

1 AN ACT concerning insurance.

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

4 Section 5. The Illinois Health Insurance Portability and
5 Accountability Act is amended by changing Sections 5 and 50 and
6 by adding Section 60 as follows:

7 (215 ILCS 97/5)

8 Sec. 5. Definitions.

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

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

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

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

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

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

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

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

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

1 "Church plan" has the meaning given that term under Section
2 3(33) of the Employee Retirement Income Security Act of 1974.

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

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

7 (2) Part 6 of subtitle B of title I of the Employee
8 Retirement Income Security Act of 1974, other than Section
9 609 of that Act.

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

11 "Control" means the possession, direct or indirect, of the
12 power to direct or cause the direction of the management and
13 policies of a person, whether through the ownership of voting
14 securities, the holding of policyholders' proxies by contract
15 other than a commercial contract for goods or non-management
16 services, or otherwise, unless the power is solely the result
17 of an official position with or corporate office held by the
18 person. Control is presumed to exist if any person, directly or
19 indirectly, owns, controls, holds with the power to vote, or
20 holds shareholders' proxies representing 10% or more of the
21 voting securities of any other person or holds or controls
22 sufficient policyholders' proxies to elect the majority of the
23 board of directors of the domestic company. This presumption
24 may be rebutted by a showing made in a manner as the Secretary
25 may provide by rule. The Secretary may determine, after
26 furnishing all persons in interest notice and opportunity to be
27 heard and making specific findings of fact to support such
28 determination, that control exists in fact, notwithstanding
29 the absence of a presumption to that effect.

30 "Department" means the Department of Insurance.

31 "Employee" has the meaning given that term under Section
32 3(6) of the Employee Retirement Income Security Act of 1974.

33 "Employer" has the meaning given that term under Section
34 3(5) of the Employee Retirement Income Security Act of 1974,
35 except that the term shall include only employers of 2 or more
36 employees.

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

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

10 "Governmental plan" has the meaning given that term under
11 Section 3(32) of the Employee Retirement Income Security Act of
12 1974 and any federal governmental plan.

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

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

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

31 "Health insurance issuer" means an insurance company,
32 insurance service, or insurance organization (including a
33 health maintenance organization, as defined herein) which is
34 licensed to engage in the business of insurance in a state and
35 which is subject to Illinois law which regulates insurance
36 (within the meaning of Section 514(b)(2) of the Employee

1 Retirement Income Security Act of 1974). The term does not
2 include a group health plan.

3 "Health maintenance organization (HMO)" means:

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

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

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

12 "Individual health insurance coverage" means health
13 insurance coverage offered to individuals in the individual
14 market, but does not include short-term limited duration
15 insurance.

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

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

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

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

36 (3) Predecessors. Any reference in this Act to an

1 employer shall include a reference to any predecessor of
2 such employer.

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

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

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

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

15 "Medical care" means amounts paid for:

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

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

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

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

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

30 "Participant" has the meaning given that term under Section
31 3(7) of the Employee Retirement Income Security Act of 1974.

32 "Person" means an individual, a corporation, a
33 partnership, an association, a joint stock company, a trust, an
34 unincorporated organization, any similar entity, or any
35 combination of the foregoing acting in concert, but does not
36 include any securities broker performing no more than the usual

1 and customary broker's function or joint venture partnership
2 exclusively engaged in owning, managing, leasing, or
3 developing real or tangible personal property other than
4 capital stock.

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

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

15 "Preexisting condition exclusion" means, with respect to
16 coverage, a limitation or exclusion of benefits relating to a
17 condition based on the fact that the condition was present
18 before the date of enrollment for such coverage, whether or not
19 any medical advice, diagnosis, care, or treatment was
20 recommended or received before such date.

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

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

32 (2) Employers not in existence in preceding year. In
33 the case of an employer which was not in existence
34 throughout the preceding calendar year, the determination
35 of whether the employer is a small employer shall be based
36 on the average number of employees that it is reasonably

1 expected the employer will employ on business days in the
2 current calendar year.

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

6 "Small group market" means the health insurance market
7 under which individuals obtain health insurance coverage
8 (directly or through any arrangement) on behalf of themselves
9 (and their dependents) through a group health plan maintained
10 by a small employer.

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

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

19 (Source: P.A. 90-30, eff. 7-1-97.)

20 (215 ILCS 97/50)

21 Sec. 50. Guaranteed renewability of individual health
22 insurance coverage.

23 (A) In general. Except as provided in this Section, a
24 health insurance issuer that provides individual health
25 insurance coverage to an individual shall renew or continue in
26 force such coverage at the option of the individual.

27 (B) General exceptions. A health insurance issuer may
28 nonrenew or discontinue health insurance coverage of an
29 individual in the individual market based only on one or more
30 of the following:

31 (1) Nonpayment of premiums. The individual has failed
32 to pay premiums or contributions in accordance with the
33 terms of the health insurance coverage or the issuer has
34 not received timely premium payments.

35 (2) Fraud. The individual has performed an act or

1 practice that constitutes fraud or made an intentional
2 misrepresentation of material fact under the terms of the
3 coverage.

4 (3) Termination of plan. The issuer is ceasing to offer
5 coverage in the individual market in accordance with
6 subsection (C) of this Section and applicable Illinois law.

7 (4) Movement outside the service area. In the case of a
8 health insurance issuer that offers health insurance
9 coverage in the market through a network plan, the
10 individual no longer resides, lives, or works in the
11 service area (or in an area for which the issuer is
12 authorized to do business), but only if such coverage is
13 terminated under this paragraph uniformly without regard
14 to any health status-related factor of covered
15 individuals.

16 (5) Association membership ceases. In the case of
17 health insurance coverage that is made available in the
18 individual market only through one or more bona fide
19 associations, the membership of the individual in the
20 association (on the basis of which the coverage is
21 provided) ceases, but only if such coverage is terminated
22 under this paragraph uniformly without regard to any health
23 status-related factor of covered individuals.

24 (C) Requirements for uniform termination of coverage.

25 (1) Particular type of coverage not offered. In any
26 case in which an issuer decides to discontinue offering a
27 particular type of health insurance coverage offered in the
28 individual market, coverage of such type may be
29 discontinued by the issuer only if:

30 (a) the issuer provides notice to each covered
31 individual provided coverage of this type in such
32 market of such discontinuation at least 90 days prior
33 to the date of the discontinuation of such coverage;

34 (b) the issuer offers, to each individual in the
35 individual market provided coverage of this type, the
36 option to purchase any other individual health

1 insurance coverage currently being offered by the
2 issuer for individuals in such market; and

3 (c) in exercising the option to discontinue
4 coverage of that type and in offering the option of
5 coverage under subparagraph (b), the issuer acts
6 uniformly without regard to any health status-related
7 factor of enrolled individuals or individuals who may
8 become eligible for such coverage.

9 (2) Discontinuance of all coverage.

10 (a) In general. Subject to subparagraph (c), in any
11 case in which a health insurance issuer elects to
12 discontinue offering all health insurance coverage in
13 the individual market in Illinois, health insurance
14 coverage may be discontinued by the issuer only if:

15 (i) the issuer provides notice to the Director
16 and to each individual of the discontinuation at
17 least 180 days prior to the date of the expiration
18 of such coverage; ~~and~~

19 (ii) all health insurance issued or delivered
20 for issuance in Illinois in such market is
21 discontinued and coverage under such health
22 insurance coverage in such market is not renewed;
23 and.

24 (iii) in the case where the issuer has
25 affiliates in the individual market, the issuer
26 gives notice to each affected individual at least
27 180 days prior to the date of the expiration of the
28 coverage of the individual's option to purchase
29 all other individual health benefit plans
30 currently offered by any affiliate of the carrier.

31 (b) Prohibition on market reentry. In the case of a
32 discontinuation under subparagraph (a) in the
33 individual market, the issuer may not provide for the
34 issuance of any health insurance coverage in Illinois
35 involved during the 5-year period beginning on the date
36 of the discontinuation of the last health insurance

1 coverage not so renewed.

2 (c) If an issuer elects to discontinue offering all
3 health insurance coverage in the individual market
4 under subparagraph (a), its affiliates that offer
5 health insurance coverage in the individual market in
6 Illinois shall offer individual health insurance
7 coverage to all individuals who were covered by the
8 discontinued health insurance coverage on the date of
9 the notice provided to affected individuals under
10 subdivision (iii) of subparagraph (a) of this item (2)
11 if the individual applies for coverage no later than 63
12 days after the discontinuation of coverage.

13 (d) Subject to subparagraph (e) of this item (2),
14 an affiliate that issues coverage under subparagraph
15 (c) shall waive the preexisting condition exclusion
16 period to the extent that the individual has satisfied
17 the preexisting condition exclusion period under the
18 individual's prior contract or policy.

19 (e) An affiliate that issues coverage under
20 subparagraph (c) may require the individual to satisfy
21 the remaining part of the preexisting condition
22 exclusion period, if any, under the individual's prior
23 contract or policy that has not been satisfied, unless
24 the coverage has a shorter preexisting condition
25 exclusion period, and may include in any coverage
26 issued under subparagraph (c) any waivers or
27 limitations of coverage that were included in the
28 individual's prior contract or policy.

29 (D) Exception for uniform modification of coverage. At the
30 time of coverage renewal, a health insurance issuer may modify
31 the health insurance coverage for a policy form offered to
32 individuals in the individual market so long as the
33 modification is consistent with Illinois law and effective on a
34 uniform basis among all individuals with that policy form.

35 (E) Application to coverage offered only through
36 associations. In applying this Section in the case of health

1 insurance coverage that is made available by a health insurance
2 issuer in the individual market to individuals only through one
3 or more associations, a reference to an "individual" is deemed
4 to include a reference to such an association (of which the
5 individual is a member).

6 The changes to this Section made by this amendatory Act of
7 the 94th General Assembly apply only to discontinuances of
8 coverage occurring on or after the effective date of this
9 amendatory Act of the 94th General Assembly.

10 (Source: P.A. 90-567, eff. 1-23-98.)

11 (215 ILCS 97/60 new)

12 Sec. 60. Notice requirement. In any case where a health
13 insurance issuer elects to uniformly modify coverage,
14 uniformly terminate coverage, or discontinue coverage in a
15 marketplace in accordance with Sections 30 and 50 of this Act,
16 the issuer shall provide notice to the Department prior to
17 notifying the plan sponsors, participants, beneficiaries, and
18 covered individuals. The notice shall be sent by certified mail
19 to the Department 90 days in advance of any notification of the
20 company's actions sent to plan sponsors, participants,
21 beneficiaries, and covered individuals. The notice shall
22 include: (i) a complete description of the action to be taken,
23 (ii) a specific description of the type of coverage affected,
24 (iii) the total number of covered lives affected, (iv) a sample
25 draft of all letters being sent to the plan sponsors,
26 participants, beneficiaries, or covered individuals, (v) time
27 frames for the actions being taken, (vi) options the plans
28 sponsors, participants, beneficiaries, or covered individuals
29 may have available to them under this Act, and (vii) any other
30 information as required by the Department.

31 This Section applies only to discontinuances of coverage
32 occurring on or after the effective date of this amendatory Act
33 of the 94th General Assembly.

34 Section 99. Effective date. This Act takes effect upon

1 becoming law.