HB4349

LRB10223027BMS32181b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB4349

Introduced 1/5/2022, by Rep. Kathleen Willis

SYNOPSIS AS INTRODUCED:

5 ILCS 375/6.11
215 ILCS 5/356c from Ch. 73, par. 968c
215 ILCS 5/356z.53 new

Amends the Illinois Insurance Code. In provisions requiring coverage for newborn infants, provides that coverage for congenital defects shall include treatment of cranial facial anomalies. Provides that an individual or group policy of accident and health insurance amended, delivered, issued, or renewed after the effective date of the amendatory Act shall cover charges incurred and services provided for outpatient and inpatient care in conjunction with services that are provided to a covered individual related to the diagnosis and treatment of a congenital anomaly or birth defect. Provides that the required coverage includes any services to functionally improve, repair, or restore a body part involving the cranial facial area that is medically necessary to achieve normal function or appearance. Provides that any coverage provided may be subject to coverage limits, such as pre-authorization or pre-certification, as required by the plan or issuer that are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. Provides that coverage for a congenital anomaly or birth defect shall include expenses for specified services and items up to the age of 19. Provides that coverage shall not be denied solely on the grounds that the treatment is for cosmetic purposes or is not for a functional defect or impairment. Provides that the coverage does not apply to a policy that covers only dental care. Defines "treatment". Makes conforming changes in the State Employees Group Insurance Act of 1971. Effective January 1, 2024.

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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, 356q, 356u, 356w, 356x, 356z.2, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51, and 356z.53 ~~and 356z.43~~ of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 and Article XXXIIB of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section with respect to Sections 370c and 370c.1 of the Illinois Insurance Code; all

other requirements of this Section shall be enforced by the Department of Central Management Services.

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. 101-13, eff. 6-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; revised 10-26-21.)

Section 10. The Illinois Insurance Code is amended by changing Section 356c and by adding Section 356z.53 as follows:

(215 ILCS 5/356c) (from Ch. 73, par. 968c)

Sec. 356c. (1) No policy of accident and health insurance providing coverage of hospital expenses or medical expenses or both on an expense incurred basis which in addition to covering the insured, also covers members of the insured's immediate family, shall contain any disclaimer, waiver or other limitation of coverage relative to the hospital or

medical coverage or insurability of newborn infants from and after the moment of birth.

(2) Each such policy of accident and health insurance shall contain a provision stating that the accident and health insurance benefits applicable for children shall be granted immediately with respect to a newly born child from the moment of birth. The coverage for newly born children shall include coverage of illness, injury, congenital defects (including the treatment of cranial facial anomalies, including, but not limited to, cleft lip or cleft palate), birth abnormalities and premature birth.

(3) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child must be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond such 31 day period and may require payment of the appropriate premium.

(4) In the event that no other members of the insured's immediate family are covered, immediate coverage for the first newborn infant shall be provided if the insured applies for dependent's coverage within 31 days of the newborn's birth. Such coverage shall be contingent upon payment of the additional premium.

(5) The requirements of this Section shall apply, on or after the sixtieth day following the effective date of this Section, (a) to all such non-group policies delivered or

issued for delivery, and (b) to all such group policies delivered, issued for delivery, renewed or amended. The insurers of such non-group policies in effect on the sixtieth day following the effective date of this Section shall extend to owners of said policies, on or before the first policy anniversary following such date, the opportunity to apply for the addition to their policies of a provision as set forth in paragraph (2) above, with, at the option of the insurer, payment of a premium appropriate thereto.

(Source: P.A. 85-220.)

(215 ILCS 5/356z.53 new)

Sec. 356z.53. Coverage for congenital anomaly or birth defect.

(a) An individual or group policy of accident and health insurance amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 102nd General Assembly shall cover charges incurred and services provided for outpatient and inpatient care in conjunction with services that are provided to a covered individual related to the diagnosis and treatment of a congenital anomaly or birth defect, including, but not limited to, cleft lip and cleft palate.

(b) Coverage required under this Section includes any services to functionally improve, repair, or restore a body part involving the cranial facial area, including cleft lip

and cleft palate, that is medically necessary to achieve normal function or appearance. Any coverage provided may be subject to coverage limits, such as pre-authorization or pre-certification, as required by the plan or issuer that are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan.

(c) As used in this Section, "treatment" includes inpatient and outpatient care and services performed to improve or restore body function, or performed to approximate a normal appearance, due to a congenital anomaly, such as cleft lip or cleft palate, involving the cranial facial area and includes treatment of gross abnormalities of the lip and palate and any condition or illness that is related to or developed as a result of cleft lip or cleft palate. "Treatment" does not include cosmetic surgery performed to reshape normal facial structure or to improve appearance or self-esteem.

(d) Coverage shall include, but not be limited to, expenses for the following services up to the age of 19:

(1) oral surgery of the lip, palate, jaw, and related structures, including bone grafts;

(2) facial surgery of the lip, palate, jaw, nose, and related structures, including bone grafts;

(3) prosthetic treatment and appliances and prosthodontia, including obturators, speech appliances,

and feeding appliances;

(4) orthodontic treatment and appliances and orthodontia;

(5) preventative and restorative dentistry;

(6) otolaryngology treatment and management; and

(7) anesthetics provided by a dentist with a permit provided under Section 8.1 of the Illinois Dental Practice Act when performed in conjunction with the treatment described in this Section.

Coverage shall not be denied solely on the grounds that the treatment is for cosmetic purposes or is not for a functional defect or impairment as provided in this Section.

(e) This Section does not apply to a policy that covers only dental care.

Section 99. Effective date. This Act takes effect January 1, 2024.