

## 215 ILCS 97/40(B)(C)(D)(E) HIPAA Network Plans Exceptions

### (B) Special rules for network plans.

- (1) In general. In the case of a health insurance issuer that offers health insurance coverage in the small group market through a network plan, the issuer may:
  - (a) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and
  - (b) within the service area of such plan, deny such coverage to such employers if the issuer has demonstrated, if required, to the Department that:
    - (i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and
    - (ii) it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.
- (2) 180-day suspension upon denial of coverage. An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(b), may not offer coverage in the small group market within such service area for a period of 180 days after the date such coverage is denied.

### (C) Application of financial capacity limits.

#### (1) In general.

A health insurance issuer may deny health insurance coverage in the small group market if the issuer has demonstrated, if required, to the Department:

- (a) it does not have the financial capacity necessary to underwrite additional coverage; and
- (b) it is applying this paragraph uniformly to all employers in the small group market in the State and without regard to the claims experience of those employers and their employees (and their dependents) or any health status related factor relating to such employees and dependents.

#### (2) 180-day suspension upon denial of coverage.

A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) may not offer coverage in connection with group health plans in the small group market for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the Department that the issuer has sufficient financial capacity to underwrite additional coverage, whichever is later. The Department may provide for the application of this subsection on a service-area-specific basis.

### (D) Exception to requirement for failure to meet certain minimum participation or contribution rules.

#### (1) In general.

Subsection (A) shall not be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health plan in the small group market.

(2) Rules defined. For purposes of paragraph (1):

(a) the term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

(b) the term "group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(E) Exception for coverage offered only to bona fide association members. Subsection (A) shall not apply to health insurance coverage offered by a health insurance issuer if such coverage is made available in the small group market only through one or more bona fide associations (as defined in Section 10).

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