of all participating dentists. Nothing in this Section shall require a particular ratio for any type of provider.

(d) If the managed care dental plan uses a capitation method of compensation to its primary care providers (dentists), the plan must establish and follow procedures that ensure that:

(1) the plan application form includes a space in which each enrollee selects a primary care provider (dentist);

(2) if an enrollee who fails to select a primary care provider (dentist) is assigned a primary care provider (dentist), the enrollee shall be notified of the name and location of that primary care provider (dentist); and

(3) primary care provider (dentist) to whom an enrollee is assigned, pursuant to item (2), is physically located

1 within a reasonable travel distance, as established by rule
2 adopted by the Director, from the residence or place of
3 employment of the enrollee.
4 (e) Nothing in this Act shall be deemed to require a plan
5 to assign an enrollee to a primary care provider (dentist).
6 (Source: P.A. 91-355, eff. 1-1-00.)

7 Section 15. The Illinois Dental Practice Act is amended by
8 changing Sections 44 and 45 as follows:

9 (225 ILCS 25/44) (from Ch. 111, par. 2344)
10 (Section scheduled to be repealed on January 1, 2016)
11 Sec. 44. Practice by Corporations Prohibited. Exceptions.
12 No corporation shall practice dentistry or engage therein, or
13 hold itself out as being entitled to practice dentistry, or
14 furnish dental services or dentists, or advertise under or
15 assume the title of dentist or dental surgeon or equivalent
16 title, or furnish dental advice for any compensation, or
17 advertise or hold itself out with any other person or alone,
18 that it has or owns a dental office or can furnish dental
19 service or dentists, or solicit through itself, or its agents,
20 officers, employees, directors or trustees, dental patronage
21 for any dentist employed by any corporation.
22 Nothing contained in this Act, however, shall:
23 (a) prohibit a corporation from employing a dentist or
24 dentists to render dental services to its employees,

1 provided that such dental services shall be rendered at no
2 cost or charge to the employees;
3 (b) prohibit a corporation or association from
4 providing dental services upon a wholly charitable basis to
5 deserving recipients;
6 (c) prohibit a corporation or association from
7 furnishing information or clerical services which can be
8 furnished by persons not licensed to practice dentistry, to
9 any dentist when such dentist assumes full responsibility
10 for such information or services;
11 (d) prohibit dental corporations as authorized by the
12 Professional Service Corporation Act, dental associations
13 as authorized by the Professional Association Act, or
14 dental limited liability companies as authorized by the
15 Limited Liability Company Act;
16 (e) prohibit dental limited liability partnerships as
17 authorized by the Uniform Partnership Act (1997);
18 (f) prohibit hospitals, public health clinics,
19 federally qualified health centers, or other entities
20 specified by rule of the Department from providing dental
21 services; or
22 (g) prohibit dental management service organizations
23 from providing non-clinical business services that do not
24 violate the provisions of this Act.
25 Any corporation violating the provisions of this Section is
26 guilty of a Class A misdemeanor and each day that this Act is

violated shall be considered a separate offense.

If a dental management service organization is responsible for enrolling the dentist as a provider in managed care plans provider networks, it shall provide verification to the managed care provider network regarding whether the provider is accepting new patients at each of the specific locations listing the provider. Providers shall notify dental management service organizations electronically or in writing of any changes to their information as listed in the provider directory. Dental management service organizations shall update their directories in a manner consistent with the information provided by the provider within 10 business days after being notified of the change by the provider.

Nothing in this Section shall void any contractual relationship between the provider and the organization.

(Source: P.A. 96-328, eff. 8-11-09.)

(225 ILCS 25/45) (from Ch. 111, par. 2345)

(Section scheduled to be repealed on January 1, 2016)

Sec. 45. Advertising. The purpose of this Section is to authorize and regulate the advertisement by dentists of information which is intended to provide the public with a sufficient basis upon which to make an informed selection of dentists while protecting the public from false or misleading advertisements which would detract from the fair and rational selection process.

1 Any dentist may advertise the availability of dental
2 services in the public media or on the premises where such
3 dental services are rendered. Such advertising shall be limited
4 to the following information:
5 (a) The dental services available;
6 (b) Publication of the dentist's name, title, office
7 hours, address and telephone;
8 (c) Information pertaining to his or her area of
9 specialization, including appropriate board certification
10 or limitation of professional practice;
11 (d) Information on usual and customary fees for routine
12 dental services offered, which information shall include
13 notification that fees may be adjusted due to complications
14 or unforeseen circumstances;
15 (e) Announcement of the opening of, change of, absence
16 from, or return to business;
17 (f) Announcement of additions to or deletions from
18 professional dental staff;
19 (g) The issuance of business or appointment cards;
20 (h) Other information about the dentist, dentist's
21 practice or the types of dental services which the dentist
22 offers to perform which a reasonable person might regard as
23 relevant in determining whether to seek the dentist's
24 services. However, any advertisement which announces the
25 availability of endodontics, pediatric dentistry,
26 periodontics, prosthodontics, orthodontics and dentofacial

1 orthopedics, oral and maxillofacial surgery, or oral and
2 maxillofacial radiology by a general dentist or by a
3 licensed specialist who is not licensed in that specialty
4 shall include a disclaimer stating that the dentist does
5 not hold a license in that specialty.

6 Any dental practice with more than one location that
7 enrolls its dentist as a participating provider in a managed
8 care plan's network must verify electronically or in writing
9 whether the provider is accepting new patients at each of the
10 specific locations listing the provider. The health plan shall
11 remove the provider from the directory in accordance with
12 standard practices within 10 business days after being notified
13 of the changes by the provider. Nothing in this paragraph shall
14 void any contractual relationship between the provider and the
15 plan.

16 It is unlawful for any dentist licensed under this Act to
17 do any of the following:

18 (1) Use claims of superior quality of care to entice
19 the public.

20 (2) Advertise in any way to practice dentistry without
21 causing pain.

22 (3) Pay a fee to any dental referral service or other
23 third party who advertises a dental referral service,
24 unless all advertising of the dental referral service makes
25 it clear that dentists are paying a fee for that referral
26 service.

(4) Advertise or offer gifts as an inducement to secure dental patronage. Dentists may advertise or offer free examinations or free dental services; it shall be unlawful, however, for any dentist to charge a fee to any new patient for any dental service provided at the time that such free examination or free dental services are provided.

(5) Use the term "sedation dentistry" or similar terms in advertising unless the advertising dentist holds a valid and current permit issued by the Department to administer either general anesthesia, deep sedation, or conscious sedation as required under Section 8.1 of this Act.

This Act does not authorize the advertising of dental services when the offeror of such services is not a dentist. Nor shall the dentist use statements which contain false, fraudulent, deceptive or misleading material or guarantees of success, statements which play upon the vanity or fears of the public, or statements which promote or produce unfair competition.

A dentist shall be required to keep a copy of all advertisements for a period of 3 years. All advertisements in the dentist's possession shall indicate the accurate date and place of publication.

The Department shall adopt rules to carry out the intent of this Section.

(Source: P.A. 97-1013, eff. 8-17-12.)

1 Section 99. Effective date. This Act takes effect January
2 1, 2016.".