AN ACT concerning insurance.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Health Insurance Portability and Accountability Act is amended by changing Sections 5 and 50 and by adding Section 60 as follows:

(215 ILCS 97/5)

Sec. 5. Definitions.

"Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person specified.

"Beneficiary" has the meaning given such term under Section 3(8) of the Employee Retirement Income Security Act of 1974.

"Bona fide association" means, with respect to health insurance coverage offered in a State, an association which:

(1) has been actively in existence for at least 5 years;

(2) has been formed and maintained in good faith for purposes other than obtaining insurance;

(3) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(4) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(5) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(6) meets such additional requirements as may be imposed under State law.

"Church plan" has the meaning given that term under Section 3(33) of the Employee Retirement Income Security Act of 1974.

"COBRA continuation provision" means any of the following:

(1) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of that Section insofar as it relates to pediatric vaccines.

(2) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than Section 609 of that Act.

(3) Title XXII of federal Public Health Service Act.

"Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, the holding of policyholders' proxies by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is solely the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds shareholders' proxies representing 10% or more of the voting securities of any other person or holds or controls sufficient policyholders' proxies to elect the majority of the board of directors of the domestic company. This presumption may be rebutted by a showing made in a manner as the Secretary may provide by rule. The Secretary may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

"Department" means the Department of Insurance.

"Employee" has the meaning given that term under Section 3(6) of the Employee Retirement Income Security Act of 1974.

"Employer" has the meaning given that term under Section 3(5) of the Employee Retirement Income Security Act of 1974, except that the term shall include only employers of 2 or more employees.

"Enrollment date" means, with respect to an individual covered under a group health plan or group health insurance coverage, the date of enrollment of the individual in the plan or coverage, or if earlier, the first day of the waiting period for enrollment.

"Federal governmental plan" means a governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of that government.

"Governmental plan" has the meaning given that term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

"Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with the plan.

"Group health plan" means an employee welfare benefit plan (as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2) of that Section and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"Health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined herein) which is licensed to engage in the business of insurance in a state and which is subject to Illinois law which regulates insurance (within the meaning of Section 514(b)(2) of the Employee

Retirement Income Security Act of 1974). The term does not include a group health plan.

"Health maintenance organization (HMO)" means:

(1) a Federally qualified health maintenance organization (as defined in Section 1301(a) of the Public Health Service Act.);

(2) an organization recognized under State law as a health maintenance organization; or

(3) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(1) Application of aggregation rule for large employers. All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

(2) Employers not in existence in preceding year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(3) Predecessors. Any reference in this Act to an

employer shall include a reference to any predecessor of such employer.

"Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

"Late enrollee" means with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(1) the first period in which the individual is eligible to enroll under the plan; or

(2) a special enrollment period under subsection (F) of Section 20.

"Medical care" means amounts paid for:

(1) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) amounts paid for transportation primarily for and essential to medical care referred to in item (1); and

(3) amounts paid for insurance covering medical care referred to in items (1) and (2).

"Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

"Participant" has the meaning given that term under Section 3(7) of the Employee Retirement Income Security Act of 1974.

<u>"Person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing acting in concert, but does not include any securities broker performing no more than the usual</u>

and customary broker's function or joint venture partnership exclusively engaged in owning, managing, leasing, or developing real or tangible personal property other than capital stock.

"Placement" or being "placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by the person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation.

"Plan sponsor" has the meaning given that term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(1) Application of aggregation rule for small employers. All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

(2) Employers not in existence in preceding year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees that it is reasonably

expected the employer will employ on business days in the current calendar year.

(3) Predecessors. Any reference in this Act to a small employer shall include a reference to any predecessor of that employer.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

"State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"Waiting period" means with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period of time that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(Source: P.A. 90-30, eff. 7-1-97.)

(215 ILCS 97/50)

Sec. 50. Guaranteed renewability of individual health insurance coverage.

(A) In general. Except as provided in this Section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

(B) General exceptions. A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) Nonpayment of premiums. The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) Fraud. The individual has performed an act or

practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Termination of plan. The issuer is ceasing to offer coverage in the individual market in accordance with subsection (C) of this Section and applicable Illinois law.

(4) Movement outside the service area. In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the issuer is authorized to do business), but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(5) Association membership ceases. In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(C) Requirements for uniform termination of coverage.

(1) Particular type of coverage not offered. In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if:

(a) the issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(b) the issuer offers, to each individual in the individual market provided coverage of this type, the option to purchase any other individual health

insurance coverage currently being offered by the issuer for individuals in such market; and

(c) in exercising the option to discontinue coverage of that type and in offering the option of coverage under subparagraph (b), the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(2) Discontinuance of all coverage.

(a) In general. Subject to subparagraph (c), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in Illinois, health insurance coverage may be discontinued by the issuer only if:

(i) the issuer provides notice to the Director and to each individual of the discontinuation at least 180 days prior to the date of the expiration of such coverage; ~~and~~

(ii) all health insurance issued or delivered for issuance in Illinois in such market is discontinued and coverage under such health insurance coverage in such market is not renewed; and~~.~~

(iii) in the case where the issuer has affiliates in the individual market, the issuer gives notice to each affected individual at least 180 days prior to the date of the expiration of the coverage of the individual's option to purchase all other individual health benefit plans currently offered by any affiliate of the carrier.

(b) Prohibition on market reentry. In the case of a discontinuation under subparagraph (a) in the individual market, the issuer may not provide for the issuance of any health insurance coverage in Illinois involved during the 5-year period beginning on the date of the discontinuation of the last health insurance

coverage not so renewed.

(c) If an issuer elects to discontinue offering all health insurance coverage in the individual market under subparagraph (a), its affiliates that offer health insurance coverage in the individual market in Illinois shall offer individual health insurance coverage to all individuals who were covered by the discontinued health insurance coverage on the date of the notice provided to affected individuals under subdivision (iii) of subparagraph (a) of this item (2) if the individual applies for coverage no later than 63 days after the discontinuation of coverage.

(d) Subject to subparagraph (e) of this item (2), an affiliate that issues coverage under subparagraph (c) shall waive the preexisting condition exclusion period to the extent that the individual has satisfied the preexisting condition exclusion period under the individual's prior contract or policy.

(e) An affiliate that issues coverage under subparagraph (c) may require the individual to satisfy the remaining part of the preexisting condition exclusion period, if any, under the individual's prior contract or policy that has not been satisfied, unless the coverage has a shorter preexisting condition exclusion period, and may include in any coverage issued under subparagraph (c) any waivers or limitations of coverage that were included in the individual's prior contract or policy.

(D) Exception for uniform modification of coverage. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as the modification is consistent with Illinois law and effective on a uniform basis among all individuals with that policy form.

(E) Application to coverage offered only through associations. In applying this Section in the case of health

insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to such an association (of which the individual is a member).

The changes to this Section made by this amendatory Act of the 94th General Assembly apply only to discontinuances of coverage occurring on or after the effective date of this amendatory Act of the 94th General Assembly.

(Source: P.A. 90-567, eff. 1-23-98.)

(215 ILCS 97/60 new)

Sec. 60. Notice requirement. In any case where a health insurance issuer elects to uniformly modify coverage, uniformly terminate coverage, or discontinue coverage in a marketplace in accordance with Sections 30 and 50 of this Act, the issuer shall provide notice to the Department prior to notifying the plan sponsors, participants, beneficiaries, and covered individuals. The notice shall be sent by certified mail to the Department 90 days in advance of any notification of the company's actions sent to plan sponsors, participants, beneficiaries, and covered individuals. The notice shall include: (i) a complete description of the action to be taken, (ii) a specific description of the type of coverage affected, (iii) the total number of covered lives affected, (iv) a sample draft of all letters being sent to the plan sponsors, participants, beneficiaries, or covered individuals, (v) time frames for the actions being taken, (vi) options the plans sponsors, participants, beneficiaries, or covered individuals may have available to them under this Act, and (vii) any other information as required by the Department.

This Section applies only to discontinuances of coverage occurring on or after the effective date of this amendatory Act of the 94th General Assembly.

Section 99. Effective date. This Act takes effect upon

becoming law.