HB3754

LRB096 10358 RPM 20528 b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB3754

Introduced 2/25/2009, by Rep. Karen May

SYNOPSIS AS INTRODUCED:

New Act

Creates the Individual Health Insurance Fairness Law. Provides that no insurer authorized to transact the class of business set forth in Class 1 and Class 2 (accident and health) of the Insurance Code and issuing small group coverage may deny coverage to applicants based on health status. Creates the Health Insurance Financial Transparency Law. Provides that all insurers authorized to transact the class of business set forth in Class 1 and Class 2 (accident and health) of the Insurance Code shall maintain a minimum medical loss ratio of 85% or above for all companies in the individual and small group markets. Provides that such companies may average total costs across all plans. Creates the Small Group and Self-Employed Health Insurance Fairness Law. Provides that all insurers, as defined in the Law, shall offer one or more health insurance choice policies to employees of eligible employers in this State and to self-employed persons. Provides that an insurer offering a policy under the Law may not base insurance ratings on the health status or claims experience in the employer-based small group market. Creates the Health Insurer Accountability and Patient Protection Law. Provides that in cases of an adverse determination by an insurer or health carrier, the insurer or health carrier shall provide for external independent reviews of claim denials or adverse determinations. Sets forth provisions concerning denials of treatment for mental and emotional disorders. Creates the Illinois Affordable Health Insurance Law. Contains a short title provision only. Makes other changes.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning insurance.

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

4 ARTICLE 5. INDIVIDUAL HEALTH
5 INSURANCE FAIRNESS LAW

6 Section 5-1. Short title. This Law may be cited as the
7 Individual Health Insurance Fairness Law.

8 Section 5-5. Guaranteed issue. No insurer authorized to
9 transact the class of business set forth in subsection (b) of
10 Class 1 and subsection (a) of Class 2 of Section 4 of the
11 Illinois Insurance Code and issuing small group coverage may
12 deny coverage to applicants based on health status. An insurer
13 under this Section must use standard risk rates to set premiums
14 for each plan and may not apply any risk adjustment factor for
15 the first 4 years of implementation under this Section to
16 account for the health status of individuals. Notwithstanding
17 any other provision of this Law, this Section shall not apply
18 to cases where an:
19 (1) individual does not work or reside in the plan's
20 service area;
21 (2) insurer can demonstrate a lack of capacity for new
22 applicants; or

1 (3) individual has been an Illinois resident for 6
2 months or less, unless the individual is HIPAA-CHIP
3 eligible.

4 ARTICLE 10. HEALTH INSURANCE
5 FINANCIAL TRANSPARENCY LAW

6 Section 10-1. Short title. This Law may be cited as the
7 Health Insurance Financial Transparency Law.

8 Section 10-5. Minimum medical loss ratio. All insurers
9 authorized to transact the class of business set forth in
10 subsection (b) of Class 1 and subsection (a) of Class 2 of
11 Section 4 of the Illinois Insurance Code shall maintain a
12 minimum medical loss ratio of 85% or above for all companies in
13 the individual and small group markets. Such companies may
14 average total costs across all plans. The Division of Insurance
15 within the Department of Financial and Professional Regulation
16 may establish rules to exclude new plans for up to the first 2
17 years. For the purposes of this Section, "minimum medical loss
18 ratio" means the minimum percentage of premium dollars that
19 must be spent on medical care rather than on administrative
20 costs, marketing costs, and profit.

21 ARTICLE 15. SMALL GROUP AND SELF-EMPLOYED
22 HEALTH INSURANCE FAIRNESS LAW

1 Section 15-1. Short title. This Law may be cited as the
2 Small Group and Self-Employed Health Insurance Fairness Law.

3 Section 15-5. Definitions. For purposes of this Law:
4 "Department" means the Department of Financial and
5 Professional Regulation.
6 "Director" means the Director of the Division of Insurance
7 of the Department of Financial and Professional Regulation.
8 "Eligible employer" means a small employer (1) that has not
9 offered group health plans to its employees for at least 12
10 months before the employee applies for such coverage under a
11 health insurance choice policy; and (2) whose average annual
12 compensation paid to employees is less than 250% of the Federal
13 poverty level.
14 "Employee" means an employee who is scheduled to work not
15 less than 20 hours per week on a regular basis.
16 "Enrollee" means an individual covered under a health
17 insurance choice policy, including both an employee and his or
18 her dependents.
19 "Federal poverty level" means the federal poverty level
20 guidelines published annually by the United States Department
21 of Health and Human Services.
22 "Group health plan" has the meaning given to such term in
23 the Illinois Health Insurance Portability and Accountability
24 Act.

1 "Health insurance choice policy" or "policy" means a policy
2 of accident and health insurance that provides standard
3 required benefits.
4 "Insurer" means a small employer carrier as such term is
5 defined in the Small Employer Health Insurer Rating Act.
6 "Secretary" means the Secretary of the Department of
7 Financial and Professional Regulation.
8 "Small employer" has the meaning given that term in the
9 Illinois Health Insurance Portability and Accountability Act.
10 "State-mandated health benefits" means coverage required
11 under the laws of this State to be provided in a group major
12 medical policy for accident and health insurance or a contract
13 for a health-related condition that: (1) includes coverage for
14 specific health care services or benefits; (2) places
15 limitations or restrictions on deductibles, coinsurance,
16 co-payments, or any annual or lifetime maximum benefit amounts;
17 or (3) includes coverage for a specific category of licensed
18 health practitioner from whom an insured is entitled to receive
19 care.

20 Section 15-10. Group and self-employed health insurance
21 policies; rates.
22 (a) All insurers, as defined in Section 15-5 of this Law,
23 shall offer one or more health insurance choice policies to
24 employees of eligible employers in this State and to
25 self-employed persons.

1 (b) An insurer that offers one or more health insurance
2 choice policies under this Law to the employees of an eligible
3 employer and to self-employed persons must also offer to all
4 employees of such eligible employer at least one accident and
5 health insurance policy that has been filed with and approved
6 by the Department and includes coverage for the State-mandated
7 health benefits required of such policy.

8 (c) Each employee may elect whether he or she wants to
9 apply for coverage.

10 (d) An insurer offering a policy under this Section may not
11 base insurance ratings on the health status or claims
12 experience in the employer-based small group market. Rates for
13 small groups may vary from the adjusted community rate based
14 only on employee characteristics related to: age, geographic
15 area, family size, and participation in wellness activities.
16 Age brackets may not be smaller than 5-year increments for ages
17 20 through 65. Employees under age 20 shall be treated as those
18 age 20. The following provisions shall apply with regard to
19 age:

20 (1) Year 1: The premiums for highest-rated age group
21 may be no more than 425% of the premiums for lowest-rated
22 age group.

23 (2) Years 2 and 3: 400% variation allowed.

24 (3) Years 4 and after: 375% variation allowed.

25 Annual rate adjustments are allowed for each plan based on
26 deductible levels, benefit design, or provider network

characteristics. Adjustments may not be more than 4% of the overall adjustment for the carrier's entire small employer pool.

ARTICLE 20. HEALTH INSURER ACCOUNTABILITY
AND PATIENT PROTECTION LAW

Section 20-1. Short title. This Law may be cited as the Health Insurer Accountability and Patient Protection Law.

Section 20-5. Definitions. For the purposes of this Law:

"Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

"Authorized representative" means:

(i) a person to whom a covered person has given express written consent to represent the covered person in an external review;

(ii) a person authorized by law to provide substituted consent for a covered person;

1 (iii) a family member of the covered person; or
2 (iv) the covered person's health care provider.
3 "Clinical review criteria" means the written screening
4 procedures, decision abstracts, clinical protocols, and
5 practice guidelines used by a health carrier to determine the
6 necessity and appropriateness of health care services.
7 "Director" means the Director of the Division of Insurance
8 within the Illinois Department of Financial and Professional
9 Regulation.
10 "Covered benefits" or "benefits" means those health care
11 services to which a covered person is entitled under the terms
12 of a health benefit plan.
13 "Covered person" means a policyholder, subscriber,
14 enrollee, or other individual participating in a health benefit
15 plan.
16 "Emergency medical condition" means the sudden onset of a
17 health condition or illness that requires immediate medical
18 attention, where failure to provide medical attention would
19 result in a serious impairment to bodily functions or a serious
20 dysfunction of a bodily organ or part or would place the
21 person's health in serious jeopardy.
22 "Emergency services" means health care items and services
23 furnished or required to evaluate and treat an emergency
24 medical condition.
25 "Evidence-based standard" means a standard of care
26 developed through the judicious use of the current best

1 evidence and based on an overall systematic review of
2 applicable research.
3 "Facility" means an institution providing health care
4 services or a health care setting.
5 "Final adverse determination" means an adverse
6 determination involving a covered benefit that has been upheld
7 by a health carrier, or its designee utilization review
8 organization, at the completion of the health carrier's
9 internal grievance process procedures as set forth in Section
10 45 of the Managed Care Reform and Patient Rights Act.
11 "Health benefit plan" means a policy, contract,
12 certificate, plan, or agreement offered or issued by a health
13 carrier to provide, deliver, arrange for, pay for, or reimburse
14 any of the costs of health care services.
15 "Health care provider" or "provider" means a physician or
16 other health care practitioner licensed, accredited, or
17 certified to perform specified health care services consistent
18 with State law, responsible for recommending health care
19 services on behalf of a covered person.
20 "Health care services" means services for the diagnosis,
21 prevention, treatment, cure, or relief of a health condition,
22 illness, injury, or disease.
23 "Health carrier" means an entity subject to the insurance
24 laws and regulations of this State, or subject to the
25 jurisdiction of the Director, that contracts or offers to
26 contract to provide, deliver, arrange for, pay for, or

1 reimburse any of the costs of health care services, including a
2 sickness and accident insurance company, a health maintenance
3 organization, a nonprofit hospital and health service
4 corporation, or any other entity providing a plan of health
5 insurance, health benefits, or health care services.

6 "Health carrier" also means Limited Health Service
7 Organizations (LHSO) and Voluntary Health Service Plans.

8 "Health information" means information or data, whether
9 oral or recorded in any form or medium, and personal facts or
10 information about events or relationships that relate to:

11 (1) the past, present, or future physical, mental, or
12 behavioral health or condition of an individual or a member
13 of the individual's family;

14 (2) the provision of health care services to an
15 individual; or

16 (3) payment for the provision of health care services
17 to an individual.

18 "Independent review organization" means an entity that
19 conducts independent external reviews of adverse
20 determinations and final adverse determinations.

21 "Medical or scientific evidence" means evidence found in
22 the following sources:

23 (1) peer-reviewed scientific studies published in or
24 accepted for publication by medical journals that meet
25 nationally recognized requirements for scientific
26 manuscripts and that submit most of their published

1 articles for review by experts who are not part of the
2 editorial staff;
3 (2) peer-reviewed medical literature, including
4 literature relating to therapies reviewed and approved by a
5 qualified institutional review board, biomedical
6 compendia, and other medical literature that meet the
7 criteria of the National Institutes of Health's Library of
8 Medicine for indexing in Index Medicus (Medline) and
9 Elsevier Science Ltd. for indexing in Excerpta Medicus
10 (EMBASE);
11 (3) medical journals recognized by the Secretary of
12 Health and Human Services under Section 1861(t)(2) of the
13 federal Social Security Act;
14 (4) the following standard reference compendia:
15 (a) the American Hospital Formulary Service-Drug
16 Information;
17 (b) Drug Facts and Comparisons;
18 (c) the American Dental Association Accepted
19 Dental Therapeutics; and
20 (d) the United States Pharmacopoeia-Drug
21 Information;
22 (5) findings, studies, or research conducted by or
23 under the auspices of federal government agencies and
24 nationally recognized federal research institutes,
25 including:
26 (a) the federal Agency for Healthcare Research and

1 Quality;
2 (b) the National Institutes of Health;
3 (c) the National Cancer Institute;
4 (d) the National Academy of Sciences;
5 (e) the Centers for Medicare & Medicaid Services;
6 (f) the federal Food and Drug Administration; and
7 (g) any national board recognized by the National
8 Institutes of Health for the purpose of evaluating the
9 medical value of health care services; or
10 (6) any other medical or scientific evidence that is
11 comparable to the sources listed in items (1) through (5).
12 "Protected health information" means health information
13 (i) that identifies an individual who is the subject of the
14 information; or (ii) with respect to which there is a
15 reasonable basis to believe that the information could be used
16 to identify an individual.
17 "Utilization review" has the meaning provided by the
18 Managed Care Reform and Patient Rights Act.
19 "Utilization review organization" means a utilization
20 review program as defined by the Managed Care Reform and
21 Patient Rights Act.

22 Section 20-10. Applicability and scope.
23 (a) Except as provided in subsection (b), this Law shall
24 apply to all health carriers.
25 (b) The provisions of this Law shall not apply to a policy

1 or certificate that provides coverage only for a specified
2 disease, specified accident or accident-only coverage, credit,
3 dental, disability income, hospital indemnity, long-term care
4 insurance, as defined by Article XIXA of the Illinois Insurance
5 Code, vision care, or any other limited supplemental benefit or
6 to a Medicare supplement policy of insurance, as defined by the
7 Director by rule, coverage under a plan through Medicare,
8 Medicaid, or the federal employees health benefits program, any
9 coverage issued under Chapter 55 of Title 10, U.S. Code and any
10 coverage issued as a supplement to that coverage, any coverage
11 issued as supplemental to liability insurance, workers'
12 compensation or similar insurance, automobile medical-payment
13 insurance, or any insurance under which benefits are payable
14 with or without regard to fault, whether written on a group
15 blanket or individual basis.

16 Section 20-15. Notice of right to external review.
17 (a) In cases of an adverse determination by an insurer or
18 health carrier, the insurer or health carrier shall provide for
19 external independent reviews of claim denials or adverse
20 determinations.
21 (b) Notwithstanding any other provision of law, enrollees
22 to request an external independent review may make a request
23 for an external independent review up to 180 days after an
24 adverse determination.
25 (c) At the same time the health carrier sends written

1 notice of a covered person's right to appeal a coverage
2 decision as provided by the Managed Care Reform and Patient
3 Rights Act, a health carrier shall notify a covered person and
4 a covered person's health care provider in writing of the
5 covered person's right to request an external review as
6 provided by this Law.

7 Section 20-20. Denials of treatment for mental and
8 emotional disorders.
9 (a) For denials of treatment for mental and emotional
10 disorders, a health carrier shall communicate with the
11 insured's attending mental health provider and provide
12 specific information on review criteria, evaluation methods
13 used, and the credentials of the peer reviewer selected by the
14 carrier.
15 (b) For group policies, the insured's health care provider
16 shall make the final determination of medical necessity for the
17 treatment of mental and emotional disorders.

18 Section 20-25. Uniform applications. Health carriers in
19 the small group market shall disseminate to enrollees who
20 request an external independent review a standard application
21 form as developed by the Division. The Division shall develop a
22 standard individual health statement form to be used as the
23 sole method of determining an individual's health status for
24 independent external reviews. The Division may develop the

1 forms required under this Section in cooperation with health
2 carriers in the small group market.

3 Section 20-30. Office of Patient Protection. There is
4 hereby established within the Division of Insurance an Office
5 of Patient Protection to assist consumers, monitor health
6 insurer compliance, and investigate claims practices.

7 ARTICLE 25. ILLINOIS AFFORDABLE HEALTH INSURANCE LAW

8 Section 25-1. Short title. This Law may be cited as the
9 Illinois Affordable Health Insurance Law.