SB2807

LRB09915724MLM40023b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

SB2807

Introduced 2/17/2016, by Sen. Linda Holmes

SYNOPSIS AS INTRODUCED:

5 ILCS 375/6.11	
55 ILCS 5/5-1069.3	
65 ILCS 5/10-4-2.3	
105 ILCS 5/10-22.3f	
215 ILCS 5/2	from Ch. 73, par. 614
215 ILCS 5/356z.24 new	
215 ILCS 130/4003	from Ch. 73, par. 1504-3
215 ILCS 134/10	
215 ILCS 134/31 new	
215 ILCS 165/10	from Ch. 32, par. 604
305 ILCS 5/5-16.8	

Amends the Illinois Insurance Code. Provides that on and after the effective date of the amendatory Act, no insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace shall: (1) provide or refer to a coverage determination as medically necessary in any publication, policy, contract or agreement, or explanation of benefits made by the policy or plan, or (2) provide or state in any way that treatment or services recommended by the insured or enrollees treating, consulting, ordering, or attending physician or health care provider is not medically necessary, and that doing so is an unfair and deceptive practice under the Code. Provides that nothing shall prohibit a health care benefit determination with respect to whether treatment or services are covered under the policy or plan. Amends the Managed Care Reform and Patient Rights Act to make similar changes for health care plans. Amends the State Employees Group Insurance Act of 1971, Counties Code, Illinois Municipal Code, School Code, Health Maintenance Organization Act, Limited Health Service Organization Act, Voluntary Health Services Plans Act, and Illinois Public Aide Code to make conforming changes.

LRB099 15724 MLM 40023 b

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 State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, and 356z.22 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 356z.24, 370c, and 370c.1 of the Illinois Insurance Code.

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. 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15; 99-480, eff. 9-9-15.)

Section 10. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, and 356z.22 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, 356z.24, and 370c of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

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. 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15; 99-480, eff. 9-9-15.)

Section 15. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, and 356z.22 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, 356z.24, and 370c of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under

Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

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. 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15; 99-480, eff. 9-9-15.)

Section 20. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, and 356z.22 of the Illinois Insurance Code. Insurance policies shall comply with Sections ~~Section~~ 356z.19 and 356z.24 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a and 355b of the

Illinois Insurance Code.

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. 97-282, eff. 8-9-11; 97-343, eff. 1-1-12; 97-813, eff. 7-13-12; 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15.)

Section 25. The Illinois Insurance Code is amended by changing Section 2 and by adding Section 356z.24 as follows:

(215 ILCS 5/2) (from Ch. 73, par. 614)

Sec. 2. General definitions.

In this Code, unless the context otherwise requires,

(a) "Director" means the Director of Insurance.

(b) "Department" means the Department of Insurance.

(c) "State" or "State of the United States" includes the District of Columbia and a territory or possession of the United States.

(d) "Country" or "Foreign Country" includes a state, province or political subdivision thereof.

(e) "Company" means an insurance or surety company and shall be deemed to include a corporation, company, partnership, association, society, order, individual or aggregation of

individuals engaging in or proposing or attempting to engage in any kind of insurance or surety business, including the exchanging of reciprocal or inter-insurance contracts between individuals, partnerships and corporations.

(f) "Domestic Company" means a company incorporated or organized under the laws of this State.

(g) "Foreign Company" means a company incorporated or organized under the laws of any state of the United States other than this State.

(h) "Alien Company" means a company incorporated or organized under the laws of any country other than the United States.

(i) "Mutual Legal Reserve Life Company" means a mutual life company issuing contracts without contingent liability on the policyholder.

(j) "Assessment Legal Reserve Life Company" means a life company issuing contracts providing for contingent liability on the policyholder.

(k) "Reciprocal" includes Inter-Insurance Exchange.

(l) "Person" includes an individual, aggregation of individuals, corporation, association and partnership.

(m) Personal pronouns include all genders, the singular includes the plural and the plural includes the singular.

(n) "Policy" means an insurance policy or contract and includes certificates of fraternal benefit societies, assessment companies, mutual benefit associations, and burial

societies.

(o) "Policyholder" means a holder of an insurance policy or contract and includes holders of certificates of fraternal benefit societies, assessment companies, mutual benefit associations, and burial societies.

(p) "Articles of Incorporation" means the basic instrument of an incorporated company and all amendments thereto and includes "Charter," "Articles of Organization," "Articles of Reorganization," "Articles of Association," and "Deed of Settlement."

(q) "Officer" when used to refer to an officer of a company includes an attorney-in-fact for a reciprocal or Lloyds.

(r) "Medically necessary" means that a treating, consulting, ordering, or attending physician or health care professional or provider recommended, ordered, or provided a health care service, device, drug, or supply appropriate to the evaluation and treatment of disease, condition, illness, or injury and consistent with the applicable standard of care, including the evaluation of experimental or investigational services, procedures, drugs, or devices.

(Source: Laws 1937, p. 696.)

(215 ILCS 5/356z.24 new)

Sec. 356z.24. Medical necessity determinations. On and after the effective date of this amendatory Act of the 99th General Assembly, no insurer that amends, delivers, issues, or

renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or any other health care service shall: (1) provide or refer to a coverage determination as medically necessary in any publication, policy, contract or agreement, or explanation of benefits made by the policy or plan or (2) provide or state in any way that treatment or services recommended by the insured or enrollees treating, consulting, ordering, or attending physician or health care provider is not medically necessary, to do so shall be considered an unfair and deceptive practice under this Code. Nothing in this Section shall prohibit a health care benefit determination with respect to whether treatment or services are covered under the policy or plan.

Section 30. The Limited Health Service Organization Act is amended by changing Section 4003 as follows:

(215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

Sec. 4003. Illinois Insurance Code provisions. Limited health service 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, 155.37, 355.2, 355.3, 355b, 356v, 356z.10, 356z.21, 356z.22, 356z.24, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA,

VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code. For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited health service organizations in the following categories are deemed to be domestic companies:

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

(2) a corporation organized under the laws of another state, 30% of 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.

(Source: P.A. 97-486, eff. 1-1-12; 97-592, 1-1-12; 97-805, eff. 1-1-13; 97-813, eff. 7-13-12; 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15.)

Section 35. The Managed Care Reform and Patient Rights Act is amended by changing Section 10 and by adding Section 31 as follows:

(215 ILCS 134/10)

Sec. 10. Definitions.

"Adverse determination" means a determination by a health care plan under Section 45 or by a utilization review program under Section 85 that a health care service is not medically necessary.

"Clinical peer" means a health care professional who is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.

"Department" means the Department of Insurance.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

"Emergency medical screening examination" means a medical screening examination and evaluation by a physician licensed to practice medicine in all its branches, or to the extent permitted by applicable laws, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches to determine whether the need for emergency services exists.

"Emergency services" means, with respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and

outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.

"Enrollee" means any person and his or her dependents enrolled in or covered by a health care plan.

"Health care plan" means a plan, including, but not limited to, a health maintenance organization, a managed care community network as defined in the Illinois Public Aid Code, or an accountable care entity as defined in the Illinois Public Aid Code that receives capitated payments to cover medical services from the Department of Healthcare and Family Services, that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that subcontracts with a health care plan is, for purposes of that subcontract, a health care plan.

For purposes of this definition, "health care plan" shall not include the following:

(1) indemnity health insurance policies including

those using a contracted provider network;

(2) health care plans that offer only dental or only vision coverage;

(3) preferred provider administrators, as defined in Section 370g(g) of the Illinois Insurance Code;

(4) employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974;

(5) health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act; and

(6) not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999 that are affiliated with a union and that only extend coverage to union members and their dependents.

"Health care professional" means a physician, a registered professional nurse, or other individual appropriately licensed or registered to provide health care services.

"Health care provider" means any physician, hospital facility, facility licensed under the Nursing Home Care Act, long-term care facility as defined in Section 1-113 of the Nursing Home Care Act, or other person that is licensed or otherwise authorized to deliver health care services. Nothing in this Act shall be construed to define Independent Practice Associations or Physician-Hospital Organizations as health

care providers.

"Health care services" means any services included in the furnishing to any individual of medical care, or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury including home health and pharmaceutical services and products.

"Medical director" means a physician licensed in any state to practice medicine in all its branches appointed by a health care plan.

"Medically necessary" means that a treating, consulting, ordering, or attending physician or health care professional or provider recommended, ordered, or provided a health care service, device, drug, or supply appropriate to the evaluation and treatment of disease, condition, illness, or injury and consistent with the applicable standard of care, including the evaluation of experimental or investigational services, procedures, drugs, or devices.

"Person" means a corporation, association, partnership, limited liability company, sole proprietorship, or any other legal entity.

"Physician" means a person licensed under the Medical Practice Act of 1987.

"Post-stabilization medical services" means health care services provided to an enrollee that are furnished in a

licensed hospital by a provider that is qualified to furnish such services, and determined to be medically necessary and directly related to the emergency medical condition following stabilization.

"Stabilization" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result.

"Utilization review" means the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

"Utilization review program" means a program established by a person to perform utilization review.

(Source: P.A. 98-651, eff. 6-16-14; 98-841, eff. 8-1-14; 99-78, eff. 7-20-15.)

(215 ILCS 134/31 new)

Sec. 31. Medical necessity determinations. On and after the effective date of this amendatory Act of the 99th General Assembly, no health care plan shall: (1) provide or refer to a coverage determination as medically necessary in any publication, policy, contract or agreement, or explanation of benefits made by policy or plan or (2) provide or state in any way that treatment or services recommended by the insured or enrollees treating, consulting, ordering, or attending

physician or health care provider is not medically necessary, to do so shall be considered an unfair and deceptive practice under the Illinois Insurance Code. Nothing in this Section shall prohibit a health care benefit determination with respect to whether treatment or services are covered under the policy or plan.

Section 40. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services 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, 155.22a, 155.37, 354, 355.2, 355.3, 355b, 356g, 356g.5, 356g.5-1, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 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.18, 356z.19, 356z.21, 356z.22, 356z.24, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

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. 97-282, eff. 8-9-11; 97-343, eff. 1-1-12; 97-486, eff. 1-1-12; 97-592, eff. 1-1-12; 97-805, eff. 1-1-13; 97-813, eff. 7-13-12; 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15.)

Section 45. The Illinois Public Aid Code is amended by changing Section 5-16.8 as follows:

(305 ILCS 5/5-16.8)

Sec. 5-16.8. Required health benefits. The medical assistance program shall (i) provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356u, 356w, 356x, and 356z.6 of the Illinois Insurance Code and (ii) be subject to the provisions of Sections 356z.19, 356z.24, 364.01, 370c, and 370c.1 of the Illinois Insurance Code.

On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

To ensure full access to the benefits set forth in this Section, on and after January 1, 2016, the Department shall ensure that provider and hospital reimbursement for

post-mastectomy care benefits required under this Section are no lower than the Medicare reimbursement rate.

(Source: P.A. 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; revised 10-21-15.)