

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Health Insurance Portability and
5 Accountability Act is amended by changing Section 5 and by
6 adding Section 65 as follows:

7 (215 ILCS 97/5)

8 Sec. 5. Definitions.

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

12 "Beneficiary" has the meaning given such term under
13 Section 3(8) of the Employee Retirement Income Security Act of
14 1974.

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

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

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

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

1 dependent of an employee);

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

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

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

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

14 "COBRA continuation provision" means any of the following:

15 (1) Section 4980B of the Internal Revenue Code of
16 1986, other than subsection (f)(1) of that Section insofar
17 as it relates to pediatric vaccines.

18 (2) Part 6 of subtitle B of title I of the Employee
19 Retirement Income Security Act of 1974, other than Section
20 609 of that Act.

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

22 "Control" means the possession, direct or indirect, of the
23 power to direct or cause the direction of the management and
24 policies of a person, whether through the ownership of voting
25 securities, the holding of policyholders' proxies by contract
26 other than a commercial contract for goods or non-management

1 services, or otherwise, unless the power is solely the result
2 of an official position with or corporate office held by the
3 person. Control is presumed to exist if any person, directly
4 or indirectly, owns, controls, holds with the power to vote,
5 or holds shareholders' proxies representing 10% or more of the
6 voting securities of any other person or holds or controls
7 sufficient policyholders' proxies to elect the majority of the
8 board of directors of the domestic company. This presumption
9 may be rebutted by a showing made in a manner as the Secretary
10 may provide by rule. The Secretary may determine, after
11 furnishing all persons in interest notice and opportunity to
12 be heard and making specific findings of fact to support such
13 determination, that control exists in fact, notwithstanding
14 the absence of a presumption to that effect.

15 "Department" means the Department of Insurance.

16 "Employee" has the meaning given that term under Section
17 3(6) of the Employee Retirement Income Security Act of 1974.

18 "Employer" has the meaning given that term under Section
19 3(5) of the Employee Retirement Income Security Act of 1974,
20 except that the term shall include only employers of 2 or more
21 employees.

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

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

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

8 "Grandfathered health plan" means coverage provided by a
9 group health plan, or a group or individual health insurance
10 issuer, in which an individual was enrolled on March 23, 2010
11 for as long as the coverage maintains that status under 45 CFR
12 147.140. This definition applies separately to each benefit
13 package made available under a group health plan or health
14 insurance coverage. Accordingly, if any benefit package
15 relinquishes grandfather status, it shall not affect the
16 grandfather status of the other benefit packages.

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

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

1 otherwise.

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

9 "Health insurance issuer" means an insurance company,
10 insurance service, or insurance organization (including a
11 health maintenance organization, as defined herein) which is
12 licensed to engage in the business of insurance in a state and
13 which is subject to Illinois law which regulates insurance
14 (within the meaning of Section 514(b)(2) of the Employee
15 Retirement Income Security Act of 1974). The term does not
16 include a group health plan.

17 "Health maintenance organization (HMO)" means:

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

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

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

26 "Individual health insurance coverage" means health

1 insurance coverage offered to individuals in the individual
2 market, but does not include short-term limited duration
3 insurance.

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

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

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

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

24 (3) Predecessors. Any reference in this Act to an
25 employer shall include a reference to any predecessor of
26 such employer.

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

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

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

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

13 "Medical care" means amounts paid for:

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

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

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

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

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

1 of providers under contract with the issuer.

2 "Participant" has the meaning given that term under
3 Section 3(7) of the Employee Retirement Income Security Act of
4 1974.

5 "Person" means an individual, a corporation, a
6 partnership, an association, a joint stock company, a trust,
7 an unincorporated organization, any similar entity, or any
8 combination of the foregoing acting in concert, but does not
9 include any securities broker performing no more than the
10 usual and customary broker's function or joint venture
11 partnership exclusively engaged in owning, managing, leasing,
12 or developing real or tangible personal property other than
13 capital stock.

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

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

24 "Preexisting condition exclusion" means, with respect to
25 coverage, a limitation or exclusion of benefits relating to a
26 condition based on the fact that the condition was present

1 before the date of enrollment for such coverage, whether or
2 not any medical advice, diagnosis, care, or treatment was
3 recommended or received before such date.

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

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

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

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

25 "Small group market" means the health insurance market
26 under which individuals obtain health insurance coverage

1 (directly or through any arrangement) on behalf of themselves
2 (and their dependents) through a group health plan maintained
3 by a small employer.

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

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

12 (Source: P.A. 94-502, eff. 8-8-05.)

13 (215 ILCS 97/65 new)

14 Sec. 65. Past-due premiums.

15 (a) Except as provided in subsection (b) for a third plan
16 or policy year, a health insurance issuer in the individual,
17 small group, or large group market shall not deny coverage to
18 an individual or employer due to the individual's or
19 employer's failure to pay a premium owed under a prior policy,
20 certificate, or contract of health insurance coverage,
21 including by attributing payment of premium for a new policy,
22 certificate, or contract of health insurance coverage to the
23 prior policy, certificate, or contract. The use of "one,"
24 "first," "second," and "third" in this Section does not limit
25 its applicability to situations when terminations or

1 cancellations occur in consecutive plan or policy years.

2 (b) If a health insurance issuer terminates or cancels an
3 individual or employer's coverage for nonpayment of premium in
4 one plan or policy year and if the individual or employer
5 enrolls in or purchases a new policy, certificate, or contract
6 of health insurance coverage from the same issuer in a second
7 plan or policy year, the issuer shall comply with subsection
8 (a) if the individual or employer again enrolls in or
9 purchases a new policy, certificate, or contract of health
10 insurance coverage from the same issuer in a third plan or
11 policy year unless:

12 (1) the individual or employer had past-due premiums
13 from the first plan or policy year and all past-due
14 amounts from the first and second years have not been
15 paid; and

16 (2) during the second plan or policy year, the issuer
17 offered a payment plan to the individual or employer under
18 which all past-due premiums from the first plan or policy
19 year would be spread out over 12 monthly billing periods
20 starting with the bill for the first month of coverage in
21 the second plan or policy year and the individual or
22 employer failed to fulfill the requirements of the payment
23 plan through the end of the 12-month period. As required
24 by subsection (a), the issuer shall not attribute payments
25 of premium for the new policy, certificate, or contract to
26 amounts due under the payment plan.

1 (c) Except to the extent that a health insurance issuer
2 must adhere to the terms of a payment plan it offers under
3 paragraph (2) of subsection (b), nothing in this Section
4 prohibits a health insurance issuer from pursuing the
5 collection of past-due premiums from an individual or employer
6 by any other means permitted by law.

7 (d) Nothing in this Section shall supersede the
8 requirements of Sections 30 or 50 of this Act. Nothing in this
9 Section shall supersede any requirements related to grace
10 periods or binder payments under applicable law. Subsection
11 (b) shall be inoperative if a court or the United States
12 Department of Health and Human Services interprets any
13 exception to a provision substantially similar to subsection
14 (a) to violate 42 U.S.C. 300gg-1 or federal regulations
15 thereunder.

16 (e) For purposes of this Section, amounts are not
17 considered past due with respect to any portion of a plan or
18 policy year falling after the effective date of a termination,
19 cancellation, or rescission or after the issuer declines to
20 effectuate coverage due to the individual or employer's
21 failure to make a timely binder payment.

22 (f) This Section does not apply to a grandfathered health
23 plan.

24 (g) For the purposes of this subsection, "renewal" means
25 the continuation in force of an existing policy, certificate,
26 or contract of health insurance coverage with the same issuer

1 for a subsequent plan or policy year. This Section applies
2 only to an individual or employer enrolling in or purchasing a
3 new policy, certificate, or contract of health insurance
4 coverage and shall not be construed to establish requirements
5 or prohibitions for the renewal of an existing policy,
6 certificate, or contract of health insurance coverage.

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