



96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB2652

Introduced 2/20/2009, by Rep. Kevin Joyce

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.15 new

215 ILCS 125/5-3

215 ILCS 165/10

from Ch. 111 1/2, par. 1411.2

from Ch. 32, par. 604

Amends the Illinois Insurance Code, Health Maintenance Organization Act, and Voluntary Health Services Plans Act to provide coverage for prosthetic and customized orthotic devices that are no less favorable than the terms and conditions applicable to substantially all medical and surgical benefits provided under the plan or coverage. Provides that a policy or plan may require prior authorization. Provides that repairs and replacements of prosthetic and orthotic devices are also covered. Provides that a policy or plan may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to the Act shall be covered only if the prosthetic or orthotic devices are provided by a licensed provider employed by a provider service who contracts with or is designated by the carrier. Sets forth provisions concerning (i) patient access and (ii) in-network and out of network standards. Makes other changes. Contains a nonacceleration clause. Effective immediately.

LRB096 10389 RPM 20559 b

1 AN ACT concerning insurance.

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

4 Section 5. The Illinois Insurance Code is amended by adding
5 Section 356z.15 as follows:

6 (215 ILCS 5/356z.15 new)

7 Sec. 356z.15. Prosthetic and customized orthotic devices.

8 (a) For the purposes of this Section:

9 "Customized orthotic device", as defined in the Illinois
10 Orthotic, Prosthetic, Pedorthic practice act of 2001, means a
11 supportive device for the body or a part of the body, the head,
12 neck, or extremities, and includes the replacement or repair of
13 the device based on the patient's physical condition as
14 medically necessary. This Act shall provide benefits to any
15 person covered thereunder for expenses incurred in obtaining a
16 prosthetic or orthotic device from any Illinois licensed
17 prosthetist, licensed orthotist or licensed pedorthist.

18 "Licensed provider" means a prosthetist, orthotist or
19 pedorthist licensed to practice in this State.

20 "Prosthetic device", as defined in the Illinois Orthotic,
21 Prosthetic, Pedorthic Practice Act of 2001, means an artificial
22 device to replace, in whole or in part, an arm or leg and
23 includes accessories essential to the effective use of the

1 device and the replacement or repair of the device based on the
2 patient's physical condition as medically necessary.

3 (b) A group or individual policy of accident or health
4 insurance or managed care plan or medical/health/hospital
5 service corporation contract amended, delivered, issued, or
6 renewed after the effective date of this amendatory Act of the
7 96th General Assembly must provide coverage for prosthetic and
8 orthotic devices under terms and conditions that are no less
9 favorable than the terms and conditions applicable to
10 substantially all medical and surgical benefits provided under
11 the plan or coverage.

12 (c) The policy or plan or contract may require prior
13 authorization for the prosthetic or orthotic devices in the
14 same manner that prior authorization is required for any other
15 covered benefit. Covered benefits are limited to the most
16 appropriate model that adequately meets the medical needs of
17 the patient as determined by the insured's treating physician.

18 (d) Repairs and replacements of prosthetic and orthotic
19 devices are also covered, subject to the co-payments and
20 deductibles, unless necessitated by misuse or loss. Such
21 benefits for prosthetic and orthotic devices and components
22 under the plan or coverage may not be subject to separate
23 financial requirements that are applicable only with respect to
24 such benefits; any financial requirements applicable to such
25 benefits may be no more restrictive than the financial
26 requirements applicable to substantially all medical and

1 surgical benefits provided under the plan or coverage.

2 (e) A policy or plan or contract may require that, if
3 coverage is provided through a managed care plan, the benefits
4 mandated pursuant to this Section shall be covered benefits
5 only if the prosthetic or orthotic devices are provided by a
6 licensed provider employed by a provider service who contracts
7 with or is designated by the carrier, to the extent that the
8 carrier provides in-network and out of network service, the
9 coverage for the prosthetic or orthotic device shall be offered
10 no less extensively. All policies, plans, and contracts require
11 a minimum rate of reimbursement and coverage for such devices
12 as under the Illinois State Medicaid reimbursement schedule as
13 directed by the federal Medicare program.

14 No insurer corporation or health maintenance organization
15 shall impose upon any person receiving benefits pursuant to
16 this Section, any annual lifetime dollar maximum on coverage
17 for prosthetic and orthotic devices other than an annual or
18 lifetime dollar maximum that applies in the aggregate to all
19 items and services covered under the policy or plan. The
20 coverage may be made subject to, and no more restrictive than
21 the provisions of a health insurance policy that applies to
22 other benefits under the policy or plan.

23 (f) The following provisions apply to patient access:

24 (1) The health plan shall have available, either
25 directly or through arrangements, appropriate and
26 sufficient licensed providers of prosthetic care and

1 custom fabricated orthotic devices for people with severe
2 permanent physical disabilities to meet the projected
3 needs of its enrollees within a reasonable travel distance.

4 (2) Any health plan that does not provide coverage for
5 benefits outside of the network shall ensure that its
6 network contains a sufficient number of licensed providers
7 for prosthetic care and custom fabricated orthotic devices
8 for people with severe permanent physical disabilities to
9 ensure that enrollees may obtain such services from a
10 network provider located within a reasonable travel
11 distance.

12 (3) Within the health plan's service area, the
13 reasonable travel distance or time to the nearest licensed
14 provider of prosthetic care or custom fabricated orthotics
15 must be designated and the method used must be defined as
16 the lesser of either travel distance or time. Reasonable
17 travel distance or time shall be the lesser of 30 miles or
18 30 minutes to the nearest licensed provider.

19 (4) A request for an exception to the requirements of
20 item 3 of this subsection (f) shall be considered. The
21 health plan shall submit specific data in support of its
22 request.

23 (g) The following provisions apply to in-network and out of
24 network standards:

25 (1) In the case of a group health plan or health
26 insurance coverage that provides both medical and surgical

1 benefits and benefits for prosthetic and custom fabricated
2 orthotic devices for severe permanent physical
3 disabilities and components and that provides both
4 in-network benefits for prosthetic and custom orthotic
5 devices for people with disabilities and out of network
6 benefits for prosthetic and custom orthotic devices for
7 people with disabilities, the requirements of this Section
8 shall apply separately with respect to the benefits
9 provided under the plan on an in-network basis and benefits
10 provided under the plan on an out of network basis.

11 (2) Nothing in item (1) of this subsection (f) shall be
12 construed as requiring that a group health plan or health
13 insurance coverage offered in connection with such a plan
14 eliminate an out-of-network provider option from such plan
15 or coverage pursuant to the terms of the plan or coverage.

16 Section 10. The Health Maintenance Organization Act is
17 amended by changing Section 5-3 as follows:

18 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

19 (Text of Section before amendment by P.A. 95-958)

20 Sec. 5-3. Insurance Code provisions.

21 (a) Health Maintenance Organizations shall be subject to
22 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
23 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
24 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x,

1 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10,
2 356z.13 ~~356z.11~~, 356z.14, 356z.15, 364.01, 367.2, 367.2-5,
3 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403,
4 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of
5 subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII,
6 XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois
7 Insurance Code.

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

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

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

16 (3) a corporation organized under the laws of another
17 state, 30% or more of the enrollees of which are residents
18 of this State, except a corporation subject to
19 substantially the same requirements in its state of
20 organization as is a "domestic company" under Article VIII
21 1/2 of the Illinois Insurance Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06;
12 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.
13 8-21-08; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised
14 12-15-08.)

15 (Text of Section after amendment by P.A. 95-958)

16 Sec. 5-3. Insurance Code provisions.

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19 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
20 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x,
21 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10,
22 356z.11, 356z.12, 356z.13 ~~356z.11~~, 356z.14, 356z.15, 364.01,
23 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401,
24 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
25 paragraph (c) of subsection (2) of Section 367, and Articles

1 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of
2 the Illinois Insurance Code.

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

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

11 (3) a corporation organized under the laws of another
12 state, 30% or more of the enrollees of which are residents
13 of this State, except a corporation subject to
14 substantially the same requirements in its state of
15 organization as is a "domestic company" under Article VIII
16 1/2 of the Illinois Insurance Code.

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

20 (1) the Director shall give primary consideration to
21 the continuation of benefits to enrollees and the financial
22 conditions of the acquired Health Maintenance Organization
23 after the merger, consolidation, or other acquisition of
24 control takes effect;

25 (2) (i) the criteria specified in subsection (1) (b) of
26 Section 131.8 of the Illinois Insurance Code shall not

1 apply and (ii) the Director, in making his determination
2 with respect to the merger, consolidation, or other
3 acquisition of control, need not take into account the
4 effect on competition of the merger, consolidation, or
5 other acquisition of control;

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

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

11 (B) pro forma financial statements reflecting the
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13 the Health Maintenance Organization sought to be
14 acquired as of the end of the preceding year and as of
15 a date 90 days prior to the acquisition, as well as pro
16 forma financial statements reflecting projected
17 combined operation for a period of 2 years;

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

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

24 (d) The provisions of Article VIII 1/2 of the Illinois
25 Insurance Code and this Section 5-3 shall apply to the sale by
26 any health maintenance organization of greater than 10% of its

1 enrollee population (including without limitation the health
2 maintenance organization's right, title, and interest in and to
3 its health care certificates).

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

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

21 (i) the amount of, and other terms and conditions with
22 respect to, the refund or additional premium are set forth
23 in the group or enrollment unit contract agreed in advance
24 of the period for which a refund is to be paid or
25 additional premium is to be charged (which period shall not
26 be less than one year); and

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

16 The Health Maintenance Organization shall include a
17 statement in the evidence of coverage issued to each enrollee
18 describing the possibility of a refund or additional premium,
19 and upon request of any group or enrollment unit, provide to
20 the group or enrollment unit a description of the method used
21 to calculate (1) the Health Maintenance Organization's
22 profitable experience with respect to the group or enrollment
23 unit and the resulting refund to the group or enrollment unit
24 or (2) the Health Maintenance Organization's unprofitable
25 experience with respect to the group or enrollment unit and the
26 resulting additional premium to be paid by the group or

1 enrollment unit.

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

6 (Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06;
7 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.
8 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005,
9 eff. 12-12-08; revised 12-15-08.)

10 Section 15. The Voluntary Health Services Plans Act is
11 amended by changing Section 10 as follows:

12 (215 ILCS 165/10) (from Ch. 32, par. 604)

13 (Text of Section before amendment by P.A. 95-958)

14 Sec. 10. Application of Insurance Code provisions. Health
15 services plan corporations and all persons interested therein
16 or dealing therewith shall be subject to the provisions of
17 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,
18 149, 155.37, 354, 355.2, 356g.5, 356r, 356t, 356u, 356v, 356w,
19 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8,
20 356z.9, 356z.10, 356z.13 ~~356z.11~~, 356z.14, 356z.15, 364.01,
21 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412,
22 and paragraphs (7) and (15) of Section 367 of the Illinois
23 Insurance Code.

24 (Source: P.A. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07;

1 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff.
2 8-28-07; 95-876, eff. 8-21-08; 95-978, eff. 1-1-09; 95-1005,
3 eff. 12-12-08; revised 12-15-08.)

4 (Text of Section after amendment by P.A. 95-958)

5 Sec. 10. Application of Insurance Code provisions. Health
6 services plan corporations and all persons interested therein
7 or dealing therewith shall be subject to the provisions of
8 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,
9 149, 155.37, 354, 355.2, 356g.5, 356r, 356t, 356u, 356v, 356w,
10 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8,
11 356z.9, 356z.10, 356z.11, 356z.12, 356z.13 ~~356z.11~~, 356z.14,
12 356z.15, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408,
13 408.2, and 412, and paragraphs (7) and (15) of Section 367 of
14 the Illinois Insurance Code.

15 (Source: P.A. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07;
16 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff.
17 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978,
18 eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

19 Section 95. No acceleration or delay. Where this Act makes
20 changes in a statute that is represented in this Act by text
21 that is not yet or no longer in effect (for example, a Section
22 represented by multiple versions), the use of that text does
23 not accelerate or delay the taking effect of (i) the changes
24 made by this Act or (ii) provisions derived from any other

1 Public Act.

2 Section 99. Effective date. This Act takes effect upon
3 becoming law.