



Sen. David Koehler

Filed: 5/4/2010

09600HB5085sam002

LRB096 17984 RPM 41106 a

1 AMENDMENT TO HOUSE BILL 5085

2 AMENDMENT NO. _____. Amend House Bill 5085 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The State Employees Group Insurance Act of 1971
5 is amended by changing Section 6.11 as follows:

6 (5 ILCS 375/6.11)

7 Sec. 6.11. Required health benefits; Illinois Insurance
8 Code requirements. The program of health benefits shall provide
9 the post-mastectomy care benefits required to be covered by a
10 policy of accident and health insurance under Section 356t of
11 the Illinois Insurance Code. The program of health benefits
12 shall provide the coverage required under Sections 356g,
13 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4,
14 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, ~~and~~
15 356z.13, ~~and~~ 356z.14, 356z.15 ~~and 356z.14,~~ ~~and~~ 356z.17 ~~356z.15,~~
16 and 364.01 of the Illinois Insurance Code. The program of

1 health benefits must comply with Section 155.37 of the Illinois
2 Insurance Code.

3 Rulemaking authority to implement Public Act 95-1045 ~~this~~
4 ~~amendatory Act of the 95th General Assembly~~, if any, is
5 conditioned on the rules being adopted in accordance with all
6 provisions of the Illinois Administrative Procedure Act and all
7 rules and procedures of the Joint Committee on Administrative
8 Rules; any purported rule not so adopted, for whatever reason,
9 is unauthorized.

10 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
11 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff.
12 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1044,
13 eff. 3-26-09; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10;
14 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10;
15 revised 10-22-09.)

16 Section 10. The Counties Code is amended by changing
17 Section 5-1069.3 as follows:

18 (55 ILCS 5/5-1069.3)

19 Sec. 5-1069.3. Required health benefits. If a county,
20 including a home rule county, is a self-insurer for purposes of
21 providing health insurance coverage for its employees, the
22 coverage shall include coverage for the post-mastectomy care
23 benefits required to be covered by a policy of accident and
24 health insurance under Section 356t and the coverage required

1 under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x,
2 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, ~~and~~
3 356z.13, ~~and~~ 356z.14, ~~and~~ 356z.15 ~~356z.14~~, and 364.01 of the
4 Illinois Insurance Code. The requirement that health benefits
5 be covered as provided in this Section is an exclusive power
6 and function of the State and is a denial and limitation under
7 Article VII, Section 6, subsection (h) of the Illinois
8 Constitution. A home rule county to which this Section applies
9 must comply with every provision of this Section.

10 Rulemaking authority to implement Public Act 95-1045 ~~this~~
11 ~~amendatory Act of the 95th General Assembly~~, if any, is
12 conditioned on the rules being adopted in accordance with all
13 provisions of the Illinois Administrative Procedure Act and all
14 rules and procedures of the Joint Committee on Administrative
15 Rules; any purported rule not so adopted, for whatever reason,
16 is unauthorized.

17 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
18 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff.
19 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045,
20 eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10;
21 96-328, eff. 8-11-09; revised 10-22-09.)

22 Section 15. The Illinois Municipal Code is amended by
23 changing Section 10-4-2.3 as follows:

24 (65 ILCS 5/10-4-2.3)

1 Sec. 10-4-2.3. Required health benefits. If a
2 municipality, including a home rule municipality, is a
3 self-insurer for purposes of providing health insurance
4 coverage for its employees, the coverage shall include coverage
5 for the post-mastectomy care benefits required to be covered by
6 a policy of accident and health insurance under Section 356t
7 and the coverage required under Sections 356g, 356g.5,
8 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10,
9 356z.11, 356z.12, ~~and~~ 356z.13, ~~and~~ 356z.14, ~~and~~ 356z.15
10 ~~356z.14,~~ and 364.01 of the Illinois Insurance Code. The
11 requirement that health benefits be covered as provided in this
12 is an exclusive power and function of the State and is a denial
13 and limitation under Article VII, Section 6, subsection (h) of
14 the Illinois Constitution. A home rule municipality to which
15 this Section applies must comply with every provision of this
16 Section.

17 Rulemaking authority to implement Public Act 95-1045 ~~this~~
18 ~~amendatory Act of the 95th General Assembly,~~ if any, is
19 conditioned on the rules being adopted in accordance with all
20 provisions of the Illinois Administrative Procedure Act and all
21 rules and procedures of the Joint Committee on Administrative
22 Rules; any purported rule not so adopted, for whatever reason,
23 is unauthorized.

24 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
25 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff.
26 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045,

1 eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10;
2 96-328, eff. 8-11-09; revised 10-23-09.)

3 Section 20. The School Code is amended by changing Section
4 10-22.3f as follows:

5 (105 ILCS 5/10-22.3f)

6 Sec. 10-22.3f. Required health benefits. Insurance
7 protection and benefits for employees shall provide the
8 post-mastectomy care benefits required to be covered by a
9 policy of accident and health insurance under Section 356t and
10 the coverage required under Sections 356g, 356g.5, 356g.5-1,
11 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12,
12 356z.13, ~~and 356z.14, and 356z.15~~ 356z.14, and 364.01 of the
13 Illinois Insurance Code.

14 Rulemaking authority to implement Public Act 95-1045 ~~this~~
15 ~~amendatory Act of the 95th General Assembly~~, if any, is
16 conditioned on the rules being adopted in accordance with all
17 provisions of the Illinois Administrative Procedure Act and all
18 rules and procedures of the Joint Committee on Administrative
19 Rules; any purported rule not so adopted, for whatever reason,
20 is unauthorized.

21 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
22 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;
23 95-1005, 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.
24 1-1-10; 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; revised

1 10-23-09.)

2 Section 25. The Illinois Insurance Code is amended by
3 changing Sections 356z.3 and 364.01 and by adding Section
4 356z.3a as follows:

5 (215 ILCS 5/356z.3)

6 Sec. 356z.3. Disclosure of limited benefit. An insurer that
7 issues, delivers, amends, or renews an individual or group
8 policy of accident and health insurance in this State after the
9 effective date of this amendatory Act of the 92nd General
10 Assembly and arranges, contracts with, or administers
11 contracts with a provider whereby beneficiaries are provided an
12 incentive to use the services of such provider must include the
13 following disclosure on its contracts and evidences of
14 coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN
15 NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that
16 when you elect to utilize the services of a non-participating
17 provider for a covered service in non-emergency situations,
18 benefit payments to such non-participating provider are not
19 based upon the amount billed. The basis of your benefit payment
20 will be determined according to your policy's fee schedule,
21 usual and customary charge (which is determined by comparing
22 charges for similar services adjusted to the geographical area
23 where the services are performed), or other method as defined
24 by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE

1 AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS
2 REQUIRED PORTION. Non-participating providers may bill members
3 for any amount up to the billed charge after the plan has paid
4 its portion of the bill as provided in Section 356z.3a of this
5 Code. Participating providers have agreed to accept discounted
6 payments for services with no additional billing to the member
7 other than co-insurance and deductible amounts. You may obtain
8 further information about the participating status of
9 professional providers and information on out-of-pocket
10 expenses by calling the toll free telephone number on your
11 identification card."

12 (Source: P.A. 95-331, eff. 8-21-07.)

13 (215 ILCS 5/356z.3a new)

14 Sec. 356z.3a. Nonparticipating facility-based physicians
15 and providers.

16 (a) For purposes of this Section, "facility-based
17 provider" means a physician or other provider who provide
18 radiology, anesthesiology, pathology, neonatology, or
19 emergency department services to insureds, beneficiaries, or
20 enrollees in a participating hospital or participating
21 ambulatory surgical treatment center.

22 (b) When a beneficiary, insured, or enrollee utilizes a
23 participating network hospital or a participating network
24 ambulatory surgery center and, due to any reason, in network
25 services for radiology, anesthesiology, pathology, emergency

1 physician, or neonatology are unavailable and are provided by a
2 nonparticipating facility-based physician or provider, the
3 insurer or health plan shall ensure that the beneficiary,
4 insured, or enrollee shall incur no greater out-of-pocket costs
5 than the beneficiary, insured, or enrollee would have incurred
6 with a participating physician or provider for covered
7 services.

8 (c) If a beneficiary, insured, or enrollee agrees in
9 writing, notwithstanding any other provision of this Code, any
10 benefits a beneficiary, insured, or enrollee receives for
11 services under the situation in subsection (b) are assigned to
12 the nonparticipating facility-based providers. The insurer or
13 health plan shall provide the nonparticipating provider with a
14 written explanation of benefits that specifies the proposed
15 reimbursement and the applicable deductible, copayment or
16 coinsurance amounts owed by the insured, beneficiary or
17 enrollee. The insurer or health plan shall pay any
18 reimbursement directly to the nonparticipating facility-based
19 provider. The nonparticipating facility-based physician or
20 provider shall not bill the beneficiary, insured, or enrollee,
21 except for applicable deductible, copayment, or coinsurance
22 amounts that would apply if the beneficiary, insured, or
23 enrollee utilized a participating physician or provider for
24 covered services. If a beneficiary, insured, or enrollee
25 specifically rejects assignment under this Section in writing
26 to the nonparticipating facility-based provider, then the

1 nonparticipating facility-based provider may bill the
2 beneficiary, insured, or enrollee for the services rendered.

3 (d) For bills assigned under subsection (c), the
4 nonparticipating facility-based provider may bill the insurer
5 or health plan for the services rendered, and the insurer or
6 health plan may pay the billed amount or attempt to negotiate
7 reimbursement with the nonparticipating facility-based
8 provider. If attempts to negotiate reimbursement for services
9 provided by a nonparticipating facility-based provider do not
10 result in a resolution of the payment dispute within 30 days
11 after receipt of written explanation of benefits by the insurer
12 or health plan, then an insurer or health plan or
13 nonparticipating facility-based physician or provider may
14 initiate binding arbitration to determine payment for services
15 provided on a per bill basis. The party requesting arbitration
16 shall notify the other party arbitration has been initiated and
17 state its final offer before arbitration. In response to this
18 notice, the nonrequesting party shall inform the requesting
19 party of its final offer before the arbitration occurs.
20 Arbitration shall be initiated by filing a request with the
21 Department of Insurance.

22 (e) The Department of Insurance shall publish a list of
23 approved arbitrators or entities that shall provide binding
24 arbitration. These arbitrators shall be American Arbitration
25 Association or American Health Lawyers Association trained
26 arbitrators. Both parties must agree on an arbitrator from the

1 Department of Insurance's list of arbitrators. If no agreement
2 can be reached, then a list of 5 arbitrators shall be provided
3 by the Department of Insurance. From the list of 5 arbitrators,
4 the insurer can veto 2 arbitrators and the provider can veto 2
5 arbitrators. The remaining arbitrator shall be the chosen
6 arbitrator. This arbitration shall consist of a review of the
7 written submissions by both parties. Binding arbitration shall
8 provide for a written decision within 45 days after the request
9 is filed with the Department of Insurance. Both parties shall
10 be bound by the arbitrator's decision. The arbitrator's
11 expenses and fees, together with other expenses, not including
12 attorney's fees, incurred in the conduct of the arbitration,
13 shall be paid as provided in the decision.

14 (f) This Section 356z.3a does not apply to a beneficiary,
15 insured, or enrollee who willfully chooses to access a
16 nonparticipating facility-based physician or provider for
17 health care services available through the insurer's or plan's
18 network of participating physicians and providers. In these
19 circumstances, the contractual requirements for
20 nonparticipating facility-based provider reimbursements will
21 apply.

22 (g) Section 368a of this Act shall not apply during the
23 pendency of a decision under subsection (d) any interest
24 required to be paid a provider under Section 368a shall not
25 accrue until after 30 days of an arbitrator's decision as
26 provided in subsection (d), but in no circumstances longer than

1 150 days from date the nonparticipating facility-based
2 provider billed for services rendered."

3 (215 ILCS 5/364.01)

4 Sec. 364.01. Qualified clinical cancer trials.

5 (a) No individual or group policy of accident and health
6 insurance issued or renewed in this State may be cancelled or
7 non-renewed for any individual based on that individual's
8 participation in a qualified clinical cancer trial.

9 (b) Qualified clinical cancer trials must meet the
10 following criteria:

11 (1) the effectiveness of the treatment has not been
12 determined relative to established therapies;

13 (2) the trial is under clinical investigation as part
14 of an approved cancer research trial in Phase II, Phase
15 III, or Phase IV of investigation;

16 (3) the trial is:

17 (A) approved by the Food and Drug Administration;

18 or

19 (B) approved and funded by the National Institutes
20 of Health, the Centers for Disease Control and
21 Prevention, the Agency for Healthcare Research and
22 Quality, the United States Department of Defense, the
23 United States Department of Veterans Affairs, or the
24 United States Department of Energy in the form of an
25 investigational new drug application, or a cooperative

1 group or center of any entity described in this
2 subdivision (B); and

3 (4) the patient's primary care physician, if any, is
4 involved in the coordination of care.

5 (c) No group policy of accident and health insurance shall
6 exclude coverage for any routine patient care administered to
7 an insured who is a qualified individual participating in a
8 qualified clinical cancer trial, if the policy covers that same
9 routine patient care of insureds not enrolled in a qualified
10 clinical cancer trial.

11 (d) The coverage that may not be excluded under subsection
12 (c) of this Section is subject to all terms, conditions,
13 restrictions, exclusions, and limitations that apply to the
14 same routine patient care received by an insured not enrolled
15 in a qualified clinical cancer trial, including the application
16 of any authorization requirement, utilization review, or
17 medical management practices. The insured or enrollee shall
18 incur no greater out-of-pocket liability than had the insured
19 or enrollee not enrolled in a qualified clinical cancer trial.

20 (e) If the group policy of accident and health insurance
21 uses a preferred provider program and a preferred provider
22 provides routine patient care in connection with a qualified
23 clinical cancer trial, then the insurer may require the insured
24 to use the preferred provider if the preferred provider agrees
25 to provide to the insured that routine patient care.

26 (f) A qualified clinical cancer trial may not pay or refuse

1 to pay for routine patient care of a individual participating
2 in the trial, based in whole or in part on the person's having
3 or not having coverage for routine patient care under a group
4 policy of accident and health insurance.

5 (g) Nothing in this Section shall be construed to limit an
6 insurer's coverage with respect to clinical trials.

7 (h) Nothing in this Section shall require coverage for
8 out-of-network services where the underlying health benefit
9 plan does not provide coverage for out-of-network services.

10 (i) As used in this Section, "routine patient care" means
11 all health care services provided in the qualified clinical
12 cancer trial that are otherwise generally covered under the
13 policy if those items or services were not provided in
14 connection with a qualified clinical cancer trial consistent
15 with the standard of care for the treatment of cancer,
16 including the type and frequency of any diagnostic modality,
17 that a provider typically provides to a cancer patient who is
18 not enrolled in a qualified clinical cancer trial. "Routine
19 patient care" does not include, and a group policy of accident
20 and health insurance may exclude, coverage for:

21 (1) a health care service, item, or drug that is the
22 subject of the cancer clinical trial;

23 (2) a health care service, item, or drug provided
24 solely to satisfy data collection and analysis needs for
25 the qualified clinical cancer trial that is not used in the
26 direct clinical management of the patient;

1 (3) an investigational drug or device that has not been
2 approved for market by the United States Food and Drug
3 Administration;

4 (4) transportation, lodging, food, or other expenses
5 for the patient or a family member or companion of the
6 patient that are associated with the travel to or from a
7 facility providing the qualified clinical cancer trial,
8 unless the policy covers these expenses for a cancer
9 patient who is not enrolled in a qualified clinical cancer
10 trial;

11 (5) a health care service, item, or drug customarily
12 provided by the qualified clinical cancer trial sponsors
13 free of charge for any patient;

14 (6) a health care service or item, which except for the
15 fact that it is being provided in a qualified clinical
16 cancer trial, is otherwise specifically excluded from
17 coverage under the insured's policy, including:

18 (A) costs of extra treatments, services,
19 procedures, tests, or drugs that would not be performed
20 or administered except for the fact that the insured is
21 participating in the cancer clinical trial; and

22 (B) costs of nonhealth care services that the
23 patient is required to receive as a result of
24 participation in the approved cancer clinical trial;

25 (7) costs for services, items, or drugs that are
26 eligible for reimbursement from a source other than a

1 patient's contract or policy providing for third-party
2 payment or prepayment of health or medical expenses,
3 including the sponsor of the approved cancer clinical
4 trial; or

5 (8) costs associated with approved cancer clinical
6 trials designed exclusively to test toxicity or disease
7 pathophysiology, unless the policy covers these expenses
8 for a cancer patient who is not enrolled in a qualified
9 clinical cancer trial; or

10 (9) a health care service or item that is eligible for
11 reimbursement by a source other than the insured's policy,
12 including the sponsor of the qualified clinical cancer
13 trial.

14 The definitions of the terms "health care services",
15 "Non-Preferred Provider", "Preferred Provider", and "Preferred
16 Provider Program", stated in 50 IL Adm. Code Part 2051
17 Preferred Provider Programs apply to these terms in this
18 Section.

19 (j) The external review procedures established under the
20 Health Carrier External Review Act shall apply to the
21 provisions under this Section.

22 (Source: P.A. 93-1000, eff. 1-1-05.)

23 Section 30. The Health Maintenance Organization Act is
24 amended by changing Section 5-3 as follows:

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

2 (Text of Section before amendment by P.A. 96-833)

3 Sec. 5-3. Insurance Code provisions.

4 (a) Health Maintenance Organizations shall be subject to
5 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
6 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
7 154.6, 154.7, 154.8, 155.04, 355.2, 356g.5-1, 356m, 356v, 356w,
8 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9,
9 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15 ~~356z.14,~~
10 356z.17 ~~356z.15,~~ 364.01, 367.2, 367.2-5, 367i, 368a, 368b,
11 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2,
12 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of
13 Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII,
14 XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

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

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

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

23 (3) a corporation organized under the laws of another
24 state, 30% or more of the enrollees of which are residents
25 of this State, except a corporation subject to
26 substantially the same requirements in its state of

1 organization as is a "domestic company" under Article VIII
2 1/2 of the Illinois Insurance Code.

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

6 (1) the Director shall give primary consideration to
7 the continuation of benefits to enrollees and the financial
8 conditions of the acquired Health Maintenance Organization
9 after the merger, consolidation, or other acquisition of
10 control takes effect;

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

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

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

23 (B) pro forma financial statements reflecting the
24 combined balance sheets of the acquiring company and
25 the Health Maintenance Organization sought to be
26 acquired as of the end of the preceding year and as of

1 a date 90 days prior to the acquisition, as well as pro
2 forma financial statements reflecting projected
3 combined operation for a period of 2 years;

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

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

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

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

26 (f) Except for small employer groups as defined in the

1 Small Employer Rating, Renewability and Portability Health
2 Insurance Act and except for medicare supplement policies as
3 defined in Section 363 of the Illinois Insurance Code, a Health
4 Maintenance Organization may by contract agree with a group or
5 other enrollment unit to effect refunds or charge additional
6 premiums under the following terms and conditions:

7 (i) the amount of, and other terms and conditions with
8 respect to, the refund or additional premium are set forth
9 in the group or enrollment unit contract agreed in advance
10 of the period for which a refund is to be paid or
11 additional premium is to be charged (which period shall not
12 be less than one year); and

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

1 plan years.

2 The Health Maintenance Organization shall include a
3 statement in the evidence of coverage issued to each enrollee
4 describing the possibility of a refund or additional premium,
5 and upon request of any group or enrollment unit, provide to
6 the group or enrollment unit a description of the method used
7 to calculate (1) the Health Maintenance Organization's
8 profitable experience with respect to the group or enrollment
9 unit and the resulting refund to the group or enrollment unit
10 or (2) the Health Maintenance Organization's unprofitable
11 experience with respect to the group or enrollment unit and the
12 resulting additional premium to be paid by the group or
13 enrollment unit.

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

18 (g) Rulemaking authority to implement Public Act 95-1045
19 ~~this amendatory Act of the 95th General Assembly~~, if any, is
20 conditioned on the rules being adopted in accordance with all
21 provisions of the Illinois Administrative Procedure Act and all
22 rules and procedures of the Joint Committee on Administrative
23 Rules; any purported rule not so adopted, for whatever reason,
24 is unauthorized.

25 (Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07;
26 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;

1 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.
2 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; revised
3 10-23-09.)

4 (Text of Section after amendment by P.A. 96-833)

5 Sec. 5-3. Insurance Code provisions.

6 (a) Health Maintenance Organizations shall be subject to
7 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
8 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
9 154.6, 154.7, 154.8, 155.04, 355.2, 356g.5-1, 356m, 356v, 356w,
10 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9,
11 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
12 356z.18, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d,
13 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412,
14 444, and 444.1, paragraph (c) of subsection (2) of Section 367,
15 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV,
16 and XXVI of the Illinois Insurance Code.

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

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

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

25 (3) a corporation organized under the laws of another

1 state, 30% or more of the enrollees of which are residents
2 of this State, except a corporation subject to
3 substantially the same requirements in its state of
4 organization as is a "domestic company" under Article VIII
5 1/2 of the Illinois Insurance Code.

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

9 (1) the Director shall give primary consideration to
10 the continuation of benefits to enrollees and the financial
11 conditions of the acquired Health Maintenance Organization
12 after the merger, consolidation, or other acquisition of
13 control takes effect;

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

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

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

26 (B) pro forma financial statements reflecting the

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

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

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

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

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

1 effect of the management contract or service agreement on
2 competition.

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

10 (i) the amount of, and other terms and conditions with
11 respect to, the refund or additional premium are set forth
12 in the group or enrollment unit contract agreed in advance
13 of the period for which a refund is to be paid or
14 additional premium is to be charged (which period shall not
15 be less than one year); and

16 (ii) the amount of the refund or additional premium
17 shall not exceed 20% of the Health Maintenance
18 Organization's profitable or unprofitable experience with
19 respect to the group or other enrollment unit for the
20 period (and, for purposes of a refund or additional
21 premium, the profitable or unprofitable experience shall
22 be calculated taking into account a pro rata share of the
23 Health Maintenance Organization's administrative and
24 marketing expenses, but shall not include any refund to be
25 made or additional premium to be paid pursuant to this
26 subsection (f)). The Health Maintenance Organization and

1 the group or enrollment unit may agree that the profitable
2 or unprofitable experience may be calculated taking into
3 account the refund period and the immediately preceding 2
4 plan years.

5 The Health Maintenance Organization shall include a
6 statement in the evidence of coverage issued to each enrollee
7 describing the possibility of a refund or additional premium,
8 and upon request of any group or enrollment unit, provide to
9 the group or enrollment unit a description of the method used
10 to calculate (1) the Health Maintenance Organization's
11 profitable experience with respect to the group or enrollment
12 unit and the resulting refund to the group or enrollment unit
13 or (2) the Health Maintenance Organization's unprofitable
14 experience with respect to the group or enrollment unit and the
15 resulting additional premium to be paid by the group or
16 enrollment unit.

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

21 (g) Rulemaking authority to implement Public Act 95-1045,
22 if any, is conditioned on the rules being adopted in accordance
23 with all provisions of the Illinois Administrative Procedure
24 Act and all rules and procedures of the Joint Committee on
25 Administrative Rules; any purported rule not so adopted, for
26 whatever reason, is unauthorized.

1 (Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07;
2 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;
3 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.
4 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; 96-833, eff.
5 6-1-10.)

6 Section 35. The Voluntary Health Services Plans Act is
7 amended by changing Section 10 as follows:

8 (215 ILCS 165/10) (from Ch. 32, par. 604)

9 (Text of Section before amendment by P.A. 96-833)

10 Sec. 10. Application of Insurance Code provisions. Health
11 services plan corporations and all persons interested therein
12 or dealing therewith shall be subject to the provisions of
13 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,
14 149, 155.37, 354, 355.2, 356g, 356g.5, 356g.5-1, 356r, 356t,
15 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5,
16 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
17 356z.14, 356z.15 ~~356z.14~~, 364.01, 367.2, 368a, 401, 401.1, 402,
18 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of
19 Section 367 of the Illinois Insurance Code.

20 Rulemaking authority to implement Public Act 95-1045 ~~this~~
21 ~~amendatory Act of the 95th General Assembly~~, if any, is
22 conditioned on the rules being adopted in accordance with all
23 provisions of the Illinois Administrative Procedure Act and all
24 rules and procedures of the Joint Committee on Administrative

1 Rules; any purported rule not so adopted, for whatever reason,
2 is unauthorized.

3 (Source: P.A. 95-189, eff. 8-16-07; 95-331, eff. 8-21-07;
4 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.
5 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005,
6 eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10;
7 96-328, eff. 8-11-09; revised 9-25-09.)

8 (Text of Section after amendment by P.A. 96-833)

9 Sec. 10. Application of Insurance Code provisions. Health
10 services plan corporations and all persons interested therein
11 or dealing therewith shall be subject to the provisions of
12 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,
13 149, 155.37, 354, 355.2, 356g, 356g.5, 356g.5-1, 356r, 356t,
14 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5,
15 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
16 356z.14, 356z.15, 356z.18, 364.01, 367.2, 368a, 401, 401.1,
17 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and
18 (15) of Section 367 of the Illinois Insurance Code.

19 Rulemaking authority to implement Public Act 95-1045, if
20 any, is conditioned on the rules being adopted in accordance
21 with all provisions of the Illinois Administrative Procedure
22 Act and all rules and procedures of the Joint Committee on
23 Administrative Rules; any purported rule not so adopted, for
24 whatever reason, is unauthorized.

25 (Source: P.A. 95-189, eff. 8-16-07; 95-331, eff. 8-21-07;

1 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.
2 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005,
3 eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10;
4 96-328, eff. 8-11-09; 96-833, eff. 6-1-10.)

5 Section 97. No acceleration or delay. Where this Act makes
6 changes in a statute that is represented in this Act by text
7 that is not yet or no longer in effect (for example, a Section
8 represented by multiple versions), the use of that text does
9 not accelerate or delay the taking effect of (i) the changes
10 made by this Act or (ii) provisions derived from any other
11 Public Act.

12 Section 99. Effective date. This Act takes effect January
13 1, 2011."