Rep. Greg Harris

Filed: 3/31/2009

AMENDMENT TO HOUSE BILL 3923

AMENDMENT NO. _____. Amend House Bill 3923, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by adding Sections 359a.1 and 359a.2 and Article XLV and by changing Section 370c as follows:

(215 ILCS 5/359a.1 new)

Sec. 359a.1. Standard small group applications. The Director shall develop, by rule, a standard application form for use by small employers applying for coverage under a health benefit plan offered by small employer carriers. Small employer carriers shall be required to use the standard application form not less than 6 months after the rules developing the form become effective. The Director shall revise the standard application form at least every 3 years. For purposes of this

Section, "health benefit plan", "small employer", and "small employer carrier" shall have the meaning given those terms in the Small Employer Health Insurance Rating Act.

(215 ILCS 5/359a.2 new)

Sec. 359a.2. Standard individual market health statements. The Director shall develop, by rule, a standard health statement for use by individuals applying for a health benefit plan in the individual market. All carriers who offer health benefit plans in the individual market and evaluate the health status of individuals shall be required to use the standard health statement not less than 6 months after the statement becomes effective and thereafter may not use any other method to determine the health status of an individual. Nothing in this Section shall prevent a carrier from using health information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan. For purposes of this Section, "health benefit plan" shall have the meaning given the term in the Small Employer Health Insurance Rating Act and "individual market" shall have meaning given the term in the Illinois Health Insurance Portability and Accountability Act.

(215 ILCS 5/370c) (from Ch. 73, par. 982c)

Sec. 370c. Mental and emotional disorders.

(a) (1) On and after the effective date of this Section,

every insurer which delivers, issues for delivery or renews or modifies group A&H policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall offer to the applicant or group policyholder subject to the insurers standards of insurability, coverage for reasonable and necessary treatment and services for mental, emotional or nervous disorders or conditions, other than serious mental illnesses as defined in item (2) of subsection (b), up to the limits provided in the policy for other disorders or conditions, except (i) the insured may be required to pay up to 50% of expenses incurred as a result of the treatment or services, and (ii) the annual benefit limit may be limited to the lesser of $10,000 or 25% of the lifetime policy limit.

(2) Each insured that is covered for mental, emotional or nervous disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist of his choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist up to the limits of coverage, provided (i) the disorder or condition treated is

covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his profession.

(3) Insofar as this Section applies solely to licensed clinical social workers, licensed clinical professional counselors, and licensed marriage and family therapists, those persons who may provide services to individuals shall do so after the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist has informed the patient of the desirability of the patient conferring with the patient's primary care physician and the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist has provided written notification to the patient's primary care physician, if any, that services are being provided to the patient. That notification may, however, be waived by the patient on a written form. Those forms shall be retained by the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist for a period of not less than 5 years.

(b) (1) An insurer that provides coverage for hospital or medical expenses under a group policy of accident and health insurance or health care plan amended, delivered, issued, or

renewed after the effective date of this amendatory Act of the 92nd General Assembly shall provide coverage under the policy for treatment of serious mental illness under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. The coverage required under this Section must provide for same durational limits, amount limits, deductibles, and co-insurance requirements for serious mental illness as are provided for other illnesses and diseases. This subsection does not apply to coverage provided to employees by employers who have 50 or fewer employees.

(2) "Serious mental illness" means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

(A) schizophrenia;

(B) paranoid and other psychotic disorders;

(C) bipolar disorders (hypomanic, manic, depressive, and mixed);

(D) major depressive disorders (single episode or recurrent);

(E) schizoaffective disorders (bipolar or depressive);

(F) pervasive developmental disorders;

(G) obsessive-compulsive disorders;

(H) depression in childhood and adolescence;

(I) panic disorder;

(J) post-traumatic stress disorders (acute, chronic,

or with delayed onset); and

(K) anorexia nervosa and bulimia nervosa.

(3) (Blank). ~~Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. An insurer shall provide a mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or herself), the patient's provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity of a treatment proposed by a patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for serous mental illness, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses~~

~~covered under the policy, including an appeals process.~~

(4) A group health benefit plan:

(A) shall provide coverage based upon medical necessity for the following treatment of mental illness in each calendar year:

(i) 45 days of inpatient treatment; and

(ii) beginning on June 26, 2006 (the effective date of Public Act 94-921), 60 visits for outpatient treatment including group and individual outpatient treatment; and

(iii) for plans or policies delivered, issued for delivery, renewed, or modified after January 1, 2007 (the effective date of Public Act 94-906), 20 additional outpatient visits for speech therapy for treatment of pervasive developmental disorders that will be in addition to speech therapy provided pursuant to item (ii) of this subparagraph (A);

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and

(C) shall include the same amount limits, deductibles, copayments, and coinsurance factors for serious mental illness as for physical illness.

(5) An issuer of a group health benefit plan may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of

medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

(6) An issuer of a group health benefit plan may provide or offer coverage required under this Section through a managed care plan.

(7) This Section shall not be interpreted to require a group health benefit plan to provide coverage for treatment of:

(A) an addiction to a controlled substance or cannabis that is used in violation of law; or

(B) mental illness resulting from the use of a controlled substance or cannabis in violation of law.

(8) (Blank).

(9) On and after June 1, 2010, coverage for the treatment of mental and emotional disorders as provided by subsections (a) and (b) of this Section shall not be denied under the policy, provided that services are medically necessary as determined by the insured's treating physician. For purposes of this Section, "medically necessary" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must be

intended to either help restore or maintain the enrollee's health or prevent deterioration of the enrollee's condition. Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary.

(Source: P.A. 94-402, eff. 8-2-05; 94-584, eff. 8-15-05; 94-906, eff. 1-1-07; 94-921, eff. 6-26-06; 95-331, eff. 8-21-07; 95-972, eff. 9-22-08; 95-973, eff. 1-1-09; revised 10-14-08.)

(215 ILCS 5/Art. XLV heading new)

ARTICLE XLV. MINIMUM MEDICAL LOSS RATIO LAW

(215 ILCS 5/1501 new)

Sec. 1501. Short title. This Law may be cited as the Minimum Medical Loss Ratio Law.

(215 ILCS 5/1505 new)

Sec. 1505. Purpose. The General Assembly recognizes that a significant share of the premium dollars paid by individuals and small employers to health insurers and health maintenance organizations is directed toward administrative and marketing activities and profit. It is the intent of this Law to ensure that premium costs for consumers more accurately reflect the value of health care they receive by increasing the portion of

premium dollars dedicated to medical services.

(215 ILCS 5/1510 new)

Sec. 1510. Definitions. In this Law:

"Company" means any entity that provides health insurance in this State. For the purposes of this Law, company includes a licensed insurance company, a health maintenance organization, or any other entity providing a plan of health insurance or health benefits subject to State insurance regulation.

"Division" means the Division of Insurance within the Illinois Department of Financial and Professional Regulation.

"Health benefit plan" means any hospital or medical expense-incurred policy, hospital or medical service plan contract, or health maintenance organization subscriber contract. "Health benefit plan" shall not include accident-only, credit, dental, vision, Medicare supplement, hospital indemnity, long term care, specific disease, stop loss or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

"Health care benefits" means health care services that are either provided or reimbursed by a managed care entity or its contracted providers as benefits to its policyholders and insurers. Health care benefits shall include:

(A) The costs of programs or activities, including training and the provision of informational materials that

are determined as part of the regulation to improve the provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine.

(B) Disease management expenses using cost-effective evidence-based guidelines.

(C) Plan medical advice by telephone.

(D) Payments to providers as risk pool payments of pay-for-performance initiatives.

"Health care benefits" shall not include administrative costs as determined by the Division.

"Individual market" means the individual market as defined by the Illinois Health Insurance Portability and Accountability Act.

"Small group market" means "small group market" as defined by the Illinois Health Insurance Portability and Accountability Act.

(215 ILCS 5/1515 new)

Sec. 1515. Minimum medical loss requirement for companies offering coverage in the individual and small group market.

(a) Any company selling a health benefit plan in the individual or small group market shall, on and after June 1, 2011, expend in the form of health care benefits no less than 75% of the aggregate dues, fees, premiums, or other periodic payments received by the company. For purposes of this Section, the company may deduct from the aggregate dues, fees, premiums,

or other periodic payments received by the company the amount of income taxes or other taxes that the company expensed.

(b) To assess compliance with this Section, a company with a valid certificate of authority may average its total costs across all health benefit plans issued, amended, or renewed in Illinois, and all health benefit plans issued, amended, or renewed by its affiliated companies that are licensed to operate in Illinois.

(c) The Division shall adopt rules to implement this Section and to establish uniform reporting by companies of the information necessary to determine compliance with this Section.

(d) The Division may exclude from the determination of compliance with the requirement of subsection (a) of this Section any new health benefit plans for up to the first 2 years that these health benefit plans are offered for sale in Illinois, provided that the Division determines that the new health benefit plans are substantially different from the existing health benefit plans being issued, amended, or renewed by the company seeking the exclusion.

Section 10. The Managed Care Reform and Patient Rights Act is amended by changing Section 90 as follows:

(215 ILCS 134/90)

Sec. 90. Office of Consumer Health Insurance.

(a) The Director of Insurance shall establish the Office of Consumer Health Insurance within the Department of Insurance to provide assistance and information to all health care consumers within the State and to ensure that persons covered by health insurance companies or health care plans are provided benefits due under the Illinois Insurance Code and related statutes and are protected from health insurance company and health care plan actions or policy provisions that are unjust, unfair, inequitable, ambiguous, misleading, inconsistent, deceptive, or contrary to the law or to the public policy of this State or that unreasonably or deceptively affect the risk purposed to be assumed. Within the appropriation allocated, the Office shall provide information and assistance to all health care consumers. ~~by~~ The responsibilities of the Office shall include, but not be limited to, the following:

(1) assisting consumers in understanding health insurance marketing materials and the coverage provisions of individual plans;

(2) educating enrollees about their rights within individual plans;

(3) assisting enrollees with the process of filing formal grievances and appeals;

(4) establishing and operating a toll-free "800" telephone number line to handle consumer inquiries;

(5) making related information available in languages other than English that are spoken as a primary language by

a significant portion of the State's population, as determined by the Department;

(6) analyzing, commenting on, monitoring, and making publicly available reports on the development and implementation of federal, State, and local laws, regulations, and other governmental policies and actions that pertain to the adequacy of health care plans, facilities, and services in the State;

(7) filing an annual report with the Governor, the Director, and the General Assembly, which shall contain recommendations for improvement of the regulation of health insurance plans, including recommendations on improving health care consumer assistance and patterns, abuses, and progress that it has identified from its interaction with health care consumers; ~~and~~

(8) performing oversight of health insurance companies and health care plans with respect to:

(A) improper claims practices as set forth in Sections 154.5 and 154.6 of the Illinois Insurance Code;

(B) emergency services;

(C) compliance with this Act;

(D) ensuring proper coverage for mental health treatment;

(E) reviewing insurance company and health care plan underwriting, rating, and rescission practices;

and

(F) reviewing insurance company and health care plan billing practices, including, but not limited to, consumer cost-sharing that results from co-pay, deductible, and provider network provisions;

(9) assisting health insurance company and health care plan consumers with respect to the exercise of the grievance and appeals rights established in this Act;

(10) if an external independent review decision upholds a determination adverse to the patient, the patient has the right to appeal the final decision to the Office; if the external review decision is found by the Director through the Office to have been arbitrary and capricious, then the Director, with consultation from a licensed medical professional, may overturn the external review decision and require the health insurance company or health care plan to pay for the health care service or treatment; such decision, if any, shall be made solely on the legal or medical merits of the claim; and

(11) ~~(8)~~ performing all duties assigned to the Office by the Director.

(b) The report required under subsection (a)(7) shall be filed by January 31, 2001 and each January 31 thereafter.

(c) Nothing in this Section shall be interpreted to authorize access to or disclosure of individual patient or health care professional or provider records.

(d) The Director, in his or her discretion, may issue a Notice of Hearing requiring a health insurance company or health care plan to appear at a hearing for the purpose of determining the health insurance company or health care plan's compliance with the duties and responsibilities listed in this Act and in the Illinois Insurance Code.

(e) Nothing in this Section shall diminish or affect the powers and authority of the Director of Insurance otherwise set forth in this Act and in the Illinois Insurance Code.

(Source: P.A. 91-617, eff. 1-1-00.)

Section 99. Effective date. This Act takes effect January 1, 2010.".