AN ACT concerning regulation.

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

Section 5. The Managed Care Reform and Patient Rights Act is amended by changing Sections 15 and 90 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, highlighting any newly enacted State law or administrative rule, must be provided annually to enrollees. This requirement can be fulfilled by providing enrollees the most up-to-date accident and health checklist submitted to the Department, reflecting statutory health care coverage compliance by the health care plan. The requirement to highlight any newly enacted State laws or administrative rules does not apply to plans for beneficiaries of Medicaid.

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

this Section, 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 (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, 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, 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.

(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, if any, 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 qualified health plans for sale directly to consumers through the health insurance marketplace operating in the 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 directly to consumers through the health insurance marketplace operating in this State for any coverage year beginning on or after January 1, 2015.

(Source: P.A. 103-154, eff. 6-30-23.)

(215 ILCS 134/90)

Sec. 90. Office of Consumer Health Insurance.

(a) The Director of Insurance shall establish the Office of Consumer Health Insurance within the Department of Insurance to provide assistance and information to all health care consumers within the State. Within the appropriation allocated, the Office shall provide information and assistance to all health care consumers by:

(1) assisting consumers in understanding health insurance marketing materials and the coverage provisions of individual plans;

(2) educating enrollees about their rights within individual plans;

(3) assisting enrollees with the process of filing formal grievances and appeals;

(4) establishing and operating a toll-free "800" telephone number line to handle consumer inquiries;

(5) making related information available in languages other than English that are spoken as a primary language by a significant portion of the State's population, as determined by the Department;

(6) analyzing, commenting on, monitoring, and making publicly available an annual report, posted in a prominent location on the Department's publicly accessible website, ~~reports~~ on the development and implementation of federal, State, and local laws, regulations, and other governmental policies and actions that pertain to the adequacy of health care plans, facilities, and services in the State and, beginning January 31, 2027, the annual report shall also include a summary of all State health insurance benefit related legislation enacted in the prior calendar year that includes, at minimum, a link to the Public Act, the statutory citation, the subject, a brief summary, and the effective date;

(7) filing an annual report with the Governor, the Director, and the General Assembly, which shall contain recommendations for improvement of the regulation of health insurance plans, including recommendations on improving health care consumer assistance and patterns, abuses, and progress that it has identified from its interaction with health care consumers; and

(8) performing all duties assigned to the Office by the Director.

(a-5) The report required under paragraph (6) of subsection (a) shall be posted by January 31, 2026 and each January 31 thereafter on the Department's publicly accessible website.

(b) The report required under paragraph (7) of subsection (a) ~~subsection (a)(7)~~ shall be filed and posted by January 31, 2026 ~~January 31, 2001~~ and each January 31 thereafter on the Department's publicly accessible website.

(c) Nothing in this Section shall be interpreted to authorize access to or disclosure of individual patient or health care professional or provider records.

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

Section 10. The Uniform Health Care Service Benefits Information Card Act is amended by changing Section 15 as follows:

(215 ILCS 139/15)

Sec. 15. Uniform health care benefit information cards required.

(a) A health benefit plan, health benefit plan offering dental coverage, or ~~a~~ dental plan that issues a physical or electronic card or other technology and provides coverage for health care services including prescription drugs or devices also referred to as health care benefits and an administrator of such a plan including, but not limited to, third-party

administrators for self-insured plans and state-administered plans shall issue to its insureds a card or other technology containing uniform health care benefit information. The health care benefit information physical card, electronic card, and ~~or~~ other technology shall specifically identify and display the following mandatory data elements on the physical and electronic cards ~~card~~:

(1) processor control number, if required for claims adjudication;

(2) group number;

(3) card issuer identifier;

(4) cardholder ID number;

(5) (blank); ~~except for dental plans, the regulatory entity that holds authority over the plan; for the purpose of this requirement, the Department of Healthcare and Family Services is the regulatory entity that holds authority over plans that the Department of Healthcare and Family Services has contracted with to provide services under the medical assistance program;~~

(6) except for dental plans, any deductible applicable to the plan;

(7) except for dental plans, any out-of-pocket maximum limitation applicable to the plan;

(8) a toll-free telephone number and Internet website address through which the cardholder may seek consumer assistance information, such as up-to-date lists of

preferred providers, including health care professionals, hospitals, and other facilities, offices, or sites that are contracted to furnish items or services under the plan, and additional information about the plan; and

(9) cardholder name.

(b) The uniform health care benefit information physical card, electronic card, and ~~or~~ other technology shall specifically identify and display the following mandatory data elements on the back of the card:

(1) claims submission names and addresses; ~~and~~

(2) help desk telephone numbers and names; and~~.~~

(3) ~~(b-5) A uniform health care benefit information card or other technology for a health benefit plan offering dental coverage or dental plan shall include~~ a statement indicating whether the ~~health benefit~~ plan ~~offering dental coverage or dental plan~~ is self-insured or fully funded and if the plan is subject to regulation by the Department of Insurance. For the purpose of this requirement, the Department of Healthcare and Family Services is the regulatory entity that holds authority over plans that the Department of Healthcare and Family Services has contracted with to provide services under the medical assistance program.

(c) A new uniform health care benefit information physical card, electronic card, and ~~or~~ other technology shall be issued by a health benefit plan or dental plan upon enrollment and

reissued upon any change in the insured's coverage that affects mandatory data elements contained on the card.

(d) Notwithstanding subsections (a), (b), and (c) of this Section, a discounted health care services plan administrator shall issue to its beneficiaries a card containing the following mandatory data elements:

(1) an Internet website for beneficiaries to access up-to-date lists of preferred providers;

(2) a toll-free help desk number for beneficiaries and providers to access up-to-date lists of preferred providers and additional information about the discounted health care services plan;

(3) the name or logo of the provider network;

(4) a group number, if necessary for the processing of benefits;

(5) a cardholder ID number;

(6) the cardholder's name or a space to permit the cardholder to print his or her name, if the cardholder pays a periodic charge for use of the card;

(7) a processor control number, if required for claims adjudication; and

(8) a statement that the plan is not insurance.

(e) As used in this Section, "discounted health care services plan administrator" means any person, partnership, or corporation, other than an insurer, health service corporation, limited health service organization holding a

certificate of authority under the Limited Health Service Organization Act, or health maintenance organization holding a certificate of authority under the Health Maintenance Organization Act that arranges, contracts with, or administers contracts with a provider whereby insureds or beneficiaries are provided an incentive to use health care services provided by health care services providers under a discounted health care services plan in which there are no other incentives, such as copayment, coinsurance, or any other reimbursement differential, for beneficiaries to utilize the provider. "Discounted health care services plan administrator" also includes any person, partnership, or corporation, other than an insurer, health service corporation, limited health service organization holding a certificate of authority under the Limited Health Service Organization Act, or health maintenance organization holding a certificate of authority under the Health Maintenance Organization Act that enters into a contract with another administrator to enroll beneficiaries or insureds in a preferred provider program marketed as an independently identifiable program based on marketing materials or member benefit identification cards.

(Source: P.A. 102-902, eff. 1-1-24.)