Sen. Dan Kotowski

Filed: 5/12/2014

AMENDMENT TO HOUSE BILL 3638

AMENDMENT NO. _____. Amend House Bill 3638 by replacing everything after the enacting clause with the following:

"Section 1. Short title. This amendatory Act may be referred to as the Health Insurance Consumer Protection Act of 2014.

Section 3. Findings and purpose. The General Assembly finds that the federal Patient Protection and Affordable Care Act and the federal regulations implementing that Act give the State and its Department of Insurance primary responsibility for ensuring that all policies of health insurance and health care plans that are offered for sale directly to consumers in the State provide consumers with adequate information about the coverage offered to enable them to meaningfully compare plans and premiums and enroll in the appropriate policy or plan. The purpose of this amendatory Act of the 98th General Assembly is

to build on the consumer protections provided in federal law for policies or health care benefit plans offered for sale directly to consumers through the Illinois Health Benefits Exchange.

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 policy shall be offered for sale directly to consumers in this State as a qualified health plan, as defined in 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 under those Acts (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, an up-to-date 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. The formulary 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, any institutional affiliation, and whether the provider is accepting new patients. The information shall clearly identify the qualified health plan to which it applies.

(d) Each company that offers a qualified health plan 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 to consumers 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. 90-177, eff. 7-23-97; 90-372, eff. 7-1-98; 90-655, eff. 7-30-98.)

Section 10. The Managed Care Reform and Patient Rights Act is amended by changing Section 15 and by adding Sections 45.1 and 45.2 as follows:

(215 ILCS 134/15)

Sec. 15. Provision of information.

(a) A health care plan shall provide annually to enrollees and prospective enrollees, upon request, a complete list of participating health care providers in the health care plan's service area and a description of the following terms of coverage:

(1) the service area;

(2) the covered benefits and services with all

exclusions, exceptions, and limitations;

(3) the pre-certification and other utilization review procedures and requirements;

(4) a description of the process for the selection of a primary care physician, any limitation on access to specialists, and the plan's standing referral policy;

(5) the emergency coverage and benefits, including any restrictions on emergency care services;

(6) the out-of-area coverage and benefits, if any;

(7) the enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses;

(8) the provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by that provider;

(9) the appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process; and

(10) a statement of all basic health care services and all specific benefits and services mandated to be provided to enrollees by any State law or administrative rule.

(a-5) Without limiting the generality of subsection (a) of

this Section, no health care plan shall be offered for sale directly to consumers in this State as a qualified health plan, as defined in 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 under those Acts (collectively, "the Federal Act"), unless, in addition to the information required under subsection (a) of this Section, the following information is available to the consumer at the time he or she is comparing health care plans and their premiums:

(1) With respect to prescription drug benefits, an up-to-date 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. The formulary shall clearly identify the qualified health plan to which it applies.

(2) 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, any institutional affiliation, and whether the provider is accepting new patients. The

information shall clearly identify the qualified health plan to which it applies.

In the event of an inconsistency between any separate written disclosure statement and the enrollee contract or certificate, the terms of the enrollee contract or certificate shall control.

(b) Upon written request, a health care plan shall provide to enrollees a description of the financial relationships between the health care plan and any health care provider and, if requested, the percentage of copayments, deductibles, and total premiums spent on healthcare related expenses and the percentage of copayments, deductibles, and total premiums spent on other expenses, including administrative expenses, except that no health care plan shall be required to disclose specific provider reimbursement.

(c) A participating health care provider shall provide all of the following, where applicable, to enrollees upon request:

(1) Information related to the health care provider's educational background, experience, training, specialty, and board certification, if applicable.

(2) The names of licensed facilities on the provider panel where the health care provider presently has privileges for the treatment, illness, or procedure that is the subject of the request.

(3) Information regarding the health care provider's participation in continuing education programs and

compliance with any licensure, certification, or registration requirements, if applicable.

(d) A health care plan shall provide the information required to be disclosed under this Act upon enrollment and annually thereafter in a legible and understandable format. The Department shall promulgate rules to establish the format based, to the extent practical, on the standards developed for supplemental insurance coverage under Title XVIII of the federal Social Security Act as a guide, so that a person can compare the attributes of the various health care plans.

(e) The written disclosure requirements of this Section may be met by disclosure to one enrollee in a household.

(f) Each issuer of a qualified health plan offered for sale to consumers in this State shall make the information described in subsection (a) of this Section, 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.

(g) 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 and its implementing regulations, prominently provide links to Internet-based materials and tools to help consumers be informed purchasers of health care plans.

(h) 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 to consumers for any coverage year beginning on or after January 1, 2015.

(Source: P.A. 91-617, eff. 1-1-00.)

(215 ILCS 134/45.1 new)

Sec. 45.1. Medical exceptions procedures required.

(a) Every health carrier that offers a qualified health plan, as defined in 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 under those Acts (collectively, "the Federal Act"), directly to consumers in this State shall establish and maintain a medical exceptions process that allows covered persons or their authorized representatives to request any clinically appropriate prescription drug when (1) the drug is not covered based on the health benefit plan's formulary; (2) the health benefit plan is discontinuing coverage of the drug on the plan's formulary for reasons other than safety or because the prescription drug has been withdrawn from the market by the drug's manufacturer; (3) the prescription drug alternatives required to be used in accordance with a step therapy requirement (A) has been ineffective in the treatment of the enrollee's disease or medical condition or, based on

both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance or (B) has caused or, based on sound medical evidence, is likely to cause an adverse reaction or harm to the enrollee; or (4) the number of doses available under a dose restriction for the prescription drug (A) has been ineffective in the treatment of the enrollee's disease or medical condition or (B) based on both sound clinical evidence and medical and scientific evidence, the known relevant physical and mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effective or patient compliance.

(b) The health carrier's established medical exceptions procedures must require, at a minimum, the following:

(1) Any request for approval of coverage made verbally or in writing (regardless of whether made using a paper or electronic form or some other writing) at any time shall be reviewed by appropriate health care professionals.

(2) The health carrier must, within 72 hours after receipt of a request made under subsection (a) of this Section, either approve or deny the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative

and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(3) In the case of an expedited coverage determination, the health carrier must either approve or deny the request within 24 hours after receipt of the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(c) Notwithstanding any other provision of this Section, nothing in this Section shall be interpreted or implemented in a manner not consistent with the Federal Act.

(215 ILCS 134/45.2 new)

Sec. 45.2. Prior authorization form; prescription benefits.

(a) Notwithstanding any other provision of law, on and after January 1, 2015, a health insurer that provides prescription drug benefits must, within 72 hours after receipt of a paper or electronic prior authorization form from a prescribing provider or pharmacist, either approve or deny the prior authorization. In the case of a denial, the insurer shall

provide the prescriber with the reason for the denial, an alternative covered medication, if applicable, and information regarding the denial.

In the case of an expedited coverage determination, the health insurer must either approve or deny the prior authorization within 24 hours after receipt of the paper or electronic prior authorization form. In the case of a denial, the health insurer shall provide the prescriber with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(b) This Section does not apply to plans for beneficiaries of Medicare or Medicaid.

(c) For the purposes of this Section:

"Pharmacist" has the same meaning as set forth in the Pharmacy Practice Act.

"Prescribing provider" includes a provider authorized to write a prescription, as described in subsection (e) of Section 3 of the Pharmacy Practice Act, to treat a medical condition of an insured.

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