HB5302

LRB095 19109 KBJ 45318 b

95TH GENERAL ASSEMBLY

State of Illinois

2007 and 2008

HB5302

by Rep. Sara Feigenholtz

SYNOPSIS AS INTRODUCED:

See Index

Amends the State Employees Group Insurance Act of 1971, the Illinois Insurance Code, and the Health Maintenance Organization Act. Provides that a health insurer that bases payment for benefits upon a usual or customary charge or other similar reimbursement methodology must disclose certain information. Replaces references to "customary fee" with "customary charge or other similar methodology" throughout the provision. Provides that under no circumstances shall rates paid by Medicaid or Medicare, or rates negotiated or set by the insurer or any other insurer in conjunction with their contracted providers, be used to determine usual and customary charges. Provides that no health insurer shall deny reimbursement for an otherwise covered expense incurred for any drug, device, medical treatment, or procedure, including organ transplantation, solely on the basis that such procedure is deemed experimental or investigational unless certain conditions are present. Makes a corresponding change in the Health Maintenance Organization Act. Adds a new provision requiring a system of health claims appeals and external independent review. Adds a new provision authorizing coverage for wellness coverage. Requires wellness coverage under the State Employees Group Insurance Act of 1971. Repeals a provision concerning the coverage of organ transplantation procedures. In a provision concerning the continuation coverage of health benefits after termination of employment or membership, provides that in the event the employer fails or refuses to provide notice of continuation rights to the employee or member, the insurer is required to mail notice of the continuation rights to the employee or member at the last known address of the employee. Makes other changes.

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FISCAL NOTE ACT
MAY APPLY

STATE MANDATES
ACT MAY REQUIRE
REIMBURSEMENT

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.5, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, ~~and~~ 356z.9, 356z.10, and 356z.12 ~~and 356z.9~~ of the Illinois Insurance Code. The program of health benefits must comply with Section 155.37 of the Illinois Insurance Code.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 10. The Illinois Insurance Code is amended by changing Sections 355.2, 356K, 357.9, 357.9a, 367, and 367e and by adding Sections 356z.11 and 356z.12 as follows:

(215 ILCS 5/355.2) (from Ch. 73, par. 967.2)

Sec. 355.2. Reimbursement ~~Dental coverage reimbursement~~ rates.

(a) A ~~Every~~ company that issues, delivers, amends, or renews any individual or group policy of accident and health insurance on or after the effective date of this amendatory Act of the 95th General Assembly ~~1991~~ that ~~provides dental insurance and~~ bases payment for ~~those~~ benefits upon a usual and customary charge or other similar reimbursement methodology ~~fee charged by licensed dentists~~ must disclose all of the following:

(1) The frequency of the determination of the usual and customary charge or other similar methodology ~~fee~~.

(2) A general description of the methodology used to determine the usual and customary charge or other similar methodology ~~fees~~.

(3) The percentile of the usual and customary charge or other similar methodology that determines the maximum allowable charge upon which the benefit is based ~~benefit that the company will pay for any dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then determining the benefit by selecting a percentile of those fees~~.

(b) The disclosure must be provided upon request to all group and individual policy holders and group certificate

holders. All proposals for accident and health ~~dental~~ insurance must notify the prospective policy holder that information regarding the usual and customary or other similar methodology ~~fee~~ determinations is available from the insurer. ~~All employee benefit descriptions or supplemental documents must notify the employee that information regarding reimbursement rates is available from the employer.~~

(c) Under no circumstances shall rates paid by Medicaid or Medicare, or rates negotiated or set by the insurer or any other insurer in conjunction with their contracted providers, be used to determine usual and customary charges.

(d) For purposes of this Section, the usual and customary charge is the charge for health care that is consistent with the average rate or charge for similar services furnished by similar providers in the geographic area in which services were provided.

(e) Under no circumstances shall the amount of reimbursement for covered expenses be less than 50% of the usual and customary charge, or similar reasonable charge when the usual and customary charge can not be calculated, for the services provided.

(f) Companies shall make their methodology for determining usual and customary charges available to the Department upon request. Such information shall be held confidential by the Department.

(Source: P.A. 87-587.)

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

Sec. 356K. Coverage for Experimental and Investigational ~~Organ Transplantation~~ Procedures.

(a) No individual or group policy of accident or ~~and~~ health insurance issued or amended in this state after the effective date of this amendatory Act ~~insurer providing coverage under this Act for hospital or medical expenses~~ shall deny reimbursement for an otherwise covered expense incurred for any drug, device, medical treatment, or procedure, including organ transplantation, ~~procedure~~ solely on the basis that such procedure is deemed experimental or investigational unless:

(1) the drug, device, medical treatment, or procedure has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law;

(2) except as provided by Section 356y, reliable evidence shows the drug, device, medical treatment, or procedure is the subject of ongoing phase I, II, or III clinical trial or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

(3) Reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated

dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

(b) For the purpose of this Section, "reliable evidence" means published reports and articles and authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same drug, device, or medical treatment or procedure.

(c) This Section does not apply to policies that cover dental care only, short-term travel, accident-only, limited or specified disease policies, or to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under State or federal governmental plans. ~~supported by the determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services that such procedure is either experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable. If an accident and health insurer has made written request, or had one made on its behalf by a national organization, for determination by the Office of~~

~~Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services as to whether a specific organ transplantation procedure is clinically acceptable and said organization fails to respond to such a request within a period of 90 days, the failure to act may be deemed a determination that the procedure is deemed to be experimental or investigational.~~

(Source: P.A. 87-218.)

(215 ILCS 5/356z.11 new)

Sec. 356z.11. Health claims appeals and external independent reviews.

(a) No individual or group policy of accident and health insurance, including short-term and long-term disability policies, may be issued, amended, delivered, or renewed in this State after the effective date of this amendatory Act of the 95th General Assembly unless the policy contains an appeals procedure as outlined in this Act.

(b) When an appeal concerns a decision or action by an insurance company, its employees or subcontractors that relates to: (i) health care services, including, but not limited to, procedures or treatments, for a covered individual with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to the covered individual's health, or (ii) a treatment

referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to the covered individual's health, the insurance company must allow for the filing of an appeal either orally or in writing. Upon submission of the appeal, the insurance company must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the company requires to evaluate the appeal. The insurance company shall render a decision on the appeal within 24 hours after receipt of the required information. The insurance company shall notify the party filing the appeal and the covered individual and any health care provider who recommended the health care service involved in the appeal of its decision orally followed-up by a written notice of the determination.

(c) For all appeals related to health care services including, but not limited to, procedures or treatments for a covered individual and not covered by subsection (b) of this Section, the insurance company shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection, an insurance company must notify the party filing an appeal, within 3 business days, of all information that the plan requires to evaluate the appeal. The insurance company shall render a decision on the appeal within 15 business days after receipt of the required information. The insurance company shall notify the party filing the appeal, the

covered individual, and any health care provider who recommended the health care service involved in the appeal orally of its decision followed-up by a written notice of the determination.

(d) An appeal under subsection (b) or (c) of this Section may be filed by the covered individual, the covered individual's designee or guardian, or the covered individual's health care provider. An insurance company shall designate a clinical peer to review appeals, because these appeals pertain to medical or clinical matters and such an appeal must be reviewed by an appropriate health care professional. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal. The written notice of determination required under subsections (b) and (c) of this Section shall include: (i) clear and detailed reasons for the determination, (ii) the medical or clinical criteria for the determination, which shall be based upon sound clinical evidence and reviewed on a periodic basis, and (iii) in the case of an adverse determination, the procedures for requesting an external independent review under subsection (f) of this Section.

(e) If an appeal filed under subsection (b) or (c) of this Section is denied for a reason including, but not limited to, the service, procedure, or treatment is not viewed as medically necessary, denial of specific tests or procedures, denial of referral to specialist physicians or denial of hospitalization

requests or length of stay requests, any involved party may request an external independent review under subsection (f) of the adverse determination.

(f) The party seeking an external independent review shall so notify the insurance company. The insurance company shall seek to resolve all external independent reviews in the most expeditious manner and shall make a determination and provide notice of the determination no more than 24 hours after the receipt of all necessary information when a delay would significantly increase the risk to a covered individual's health or when extended health care services for a covered individual undergoing a course of treatment prescribed by a health care provider are at issue.

Within 30 days after the covered individual receives written notice of an adverse determination, if the covered individual decides to initiate an external independent review, the covered individual shall send to the insurance company a written request for an external independent review, including any information or documentation to support the covered individual's request for the covered service or claim for a covered service.

Within 30 days after the insurance company receives a request for an external independent review from a covered individual, the health care plan shall:

(1) provide a mechanism for joint selection of an external independent reviewer by the covered individual

and the insurance company; and

(2) forward to the independent reviewer all medical records and supporting documentation pertaining to the case, a summary description of the applicable issues including a statement of the insurance company's decision, the criteria used, and the medical and clinical reasons for that decision.

Within 5 days after receipt of all necessary information, the independent reviewer shall evaluate and analyze the case and render a decision that is based on whether or not the health care service or claim for the health care service is medically appropriate. The decision by the independent reviewer is final. If the external independent reviewer determines the health care service to be medically appropriate, the insurance company shall pay for the health care service.

The health care plan shall be solely responsible for paying the fees of the external independent reviewer who is selected to perform the review.

An external independent reviewer who acts in good faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external independent review, unless the acts or omissions constitute willful or wanton misconduct. For purposes of any proceeding, the good faith of the person participating shall be presumed.

Future contractual or employment action by the health care

plan regarding the patient's physician or other health care provider shall not be based solely on the physician's or other health care provider's participation in this procedure.

For the purposes of this Section, an external independent reviewer shall: (i) be a clinical peer; (ii) have no direct financial interest in connection with the case; and (iii) have not been informed of the specific identity of the enrollee.

(g) Nothing in this Section shall be construed to require a health care plan to pay for a health care service not covered under the enrollee's certificate of coverage or policy.

(h) Nothing in this Section precludes a covered individual, insured, or health care provider from filing a formal complaint with the Department of Insurance in accordance with Section 926.40 of Chapter 50 of the Illinois Administrative Code, except that if the claim has been reviewed and a determination has been made by an external independent reviewer as set forth in subsection (f) of this Section, that decision is binding.

(215 ILCS 5/356z.12 new)

Sec. 356z.12. Wellness coverage.

(a) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly, that provides coverage for hospital or medical treatment on an expense incurred basis, may offer a reasonably designed program for wellness coverage. Such

program may include incentives that allow for a reduction in premiums or for reduced medical, prescription drug or equipment copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program approved or offered by the insurer or managed care plan. The insured or enrollee may be required to provide evidence of participation in a program.

(b) For the purposes of this Section, "reasonably designed program" means a program of wellness coverage that has: (i) a reasonable chance of improving health or preventing disease; (ii) is not overly burdensome; (iii) does not discriminate based on health factors; and (iv) is not otherwise contrary to law.

(c) For the purposes of this Section, "wellness coverage" means health care coverage whose primary purpose is to engage and motivate the insured or enrollee through incentives; provision of health education, counseling, and self-management skills; identification of modifiable health risks; and other activities to influence health behavior changes.

(d) Incentives as outlined within this Section are specific and unique to the offering of wellness coverage and have no application to any other required or optional health care benefit.

(e) A plan offering wellness coverage must give participants the opportunity to qualify for offered incentives

at least once a year.

(f) A plan offering wellness coverage must allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition to satisfy otherwise applicable wellness program standards. Plans may seek physician verification that health factors make it unreasonably difficult or medically inadvisable for the participant to satisfy such standards.

(g) The total incentive under a wellness program shall not exceed 20% of the cost of employee-only coverage. The cost of employee-only coverage includes both employer and employee contributions. For plans offering family coverage, the 20% limitation applies to the cost of family coverage and applies to the entire family.

(215 ILCS 5/357.9) (from Ch. 73, par. 969.9)

Sec. 357.9. "TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid .... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof."

All claims and indemnities payable under the terms of ~~a~~ an individual or group policy of accident and health insurance shall be paid within 30 days following receipt by the insurer of due proof of loss. Failure to pay within such period shall entitle the insured to interest at the rate of 9 per cent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. An insured or an insured's assignee shall be notified by the insurer, health maintenance organization, managed care plan, health care plan, preferred provider organization, or third party administrator of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments shall be made within 30 days after the payment.

The requirements of this Section shall apply to any policy of accident and health insurance delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of this amendatory Act of 1985. The requirements of this Section also shall specifically apply to any group policy of dental insurance only, delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of this amendatory Act of 1987.

(Source: P.A. 91-605, eff. 12-14-99.)

(215 ILCS 5/357.9a) (from Ch. 73, par. 969.9a)

Sec. 357.9a. Delay in payment of claims. Periodic payments of accrued indemnities for loss-of-time coverage under individual and group accident and health policies shall commence not later than 30 days after the receipt by the company of the required written proofs of loss. An insurer which violates this Section if liable under said policy, shall pay to the insured, in addition to any other penalty provided for in this Code, interest at the rate of 9% per annum from the 30th day after receipt of such proofs of loss to the date of late payment of the accrued indemnities, provided that interest amounting to less than one dollar need not be paid.

(Source: P.A. 92-139, eff. 7-24-01.)

(215 ILCS 5/367) (from Ch. 73, par. 979)

Sec. 367. Group accident and health insurance.

(1) Group accident and health insurance is hereby declared to be that form of accident and health insurance covering not less than 2 employees, members, or employees of members, written under a master policy issued to any governmental corporation, unit, agency or department thereof, or to any corporation, copartnership, individual employer, or to any association upon application of an executive officer or trustee of such association having a constitution or bylaws and formed in good faith for purposes other than that of obtaining insurance, where officers, members, employees, employees of members or classes or department thereof, may be insured for

their individual benefit. In addition a group accident and health policy may be written to insure any group which may be insured under a group life insurance policy. The term "employees" shall include the officers, managers and employees of subsidiary or affiliated corporations, and the individual proprietors, partners and employees of affiliated individuals and firms, when the business of such subsidiary or affiliated corporations, firms or individuals, is controlled by a common employer through stock ownership, contract or otherwise.

(2) Any insurance company authorized to write accident and health insurance in this State shall have power to issue group accident and health policies. No policy of group accident and health insurance may be issued or delivered in this State unless a copy of the form thereof shall have been filed with the department and approved by it in accordance with Section 355, and it contains in substance those provisions contained in Sections 357.1 through 357.30 as may be applicable to group accident and health insurance and the following provisions:

(a) A provision that the policy, the application of the employer, or executive officer or trustee of any association, and the individual applications, if any, of the employees, members or employees of members insured shall constitute the entire contract between the parties, and that all statements made by the employer, or the executive officer or trustee, or by the individual employees, members or employees of members shall (in the

absence of fraud) be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in a written application.

(b) A provision that the insurer will issue to the employer, or to the executive officer or trustee of the association, for delivery to the employee, member or employee of a member, who is insured under such policy, an individual certificate setting forth a statement as to the insurance protection to which he is entitled and to whom payable.

(c) A provision that to the group or class thereof originally insured shall be added from time to time all new employees of the employer, members of the association or employees of members eligible to and applying for insurance in such group or class.

(3) Anything in this code to the contrary notwithstanding, any group accident and health policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services, may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid. Nothing in this subsection (3) shall prohibit an insurer from

providing incentives for insureds to utilize the services of a particular hospital or person.

(4) Special group policies may be issued to school districts providing medical or hospital service, or both, for pupils of the district injured while participating in any athletic activity under the jurisdiction of or sponsored or controlled by the district or the authorities of any school thereof. The provisions of this Section governing the issuance of group accident and health insurance shall, insofar as applicable, control the issuance of such policies issued to schools.

(5) No policy of group accident and health insurance may be issued or delivered in this State unless it provides that upon the death of the insured employee or group member the dependents' coverage, if any, continues for a period of at least 90 days subject to any other policy provisions relating to termination of dependents' coverage.

(6) No group hospital policy covering miscellaneous hospital expenses issued or delivered in this State shall contain any exception or exclusion from coverage which would preclude the payment of expenses incurred for the processing and administration of blood and its components.

(7) No policy of group accident and health insurance, delivered in this State more than 120 days after the effective day of the Section, which provides inpatient hospital coverage for sicknesses shall exclude from such coverage the treatment

of alcoholism. This subsection shall not apply to a policy which covers only specified sicknesses.

(8) No policy of group accident and health insurance, which provides benefits for hospital or medical expenses based upon the actual expenses incurred, issued or delivered in this State shall contain any specific exception to coverage which would preclude the payment of actual expenses incurred in the examination and testing of a victim of an offense defined in Sections 12-13 through 12-16 of the Criminal Code of 1961, or an attempt to commit such offense, to establish that sexual contact did occur or did not occur, and to establish the presence or absence of sexually transmitted disease or infection, and examination and treatment of injuries and trauma sustained by the victim of such offense, arising out of the offense. Every group policy of accident and health insurance which specifically provides benefits for routine physical examinations shall provide full coverage for expenses incurred in the examination and testing of a victim of an offense defined in Sections 12-13 through 12-16 of the Criminal Code of 1961, or an attempt to commit such offense, as set forth in this Section. This subsection shall not apply to a policy which covers hospital and medical expenses for specified illnesses and injuries only.

(9) For purposes of enabling the recovery of State funds, any insurance carrier subject to this Section shall upon reasonable demand by the Department of Public Health disclose

the names and identities of its insureds entitled to benefits under this provision to the Department of Public Health whenever the Department of Public Health has determined that it has paid, or is about to pay, hospital or medical expenses for which an insurance carrier is liable under this Section. All information received by the Department of Public Health under this provision shall be held on a confidential basis and shall not be subject to subpoena and shall not be made public by the Department of Public Health or used for any purpose other than that authorized by this Section.

(10) Whenever the Department of Public Health finds that it has paid all or part of any hospital or medical expenses which an insurance carrier is obligated to pay under this Section, the Department of Public Health shall be entitled to receive reimbursement for its payments from such insurance carrier provided that the Department of Public Health has notified the insurance carrier of its claim before the carrier has paid the benefits to its insureds or the insureds' assignees.

(11) (a) No group hospital, medical or surgical expense policy shall contain any provision whereby benefits otherwise payable thereunder are subject to reduction solely on account of the existence of similar benefits provided under other group or group-type accident and sickness insurance policies where such reduction would operate to reduce total benefits payable under these policies below an amount equal to 100% of total allowable

expenses provided under these policies.

(b) When dependents of insureds are covered under 2 policies, both of which contain coordination of benefits provisions, benefits of the policy of the insured whose birthday falls earlier in the year are determined before those of the policy of the insured whose birthday falls later in the year. Birthday, as used herein, refers only to the month and day in a calendar year, not the year in which the person was born. The Department of Insurance shall promulgate rules defining the order of benefit determination pursuant to this paragraph (b).

(12) Every group policy under this Section shall be subject to the provisions of Sections 356g and 356n of this Code.

(13) (Blank). ~~No accident and health insurer providing coverage for hospital or medical expenses on an expense incurred basis shall deny reimbursement for an otherwise covered expense incurred for any organ transplantation procedure solely on the basis that such procedure is deemed experimental or investigational unless supported by the determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services that such procedure is either experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable. If an accident and health~~

~~insurer has made written request, or had one made on its behalf by a national organization, for determination by the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services as to whether a specific organ transplantation procedure is clinically acceptable and said organization fails to respond to such a request within a period of 90 days, the failure to act may be deemed a determination that the procedure is deemed to be experimental or investigational.~~

(14) Whenever a claim for benefits by an insured under a dental prepayment program is denied or reduced, based on the review of x-ray films, such review must be performed by a dentist.

(Source: P.A. 91-549, eff. 8-14-99.)

(215 ILCS 5/367e) (from Ch. 73, par. 979e)

Sec. 367e. Continuation of Group Hospital, Surgical and Major Medical Coverage After Termination of Employment or Membership. A group policy delivered, issued for delivery, renewed or amended in this state which insures employees or members for hospital, surgical or major medical insurance on an expense incurred or service basis, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose insurance under the group policy would otherwise terminate because of termination of employment

or membership or because of a reduction in hours below the minimum required by the group plan shall be entitled to continue their hospital, surgical and major medical insurance under that group policy, for themselves and their eligible dependents, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the following conditions:

1. Continuation shall only be available to an employee or member who has been continuously insured under the group policy (and for similar benefits under any group policy which it replaced) during the entire 3 months period ending with such termination or reduction in hours below the minimum required by the group plan.

2. Continuation shall not be available for any person who is covered by Medicare, except for those individuals who have been covered under a group Medicare supplement policy. Neither shall continuation be available for any person who is covered by any other insured or uninsured plan which provides hospital, surgical or medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination or reduction in hours below the minimum required by the group plan or who exercises his conversion privilege under the group policy.

3. Continuation need not include dental, vision care, prescription drug benefits, disability income, specified

disease, or similar supplementary benefits which are provided under the group policy in addition to its hospital, surgical or major medical benefits.

4. Upon termination or reduction in hours below the minimum required by the group plan written notice of continuation shall be presented to the employee or member and the insurer by the employer or mailed by the employer to the last known address of the employee. An employee or member who wishes continuation of coverage must request such continuation in writing within the ten-day period following the later of: (i) the date of such termination or reduction in hours below the minimum required by the group plan, or (ii) the date the employee is given written notice of the right of continuation by either the employer or the group policyholder. ~~In no event, however, may the employee or member elect continuation more than 60 days after the date of such termination or reduction in hours below the minimum required by the group plan.~~ Written notice of continuation presented to the employee or member by the policyholder, or mailed by the policyholder to the last known address of the employee, shall constitute the giving of notice for the purpose of this provision. In the event the employer fails or refuses to provide notice of continuation rights to the employee or member, the insurer is required to mail notice of the continuation rights to the employee or member at the last known address of the

employee. In the event the employee or member contacts the insurer regarding continuation rights and advises that notice has not been provided by the employer or group policyholder, the insurer shall mail out notice to that individual.

5. An employee or member electing continuation must pay to the group policyholder or his employer, on a monthly basis in advance, the total amount of premium required by the insurer, including that portion of the premium contributed by the policyholder or employer, if any, but not more than the group rate for the insurance being continued with appropriate reduction in premium for any supplementary benefits which have been discontinued under paragraph (3) of this Section. The premium rate required by the insurer shall be the applicable premium required on the due date of each payment.

6. Continuation of insurance under the group policy for any person shall terminate when he becomes eligible for Medicare or is covered by any other insured or uninsured plan which provides hospital, surgical or medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination or reduction in hours below the minimum required by the group plan as provided in condition 2 above or, if earlier, at the first to occur of the following:

(a) The date 9 months after the date the employee's

or member's insurance under the policy would otherwise have terminated because of termination of employment or membership or reduction in hours below the minimum required by the group plan.

(b) If the employee or member fails to make timely payment of a required contribution, the end of the period for which contributions were made.

(c) The date on which the group policy is terminated or, in the case of an employee, the date his employer terminates participation under the group policy. However, if this (c) applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group policy, the following shall apply:

(i) The employee or member shall have the right to become covered under that other group policy, for the balance of the period that he would have remained covered under the prior group policy in accordance with condition 6 had a termination described in this (c) not occurred.

(ii) The prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

7. A notification of the continuation privilege shall be included in each certificate of coverage.

8. Continuation shall not be available for any employee who was discharged because of the commission of a felony in connection with his work, or because of theft in connection with his work, for which the employer was in no way responsible; provided the employee admitted his commission of the felony or theft or such act has resulted in a conviction or order of supervision by a court of competent jurisdiction.

The requirements of this amendatory Act of 1983 shall apply to any group policy as defined in this Section, delivered or issued for delivery on or after 180 days following the effective date of this amendatory Act of 1983.

The requirements of this amendatory Act of 1985 shall apply to any group policy as defined in this Section, delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of this amendatory Act of 1985.

(Source: P.A. 93-477, eff. 1-1-04.)

Section 15. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,

154.6, 154.7, 154.8, 155.04, 355.2, 356k, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.12 ~~356z.9~~, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial

conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with

respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's

profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

(215 ILCS 125/4-5 rep.)

Section 20. The Health Maintenance Organization Act is amended by repealing Section 4-5.

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Statutes amended in order of appearance