HB3968

LRB09716042RPM61195b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB3968

Introduced 1/10/2012, by Rep. Monique D. Davis

SYNOPSIS AS INTRODUCED:

215 ILCS 5/355	from Ch. 73, par. 967
215 ILCS 5/355.01 new	
215 ILCS 5/367	from Ch. 73, par. 979
215 ILCS 125/2-11.1 new	
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2

Amends the Illinois Insurance Code. Provides that a filing of premium rates with the Director of Insurance shall not be complete unless it contains all information necessary to justify the premium rate and such other information as the Director may require to determine the rate's compliance with the provision concerning health insurance premium rates and prior approval. Provides that the filing shall clearly indicate the percentage change from certain prior rates. Sets forth provisions concerning health insurance premium rates and prior approval of the Director. Prohibits policies, plans, and contracts of health insurance coverage offered by a health insurance issuer from being issued or delivered until the classification of risks and the premium rates pertaining thereto have been approved by the Director. Contains provisions concerning approvals, appeals, and requests for actuarial reasoning and data. Makes changes to the provision concerning group accident and health insurance. Amends the Health Maintenance Organization Act. Sets forth provisions concerning premium rates and filing and prior approval. Requires that the schedule of base rates for a group or individual contract or evidence of coverage to be used in conjunction with the contract or evidence of coverage be filed with the Director. Further amends the Act to comport with the provisions of the Illinois Insurance Code concerning health insurance premium rates and prior approval. Effective on January 1, 2013.

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FISCAL NOTE ACT
MAY APPLY

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 Sections 355 and 367 and by adding Section 355.01 as follows:

(215 ILCS 5/355) (from Ch. 73, par. 967)

Sec. 355. Accident and health policies-Provisions.~~)~~

(a) No individual or group policy of insurance against loss or damage from the sickness, or from the bodily injury or death of the insured by accident shall be issued or delivered to any person in this State until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the Director; nor shall it be so issued or delivered until the Director shall have approved such policy pursuant to the provisions of Section 143. If the Director disapproves the policy form he shall make a written decision stating the respects in which such form does not comply with the requirements of law and shall deliver a copy thereof to the company and it shall be unlawful thereafter for any such company to issue any policy in such form.

(b) With respect to health insurance coverage offered by a health insurance issuer, a filing of premium rates pursuant to

subsection (a) of this Section shall not be complete unless it contains all information necessary to justify the premium rate and such other information as the Director may require to determine the rate's compliance with Section 355.01 of this Code. Each rate filing must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment the rate filing is in compliance with applicable laws and regulations and that the benefits are reasonable in relation to premiums.

(c) With respect to premium rate changes, the filing under subsection (a) of this Section shall clearly indicate the percentage change from the previously filed rate and the percentage change from the rate that was in effect 12 months prior to the proposed effective date of such rate.

(d) In addition to filing premium rates, a company shall notify the Director whenever a policy form subject to this Section has been closed for sale.

(e) As used in this Section, the terms "health insurance coverage" and "health insurance issuer" have the meanings given those terms in the Illinois Health Insurance Portability and Accountability Act.

(Source: P.A. 79-777.)

(215 ILCS 5/355.01 new)

Sec. 355.01. Health insurance premium rates; prior approval.

(a) With respect to health insurance coverage offered by a health insurance issuer, no such policy, plan, or contract shall be issued or delivered to any person in this State until the classification of risks and the premium rates pertaining thereto have been approved by the Director under this Section. Any subsequent addition to or change in premium rates shall also be subject to the Director's approval under this Section. In all cases the Director shall approve or disapprove a premium rate within 60 days after submission unless the Director extends by not more than an additional 60 days the period within which the Director shall approve or disapprove such premium rate by giving written notice to the health insurance issuer of the extension before expiration of the initial 60-day period.

(b) The Director shall disapprove a premium rate under this Section if:

(1) the benefits provided are not reasonable in relation to the premium charged; or

(2) the proposed premium rate is excessive, inadequate, unjustified, or unfairly discriminatory.

The party proposing a rate has the burden of proving by clear and convincing evidence that the rate does not violate this Section.

(c) With respect to premium rate changes, the Director's review of a proposed rate change shall include an examination of the factors set forth in regulation promulgated by the

Secretary of the U.S. Department of Health and Human Services pursuant to Section 2794 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act (Pub. L. 111-148), for the purpose of determining whether a State has an effective rate review program.

(d) The Director shall notify a health insurance issuer in writing of the approval or disapproval of a premium rate under this Section, and the notice shall be posted on the Department's website. If the Director disapproves the premium rate, then the written notice shall clearly state the respects in which the premium rate does not comply with the requirements of law and it shall be unlawful thereafter for any such health insurance issuer to use the premium rate. The written notice of disapproval shall also advise the health insurance issuer of the right to a hearing under subsection (f) of this Section.

(e) With respect to a rate change approved under this Section, the rate change shall take effect no sooner than 30 days after the written approval is mailed by the Director. The rate change shall be stayed if within the 30-day period a written request for a hearing is filed with the Director under subsection (f) of this Section. A health insurance issuer shall notify in writing all policyholders to which such rate change applies at least 30 days prior to the effective date of the rate change. The written notice shall also advise the policyholders of the right to a hearing under subsection (d) of this Section.

(f) A health insurance issuer may appeal a decision by the Director under this Section by making a written request for a hearing before the Director within 30 days after receiving the written notice under subsections (d) or (g) of this Section. One percent or 25 of the covered lives (whichever is greater) to which such rate change applies may appeal a decision by the Director under this Section by submitting a written request to the Department for a hearing before the Director within 30 days after the Department posts public notice under subsection (d) of this Section.

(g) The Director may request actuarial reasons and data, as well as other information, needed to determine if a previously approved rate continues to satisfy the requirements of this Section. The Director may withdraw approval of any rate that has been previously approved on any of the grounds stated in subsection (b) of this Section. The Director shall notify a health insurance issuer in writing of the withdrawal of approval. The written notice shall clearly state the respects in which the premium rate ceases to comply with the requirements of law and shall advise the health insurance issuer of the right to a hearing under subsection (f) of this Section. The written withdrawal of approval shall take effect 30 days after the date of mailing but shall be stayed if within the 30-day period a written request for hearing is filed with the Director under subsection (f) of this Section.

(h) As used in this Section, the terms "health insurance

coverage" and "health insurance issuer" have the meanings given those terms in the Illinois Health Insurance Portability and Accountability Act.

(215 ILCS 5/367) (from Ch. 73, par. 979)

Sec. 367. Group accident and health insurance.

(1) Group accident and health insurance is hereby declared to be that form of accident and health insurance covering not less than 2 employees, members, or employees of members, written under a master policy issued to any governmental corporation, unit, agency or department thereof, or to any corporation, copartnership, individual employer, or to any association upon application of an executive officer or trustee of such association having a constitution or bylaws and formed in good faith for purposes other than that of obtaining insurance, where officers, members, employees, employees of members or classes or department thereof, may be insured for their individual benefit. In addition a group accident and health policy may be written to insure any group which may be insured under a group life insurance policy. The term "employees" shall include the officers, managers and employees of subsidiary or affiliated corporations, and the individual proprietors, partners and employees of affiliated individuals and firms, when the business of such subsidiary or affiliated corporations, firms or individuals, is controlled by a common employer through stock ownership, contract or otherwise.

(2) Any insurance company authorized to write accident and health insurance in this State shall have power to issue group accident and health policies. No policy of group accident and health insurance may be issued or delivered in this State unless a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto shall have been filed with the department and approved by it in accordance with Section 355 and Section 355.01, and it contains in substance those provisions contained in Sections 357.1 through 357.30 as may be applicable to group accident and health insurance and the following provisions:

(a) A provision that the policy, the application of the employer, or executive officer or trustee of any association, and the individual applications, if any, of the employees, members or employees of members insured shall constitute the entire contract between the parties, and that all statements made by the employer, or the executive officer or trustee, or by the individual employees, members or employees of members shall (in the absence of fraud) be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in a written application.

(b) A provision that the insurer will issue to the employer, or to the executive officer or trustee of the association, for delivery to the employee, member or

employee of a member, who is insured under such policy, an individual certificate setting forth a statement as to the insurance protection to which he is entitled and to whom payable.

(c) A provision that to the group or class thereof originally insured shall be added from time to time all new employees of the employer, members of the association or employees of members eligible to and applying for insurance in such group or class.

(3) Anything in this code to the contrary notwithstanding, any group accident and health policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services, may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid. Nothing in this subsection (3) shall prohibit an insurer from providing incentives for insureds to utilize the services of a particular hospital or person.

(4) Special group policies may be issued to school districts providing medical or hospital service, or both, for pupils of the district injured while participating in any athletic activity under the jurisdiction of or sponsored or controlled by the district or the authorities of any school

thereof. The provisions of this Section governing the issuance of group accident and health insurance shall, insofar as applicable, control the issuance of such policies issued to schools.

(5) No policy of group accident and health insurance may be issued or delivered in this State unless it provides that upon the death of the insured employee or group member the dependents' coverage, if any, continues for a period of at least 90 days subject to any other policy provisions relating to termination of dependents' coverage.

(6) No group hospital policy covering miscellaneous hospital expenses issued or delivered in this State shall contain any exception or exclusion from coverage which would preclude the payment of expenses incurred for the processing and administration of blood and its components.

(7) No policy of group accident and health insurance, delivered in this State more than 120 days after the effective day of the Section, which provides inpatient hospital coverage for sicknesses shall exclude from such coverage the treatment of alcoholism. This subsection shall not apply to a policy which covers only specified sicknesses.

(8) No policy of group accident and health insurance, which provides benefits for hospital or medical expenses based upon the actual expenses incurred, issued or delivered in this State shall contain any specific exception to coverage which would preclude the payment of actual expenses incurred in the

examination and testing of a victim of an offense defined in Sections 11-1.20 through 11-1.60 or 12-13 through 12-16 of the Criminal Code of 1961, or an attempt to commit such offense, to establish that sexual contact did occur or did not occur, and to establish the presence or absence of sexually transmitted disease or infection, and examination and treatment of injuries and trauma sustained by the victim of such offense, arising out of the offense. Every group policy of accident and health insurance which specifically provides benefits for routine physical examinations shall provide full coverage for expenses incurred in the examination and testing of a victim of an offense defined in Sections 11-1.20 through 11-1.60 or 12-13 through 12-16 of the Criminal Code of 1961, or an attempt to commit such offense, as set forth in this Section. This subsection shall not apply to a policy which covers hospital and medical expenses for specified illnesses and injuries only.

(9) For purposes of enabling the recovery of State funds, any insurance carrier subject to this Section shall upon reasonable demand by the Department of Public Health disclose the names and identities of its insureds entitled to benefits under this provision to the Department of Public Health whenever the Department of Public Health has determined that it has paid, or is about to pay, hospital or medical expenses for which an insurance carrier is liable under this Section. All information received by the Department of Public Health under this provision shall be held on a confidential basis and shall

not be subject to subpoena and shall not be made public by the Department of Public Health or used for any purpose other than that authorized by this Section.

(10) Whenever the Department of Public Health finds that it has paid all or part of any hospital or medical expenses which an insurance carrier is obligated to pay under this Section, the Department of Public Health shall be entitled to receive reimbursement for its payments from such insurance carrier provided that the Department of Public Health has notified the insurance carrier of its claim before the carrier has paid the benefits to its insureds or the insureds' assignees.

(11) (a) No group hospital, medical or surgical expense policy shall contain any provision whereby benefits otherwise payable thereunder are subject to reduction solely on account of the existence of similar benefits provided under other group or group-type accident and sickness insurance policies where such reduction would operate to reduce total benefits payable under these policies below an amount equal to 100% of total allowable expenses provided under these policies.

(b) When dependents of insureds are covered under 2 policies, both of which contain coordination of benefits provisions, benefits of the policy of the insured whose birthday falls earlier in the year are determined before those of the policy of the insured whose birthday falls later in the year. Birthday, as used herein, refers only to

the month and day in a calendar year, not the year in which the person was born. The Department of Insurance shall promulgate rules defining the order of benefit determination pursuant to this paragraph (b).

(12) Every group policy under this Section shall be subject to the provisions of Sections 356g and 356n of this Code.

(13) No accident and health insurer providing coverage for hospital or medical expenses on an expense incurred basis shall deny reimbursement for an otherwise covered expense incurred for any organ transplantation procedure solely on the basis that such procedure is deemed experimental or investigational unless supported by the determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services that such procedure is either experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable. If an accident and health insurer has made written request, or had one made on its behalf by a national organization, for determination by the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services as to whether a specific organ transplantation procedure is clinically acceptable and said organization fails to respond to such a request within a period of 90 days, the failure to act may be deemed a determination

that the procedure is deemed to be experimental or investigational.

(14) Whenever a claim for benefits by an insured under a dental prepayment program is denied or reduced, based on the review of x-ray films, such review must be performed by a dentist.

(Source: P.A. 96-1551, eff. 7-1-11.)

Section 10. The Health Maintenance Organization Act is amended by changing Section 5-3 and by adding Section 2-11.1 as follows:

(215 ILCS 125/2-11.1 new)

Sec. 2-11.1. Premium rates; filing and prior approval.

(a) Notwithstanding any other provision of law, no group or individual contract or evidence of coverage shall be issued or delivered in this State until the schedule of base rates to be used in conjunction with the contract or evidence of coverage has been filed with the Director; nor shall it be issued or delivered until the Director shall have approved such base rates pursuant to the provisions of Section 355.01 of the Illinois Insurance Code. Any subsequent addition to or change in rates is also subject to this Section.

(b) A filing of rates under this Section shall not be complete unless it contains all information necessary to justify the premium rate and such other information as the

Director may require to determine the rate's compliance with Section 355.01 of the Illinois Insurance Code. Each rate filing must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment the rate filing is in compliance with the applicable laws and regulations of this State and that the benefits are reasonable in relation to premiums.

(c) With respect to rate changes, the filing under this Section shall clearly indicate the percentage change from the previously filed rate and the percentage change from the rate that was in effect 12 months prior to the proposed effective date of such rate.

(d) In addition to filing premium rates, a health maintenance organization shall notify the Director whenever a plan subject to this Section has been closed for sale.

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.01, 355.2, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.21 ~~356z.19~~, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e,

370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois

Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or

additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable

experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; 96-833, eff. 6-1-10; 96-1000, eff. 7-2-10; 97-282, eff. 8-9-11; 97-343, eff. 1-1-12; 97-437, eff. 8-18-11; 97-486, eff. 1-1-12; 97-592, eff. 1-1-12; revised 10-13-11.)

Section 99. Effective date. This Act takes effect January 1, 2013.