AN ACT concerning regulation.

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

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

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, ~~and~~ 356z.25, 356z.26, and 356z.29 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 of the Illinois Insurance Code.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for

whatever reason, is unauthorized.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 10-3-17.)

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

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~ 356z.25, 356z.26, and 356z.29 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

Rulemaking authority to implement Public Act 95-1045, if

any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 10-5-17.)

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

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~ 356z.25<u>, 356z.26, and 356z.29</u> of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation

under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

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

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 10-5-17.)

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

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, ~~and~~ 356z.25, 356z.26, and 356z.29 of the Illinois Insurance Code. Insurance policies shall comply with Section 356z.19 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a and 355b

of the Illinois Insurance Code.

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

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 9-25-17.)

Section 25. The Illinois Insurance Code is amended by changing Section 356z.4 and adding Section 356z.29 as follows:

(215 ILCS 5/356z.4)

Sec. 356z.4. Coverage for contraceptives.

(a)(1) The General Assembly hereby finds and declares all of the following:

(A) Illinois has a long history of expanding timely access to birth control to prevent unintended pregnancy.

(B) The federal Patient Protection and Affordable Care Act includes a contraceptive coverage guarantee as part of a broader requirement for health insurance to cover key preventive care services without out-of-pocket costs for patients.

(C) The General Assembly intends to build on existing State and federal law to promote gender equity and women's

health and to ensure greater contraceptive coverage equity and timely access to all federal Food and Drug Administration approved methods of birth control for all individuals covered by an individual or group health insurance policy in Illinois.

(D) Medical management techniques such as denials, step therapy, or prior authorization in public and private health care coverage can impede access to the most effective contraceptive methods.

(2) As used in this subsection (a):

"Contraceptive services" includes consultations, examinations, procedures, and medical services related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

"Medical necessity", for the purposes of this subsection (a), includes, but is not limited to, considerations such as severity of side effects, differences in permanence and reversibility of contraceptive, and ability to adhere to the appropriate use of the item or service, as determined by the attending provider.

"Therapeutic equivalent version" means drugs, devices, or products that can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling and satisfy the following general criteria:

(i) they are approved as safe and effective;

(ii) they are pharmaceutical equivalents in that they (A) contain identical amounts of the same active drug ingredient in the same dosage form and route of administration and (B) meet compendial or other applicable standards of strength, quality, purity, and identity;

(iii) they are bioequivalent in that (A) they do not present a known or potential bioequivalence problem and they meet an acceptable in vitro standard or (B) if they do present such a known or potential problem, they are shown to meet an appropriate bioequivalence standard;

(iv) they are adequately labeled; and

(v) they are manufactured in compliance with Current Good Manufacturing Practice regulations.

(3) An individual or group policy of accident and health insurance amended, delivered, issued, or renewed in this State after the effective date of this amendatory Act of the 99th General Assembly shall provide coverage for all of the following services and contraceptive methods:

(A) All contraceptive drugs, devices, and other products approved by the United States Food and Drug Administration. This includes all over-the-counter contraceptive drugs, devices, and products approved by the United States Food and Drug Administration, excluding male condoms. The following apply:

(i) If the United States Food and Drug Administration has approved one or more therapeutic

equivalent versions of a contraceptive drug, device, or product, a policy is not required to include all such therapeutic equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing and in accordance with this Section.

(ii) If an individual's attending provider recommends a particular service or item approved by the United States Food and Drug Administration based on a determination of medical necessity with respect to that individual, the plan or issuer must cover that service or item without cost sharing. The plan or issuer must defer to the determination of the attending provider.

(iii) If a drug, device, or product is not covered, plans and issuers must have an easily accessible, transparent, and sufficiently expedient process that is not unduly burdensome on the individual or a provider or other individual acting as a patient's authorized representative to ensure coverage without cost sharing.

(iv) This coverage must provide for the dispensing of 12 months' worth of contraception at one time.

(B) Voluntary sterilization procedures.

(C) Contraceptive services, patient education, and counseling on contraception.

(D) Follow-up services related to the drugs, devices,

products, and procedures covered under this Section, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(4) Except as otherwise provided in this subsection (a), a policy subject to this subsection (a) shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided. The provisions of this paragraph do not apply to coverage of voluntary male sterilization procedures to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to the federal Internal Revenue Code, 26 U.S.C. 223.

(5) Except as otherwise authorized under this subsection (a), a policy shall not impose any restrictions or delays on the coverage required under this subsection (a).

(6) If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage outlined in this subsection (a), then this subsection (a) is

inoperative with respect to all coverage outlined in this subsection (a) other than that authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of the coverage set forth in this subsection (a).

(b) This subsection (b) shall become operative if and only if subsection (a) becomes inoperative.

An individual or group policy of accident and health insurance amended, delivered, issued, or renewed in this State after the date this subsection (b) becomes operative that provides coverage for outpatient services and outpatient prescription drugs or devices must provide coverage for the insured and any dependent of the insured covered by the policy for all outpatient contraceptive services and all outpatient contraceptive drugs and devices approved by the Food and Drug Administration. Coverage required under this Section may not impose any deductible, coinsurance, waiting period, or other cost-sharing or limitation that is greater than that required for any outpatient service or outpatient prescription drug or device otherwise covered by the policy.

Nothing in this subsection (b) shall be construed to require an insurance company to cover services related to permanent sterilization that requires a surgical procedure.

As used in this subsection (b), "outpatient contraceptive service" means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related

to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

(c) Nothing in this Section shall be construed to require an insurance company to cover services related to an abortion as the term "abortion" is defined in the Illinois Abortion Law of 1975.

(d) If a plan or issuer utilizes a network of providers, nothing in this Section shall be construed to require coverage or to prohibit the plan or issuer from imposing cost-sharing for items or services described in this Section that are provided or delivered by an out-of-network provider, unless the plan or issuer does not have in its network a provider who is able to or is willing to provide the applicable items or services.

(Source: P.A. 99-672, eff. 1-1-17.)

(215 ILCS 5/356z.29 new)

Sec. 356z.29. Coverage for fertility preservation services.

(a) As used in this Section:

"Iatrogenic infertility" means in impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

"May directly or indirectly cause" means the likely possibility that treatment will cause a side effect of

infertility, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

"Standard fertility preservation services" means procedures based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

(b) An individual or group policy of accident and health insurance amended, delivered, issued, or renewed in this State after the effective date of this amendatory Act of the 100th General Assembly must provide coverage for medically necessary expenses for standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to an enrollee.

(c) In determining coverage pursuant to this Section, an insurer shall not discriminate based on an individual's expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, or marital status.

(d) If, at any time before or after the effective date of this amendatory Act of the 100th General Assembly, the

Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register, publishes a comment in the Federal Register, or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Pub. L. 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of coverage for fertility preservation services, then this Section is inoperative with respect to all such coverage other than that authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for fertility preservation services.

Section 30. 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, 136, 137, 139, 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, 155.22a, 355.2, 355.3, 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12,

356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 364, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 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.

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

(Source: P.A. 99-761, eff. 1-1-18; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 10-5-17.)

Section 35. The Limited Health Service Organization Act is amended by changing Section 4003 as follows:

(215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

Sec. 4003. Illinois Insurance Code provisions. Limited health service organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 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, 155.37, 355.2, 355.3, 355b, 356v, 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code. For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited health service organizations in the following categories are deemed to be domestic companies:

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

(2) 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.

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-201, eff. 8-18-17; revised 10-5-17.)

Section 40. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

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

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein

or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b, 356g, 356g.5, 356g.5-1, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

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

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; revised 10-5-17.)

Section 45. The Illinois Public Aid Code is amended by changing Section 5-16.8 as follows:

(305 ILCS 5/5-16.8)

Sec. 5-16.8. Required health benefits. The medical assistance program shall (i) provide the post-mastectomy care benefits required to be covered by a policy of accident and

health insurance under Section 356t and the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.6, 356z.26, and 356z.29 ~~and 356z.25~~ of the Illinois Insurance Code and (ii) be subject to the provisions of Sections 356z.19, 364.01, 370c, and 370c.1 of the Illinois Insurance Code.

On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

To ensure full access to the benefits set forth in this Section, on and after January 1, 2016, the Department shall ensure that provider and hospital reimbursement for post-mastectomy care benefits required under this Section are no lower than the Medicare reimbursement rate.

(Source: P.A. 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-642, eff. 7-28-16; 100-138, eff. 8-18-17; revised 1-29-18.)