SB2493

LRB09615298AMC30410b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

SB2493

Introduced 10/29/2009, by Sen. Terry Link

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356v
215 ILCS 97/20

Amends the Illinois Health Insurance Portability and Accountability Act. Provides that a group health plan or a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion. Makes conforming changes, including removing a cross-reference in the Illinois Insurance Code. Effective immediately.

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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 changing Section 356v as follows:

(215 ILCS 5/356v)

Sec. 356v. Use of information derived from genetic testing. After the effective date of this amendatory Act of 1997, an insurer must comply with the provisions of the Genetic Information Privacy Act in connection with the amendment, delivery, issuance, or renewal of, or claims for or denial of coverage under, an individual or group policy of accident and health insurance. ~~Additionally, genetic information shall not be treated as a condition described in item (1) of subsection (A) of Section 20 of the Illinois Health Insurance Portability and Accountability Act in the absence of a diagnosis of the condition related to that genetic information.~~

(Source: P.A. 90-25, eff. 1-1-98; 90-655, eff. 7-30-98; 91-549, eff. 8-14-99.)

Section 10. The Illinois Health Insurance Portability and Accountability Act is amended by changing Section 20 as follows:

(215 ILCS 97/20)

Sec. 20. Increased portability through limitation on preexisting condition exclusions.

(A) Notwithstanding any law to the contrary, a group health plan or a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion. ~~Limitation of preexisting condition exclusion period; crediting for periods of previous coverage. Subject to subsection (D), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:~~

~~(1) the exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period ending on the enrollment date;~~

~~(2) the exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and~~

~~(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (C)(1)) applicable to the participant or beneficiary as of the enrollment date.~~

(B) (Blank). ~~Preexisting condition exclusion. A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.~~

~~Genetic information shall not be treated as a condition described in subsection (A)(1) in the absence of a diagnosis of the condition related to such information.~~

(C) Rules relating to crediting previous coverage.

(1) Creditable coverage defined. For purposes of this Act, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(a) A group health plan.

(b) Health insurance coverage.

(c) Part A or part B of title XVIII of the Social Security Act.

(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928.

(e) Chapter 55 of title 10, United States Code.

(f) A medical care program of the Indian Health Service or of a tribal organization.

(g) A State health benefits risk pool.

(h) A health plan offered under chapter 89 of title 5, United States Code.

(i) A public health plan (as defined in

regulations).

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(k) Title XXI of the federal Social Security Act, State Children's Health Insurance Program.

Such term does not include coverage consisting solely of coverage of excepted benefits.

(2) Excepted benefits. For purposes of this Act, the term "excepted benefits" means benefits under one or more of the following:

(a) Benefits not subject to requirements:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other

insurance benefits.

(b) Benefits not subject to requirements if offered separately:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Such other similar, limited benefits as are specified in rules.

(c) Benefits not subject to requirements if offered, as independent, noncoordinated benefits:

(i) Coverage only for a specified disease or illness.

(ii) Hospital indemnity or other fixed indemnity insurance.

(d) Benefits not subject to requirements if offered as separate insurance policy. Medicare supplemental health insurance (as defined under Section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(3) Not counting periods before significant breaks in coverage.

(a) In general. A period of creditable coverage

shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(b) Waiting period not treated as a break in coverage. For purposes of subparagraph (a) ~~and subsection (D)(3)~~, any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period ~~(as defined in subsection (G)(2))~~ shall not be taken into account in determining the continuous period under subparagraph (a).

(4) Method of crediting coverage. ~~(a)~~ Standard method. A ~~Except as otherwise provided under subparagraph (b), for purposes of applying subsection (A)(3), a~~ group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

~~(b) Election of alternative method. A group health plan, or a health insurance issuer offering group health insurance, may elect to apply subsection (A)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph~~

~~(a). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.~~

~~(c) Plan notice. In the case of an election with respect to a group health plan under subparagraph (b) (whether or not health insurance coverage is provided in connection with such plan), the plan shall:~~

~~(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election; and~~

~~(ii) include in such statements a description of the effect of this election.~~

~~(d) Issuer notice. In the case of an election under subparagraph (b) with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer:~~

~~(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election; and~~

~~(ii) shall include in such statements a~~

~~description of the effect of such election.~~

(5) Establishment of period. Periods of creditable coverage with respect to an individual shall be established through presentation or certifications described in subsection (E) or in such other manner as may be specified in regulations.

(D) (Blank). ~~Exceptions:~~

~~(1) Exclusion not applicable to certain newborns. Subject to paragraph (3), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.~~

~~(2) Exclusion not applicable to certain adopted children. Subject to paragraph (3), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage.~~

~~The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.~~

~~(3) Loss if break in coverage. Paragraphs (1) and (2)~~

~~shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.~~

(E) Certifications and disclosure of coverage.

(1) Requirement for Certification of Period of Creditable Coverage.

(a) A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (b):

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision; and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(b) The certification described in this

subparagraph is a written certification of:

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision; and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(c) To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits. In the case of an election described in subsection (C)(4)(b) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1):

(a) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such

entity's plan or coverage; and

(b) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Rules. The Department shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(4) Treatment of certain plans as group health plan for notice provision. A program under which creditable coverage described in subparagraph (c), (d), (e), or (f) of Section 20(C)(1) is provided shall be treated as a group health plan for purposes of this Section.

(F) Special enrollment periods.

(1) Individuals losing other coverage. A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(a) The employee or dependent was covered under a

group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(b) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(c) The employee's or dependent's coverage described in subparagraph (a):

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

(d) Under the terms of the plan, the employee requests such enrollment not later than 30 days after

the date of exhaustion of coverage described in subparagraph (c)(i) or termination of coverage or employer contributions described in subparagraph (c)(ii).

(2) For dependent beneficiaries.

(a) In general. If:

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

then the group health plan shall provide for a dependent special enrollment period described in subparagraph (b) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible

for coverage.

(b) Dependent special enrollment period. A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of:

(i) the date dependent coverage is made available; or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (a)(iii).

(c) No waiting period. If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

~~(G) Use of affiliation period by HMOs as alternative to preexisting condition exclusion.~~

~~(1) In general. A health maintenance organization~~

~~which offers health insurance coverage in connection with a group health plan and which does not impose any pre-existing condition exclusion allowed under subsection (A) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if:~~

~~(a) such period is applied uniformly without regard to any health status related factors; and~~

~~(b) such period does not exceed 2 months (or 3 months in the case of a late enrollee).~~

~~(2) Affiliation period.~~

~~(a) Defined. For purposes of this Act, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.~~

~~(b) Beginning. Such period shall begin on the enrollment date.~~

~~(c) Runs concurrently with waiting periods. An affiliation period under a plan shall run concurrently with any waiting period under the plan.~~

~~(3) Alternative methods. A health maintenance~~

~~organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the Department.~~

(Source: P.A. 90-30, eff. 7-1-97; 90-736, eff. 8-12-98.)

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