SB0750

LRB09904042MLM24060b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

SB0750

Introduced 2/3/2015, by Sen. Michael E. Hastings

SYNOPSIS AS INTRODUCED:

215 ILCS 5/355a	from Ch. 73, par. 967a
215 ILCS 109/25	
215 ILCS 110/10	from Ch. 32, par. 690.10
215 ILCS 110/25	from Ch. 32, par. 690.25

Amends the Illinois Insurance Code. Provides that health plan issuers offering health plans through the State health insurance marketplace update their provider directory on a monthly basis. Provides that the information in provider directories shall be offered in a manner that accommodates individuals with limited English proficiency and with disabilities. Provides that, with respect to dental plans, a dentist listed is considered an active network participant from the location published in the provider directory only if the dentist has filed a claim for a patient enrolled with the dental plan at least once in the previous 3-month period. Amends the Dental Care Patient Protection Act. Provides that managed care dental plans must only list participating dentists who have filed a claim for an enrolled patient within the past 3 months. Makes conforming changes in the Dental Service Plan Act.

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A BILL FOR

AN ACT concerning regulation.

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 355a as follows:

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

Sec. 355a. Standardization of terms and coverage.

(1) The purpose of this Section shall be (a) to provide reasonable standardization and simplification of terms and coverages of individual accident and health insurance policies to facilitate public understanding and comparisons; (b) to eliminate provisions contained in individual accident and health insurance policies which may be misleading or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims; and (c) to provide for reasonable disclosure in the sale of accident and health coverages.

(2) Definitions applicable to this Section are as follows:

(a) "Policy" means all or any part of the forms constituting the contract between the insurer and the insured, including the policy, certificate, subscriber contract, riders, endorsements, and the application if attached, which are subject to filing with and approval by

the Director.

(b) "Service corporations" means voluntary health and dental corporations organized and operating respectively under the Voluntary Health Services Plans Act and the Dental Service Plan Act.

(c) "Accident and health insurance" means insurance written under Article XX of the Insurance Code, other than credit accident and health insurance, and coverages provided in subscriber contracts issued by service corporations. For purposes of this Section such service corporations shall be deemed to be insurers engaged in the business of insurance.

(3) The Director shall issue such rules as he shall deem necessary or desirable to establish specific standards, including standards of full and fair disclosure that set forth the form and content and required disclosure for sale, of individual policies of accident and health insurance, which rules and regulations shall be in addition to and in accordance with the applicable laws of this State, and which may cover but shall not be limited to: (a) terms of renewability; (b) initial and subsequent conditions of eligibility; (c) non-duplication of coverage provisions; (d) coverage of dependents; (e) pre-existing conditions; (f) termination of insurance; (g) probationary periods; (h) limitation, exceptions, and reductions; (i) elimination periods; (j) requirements regarding replacements; (k) recurrent conditions; and (l) the

definition of terms including but not limited to the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable, and non-cancellable.

The Director may issue rules that specify prohibited policy provisions not otherwise specifically authorized by statute which in the opinion of the Director are unjust, unfair or unfairly discriminatory to the policyholder, any person insured under the policy, or beneficiary.

(4) The Director shall issue such rules as he shall deem necessary or desirable to establish minimum standards for benefits under each category of coverage in individual accident and health policies, other than conversion policies issued pursuant to a contractual conversion privilege under a group policy, including but not limited to the following categories: (a) basic hospital expense coverage; (b) basic medical-surgical expense coverage; (c) hospital confinement indemnity coverage; (d) major medical expense coverage; (e) disability income protection coverage; (f) accident only coverage; and (g) specified disease or specified accident coverage.

Nothing in this subsection (4) shall preclude the issuance of any policy which combines two or more of the categories of coverage enumerated in subparagraphs (a) through (f) of this subsection.

No policy shall be delivered or issued for delivery in this

State which does not meet the prescribed minimum standards for the categories of coverage listed in this subsection unless the Director finds that such policy is necessary to meet specific needs of individuals or groups and such individuals or groups will be adequately informed that such policy does not meet the prescribed minimum standards, and such policy meets the requirement that the benefits provided therein are reasonable in relation to the premium charged. The standards and criteria to be used by the Director in approving such policies shall be included in the rules required under this Section with as much specificity as practicable.

The Director shall prescribe by rule the method of identification of policies based upon coverages provided.

(5) (a) In order to provide for full and fair disclosure in the sale of individual accident and health insurance policies, no such policy shall be delivered or issued for delivery in this State unless the outline of coverage described in paragraph (b) of this subsection either accompanies the policy, or is delivered to the applicant at the time the application is made, and an acknowledgment signed by the insured, of receipt of delivery of such outline, is provided to the insurer. In the event the policy is issued on a basis other than that applied for, the outline of coverage properly describing the policy must accompany the policy when it is delivered and such outline shall clearly state that the policy differs, and to what extent, from that for which application was originally made.

All policies, except single premium nonrenewal policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance, that the policyholder shall have the right to return the policy within 10 days of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.

(b) The Director shall issue such rules as he shall deem necessary or desirable to prescribe the format and content of the outline of coverage required by paragraph (a) of this subsection. "Format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. "Content" shall include without limitation thereto, statements relating to the particular policy as to the applicable category of coverage prescribed under subsection 4; principal benefits; exceptions, reductions and limitations; and renewal provisions, including any reservation by the insurer of a right to change premiums. Such outline of coverage shall clearly state that it constitutes a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c) Without limiting the generality of paragraph (b) of this subsection (5), no qualified health plans shall be offered for sale directly to consumers through the health insurance marketplace operating in the State in accordance with Sections

1311 and 1321 of the federal Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued thereunder (collectively, "the Federal Act"), unless the following information is made available to the consumer at the time he or she is comparing policies and their premiums:

(i) With respect to prescription drug benefits, the most recently published formulary where a consumer can view in one location covered prescription drugs; information on tiering and the cost-sharing structure for each tier; and information about how a consumer can obtain specific copayment amounts or coinsurance percentages for a specific qualified health plan before enrolling in that plan. This information shall clearly identify the qualified health plan to which it applies.

(ii) The most recently published provider directory where a consumer can view the provider network that applies to each qualified health plan and information about each provider, including location, contact information, specialty, medical group, if any, any institutional affiliation, and whether the provider is accepting new patients. <u>The provider directory shall be updated on a monthly basis.</u> The information shall clearly identify the qualified health plan to which it applies <u>and be offered in</u>

a manner that accommodates individuals with limited English proficiency and with disabilities.

With respect to dental plans, a dentist listed in a provider network is considered an active network participant from the location published in the provider directory only if the dentist has filed a claim for a patient enrolled with the dental plan at least once in the previous 3-month period. Any dentist not meeting this criterion must be removed from the published provider directory for that specific location.

(d) Each company that offers qualified health plans for sale directly to consumers through the health insurance marketplace operating in the State shall make the information in paragraph (c) of this subsection (5), for each qualified health plan that it offers, available and accessible to the general public on the company's Internet website and through other means for individuals without access to the Internet.

(e) The Department shall ensure that State-operated Internet websites, in addition to the Internet website for the health insurance marketplace established in this State in accordance with the Federal Act, prominently provide links to Internet-based materials and tools to help consumers be informed purchasers of health insurance.

(f) Nothing in this Section shall be interpreted or implemented in a manner not consistent with the Federal Act. This Section shall apply to all qualified health plans offered for sale directly to consumers through the health insurance

marketplace operating in this State for any coverage year beginning on or after January 1, 2015.

(6) Prior to the issuance of rules pursuant to this Section, the Director shall afford the public, including the companies affected thereby, reasonable opportunity for comment. Such rulemaking is subject to the provisions of the Illinois Administrative Procedure Act.

(7) When a rule has been adopted, pursuant to this Section, all policies of insurance or subscriber contracts which are not in compliance with such rule shall, when so provided in such rule, be deemed to be disapproved as of a date specified in such rule not less than 120 days following its effective date, without any further or additional notice other than the adoption of the rule.

(8) When a rule adopted pursuant to this Section so provides, a policy of insurance or subscriber contract which does not comply with the rule shall not less than 120 days from the effective date of such rule, be construed, and the insurer or service corporation shall be liable, as if the policy or contract did comply with the rule.

(9) Violation of any rule adopted pursuant to this Section shall be a violation of the insurance law for purposes of Sections 370 and 446 of the Insurance Code.

(Source: P.A. 98-1035, eff. 8-25-14.)

Section 10. The Dental Care Patient Protection Act is

amended by changing Section 25 as follows:

(215 ILCS 109/25)

Sec. 25. Provision of information.

(a) A managed care dental plan shall provide upon request to prospective enrollees a written summary description of all of the following terms of coverage:

(1) Information about the dental plan, including how the plan operates and what general types of financial arrangements exist between dentists and the plan. Nothing in this Section shall require disclosure of any specific financial arrangements between providers and the plan.

(2) The service area.

(3) Covered benefits, exclusions, or limitations.

(4) Pre-certification requirements including any requirements for referrals made by primary care dentists to specialists, and other preauthorization requirements.

(5) A list of participating primary care dentists in the plan's service area, including provider address and phone number, for an enrollee to evaluate the managed care dental plan's network access, as well as a phone number by which the prospective enrollee may obtain additional information regarding the provider network including participating specialists. However, a managed care dental plan offering a preferred provider organization ("PPO") product that does not require the enrollee to select a

primary care dentist shall only be required to make available for inspection to enrollees and prospective enrollees a list of participating dentists in the plan's service area in which participating dentist has filed a claim for an enrollee with the managed care dental plan within the previous 3-month period for the address listed. Any dentist not meeting this criterion must be removed from the managed care provider network directory (written or electronic) for the address listed.

(6) Emergency coverage and benefits.

(7) Out-of-area coverages and benefits, if any.

(8) The process about how participating dentists are selected.

(9) The grievance process, including the telephone number to call to receive information concerning grievance procedures.

An enrollee shall be provided with an evidence of coverage as required under the Illinois Insurance Code provisions applicable to the managed care dental plan.

(b) An enrollee or prospective enrollee has the right to the most current financial statement filed by the managed care dental plan by contacting the Department of Insurance. The Department may charge a reasonable fee for providing such information.

(c) The managed care dental plan shall provide to the Department, on an annual basis, a list of all participating

dentists meeting the criteria listed in subsection (a) of this Section. Nothing in this Section shall require a particular ratio for any type of provider.

(d) If the managed care dental plan uses a capitation method of compensation to its primary care providers (dentists), the plan must establish and follow procedures that ensure that:

(1) the plan application form includes a space in which each enrollee selects a primary care provider (dentist);

(2) if an enrollee who fails to select a primary care provider (dentist) is assigned a primary care provider (dentist), the enrollee shall be notified of the name and location of that primary care provider (dentist); and

(3) primary care provider (dentist) to whom an enrollee is assigned, pursuant to item (2), is physically located within a reasonable travel distance, as established by rule adopted by the Director, from the residence or place of employment of the enrollee.

(e) Nothing in this Act shall be deemed to require a plan to assign an enrollee to a primary care provider (dentist).

(Source: P.A. 91-355, eff. 1-1-00.)

Section 15. The Dental Service Plan Act is amended by changing Sections 10 and 25 as follows:

(215 ILCS 110/10) (from Ch. 32, par. 690.10)

Sec. 10. "Participating dentist" means a dentist licensed in Illinois to practice dentistry, and who, by written agreement with a dental service plan corporation undertakes to furnish dental service to the plan's subscribers and their covered dependents at least once every 3-month period and to abide by its by-laws, rules and regulations.

(Source: Laws 1965, p. 2179.)

(215 ILCS 110/25) (from Ch. 32, par. 690.25)

Sec. 25. Application of Insurance Code provisions. Dental service plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 355.2, 355.3, 367.2, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, paragraph (c) of subsection (5) of Section 355a, and subsection (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 97-486, eff. 1-1-12; 97-805, eff. 1-1-13.)