AN ACT concerning regulation.

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

Section 5. The Limited Health Service Organization Act is amended by changing Sections 1002 and 3009 as follows:

(215 ILCS 130/1002) (from Ch. 73, par. 1501-2)

Sec. 1002. Definitions. As used in this Act, unless the context otherwise requires, the following terms shall have the meanings ascribed to them:

"Advertisement" means any printed or published material, audiovisual material and descriptive literature of the limited health care plan used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards and similar displays; and any descriptive literature or sales aids of all kinds disseminated by a representative of the limited health care plan for presentation to the public including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, form letters and prepared sales presentations.

"Copayment" means the amount that an enrollee must pay in order to receive a specific service that is not fully prepaid.

"Director" means the Director of Insurance.

"Enrollee" means an individual<u>, including a dependent, who is entitled to limited health services pursuant to a contract</u>

with an entity authorized to provide or arrange for those services under this Act ~~who has been enrolled in a limited health care plan~~.

"Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting out the coverage to which that enrollee is entitled ~~in exchange for a per capita prepaid sum~~.

"Group contract" means a contract for limited health services which by its terms limits eligibility to members of a specified group.

"In-plan covered services" means covered limited health services obtained from providers who are employed by, under contract with, referred by, or otherwise affiliated with the LHSO and emergency services.

"Limited health care plan" means any arrangement whereby an organization undertakes to provide or arrange for and, pay for or reimburse the cost of any limited health services from providers selected by the limited health service organization and such arrangement consists of arranging for or the provision of such limited health services on a per capita or fixed prepaid basis, as distinguished from mere indemnification against the cost of such limited services on a per capita prepaid basis through insurance except as otherwise provided under Section 3009.

"Limited health service" means dental care services, vision care services, mental health services, services for

substance use disorders, pharmaceutical services, podiatric care services, and such other services as may be determined by the Director to be limited health services. "Limited health service" does not include hospital, medical, surgical, or emergency services, except as these services are provided incident to the limited health services set forth in this definition ~~ambulance care services, dental care services, vision care services, pharmaceutical services, clinical laboratory services, and podiatric care services. Limited health service shall not include hospital, medical, surgical or emergency services except when those services are essential to the delivery of the limited health service. Essential hospital, medical, surgical, or emergency services shall be covered unless specifically excluded~~.

"Limited health service organization" (LHSO) means any organization formed under the laws of this or another state to provide or arrange for one or more limited health care plans under a system which causes any part of the risk of limited health care delivery to be borne by the organization or its providers.

"Net worth" means admitted assets, as defined in Section 1003 of this Act, minus liabilities.

"Organization" means any insurance company or other corporation organized under the laws of this or another state for the purpose of operating one or more limited health care plans and doing no business other than that of a health

maintenance organization or a limited health service organization or an insurance company. Organization does not include (1) any entity otherwise authorized on the effective date of this Act pursuant to the laws of this State either to provide any limited health service on a prepayment basis or to indemnity for any limited health service; nor does it include (2) any provider or other entity when providing or arranging for the provision of limited health services pursuant to a contract with a limited health service organization or with any entity described in (1) of this definition.

"Out-of-plan covered services" means non-emergency, self-referred covered limited health services obtained from providers who are not otherwise employed by, under contract with, or otherwise affiliated with the LHSO or services obtained without a referral from providers who have contracted to provide limited health services to the enrollee on behalf of the limited health care plan.

"Point-of-service product" (POS) means a group contract that includes both in-plan covered services and out-of-plan covered services as well as a POS contract in which the risk for out-of-plan covered services is borne through reinsurance. This term does not apply to indemnity benefits offered through an LHSO that are underwritten in whole by a licensed insurance carrier and offered in conjunction with the LHSO benefit package.

"Provider" means any physician, dentist, health facility,

or other person or institution which is duly licensed or otherwise authorized to deliver or furnish limited health services and also includes any other entity that arranges for the delivery or furnishing of limited health service.

"Per capita prepaid" means a basis of payment by which a fixed amount of money is prepaid per individual or any other enrollment unit to the limited health service organization or for limited health services which are provided during a definite time period regardless of the frequency or extent of the services rendered, except for copayments of a fixed amount by the limited health service organization.

"Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an organization authorized to provide or arrange for such services under this Act.

"Uncovered expense" means the cost of limited health services that are the obligation of a limited health service organization for which an enrollee may be liable in the event of the insolvency of the organization. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, shall be considered covered expenses.

(Source: P.A. 87-1079; 88-568, eff. 8-5-94; 88-667, eff. 9-16-94.)

(215 ILCS 130/3009) (from Ch. 73, par. 1503-9)

Sec. 3009. Point-of-service limited health service contracts.

(a) An LHSO that offers a POS contract:

(1) shall include as in-plan covered services all services required by law to be provided by an LHSO;

(2) shall provide incentives, which shall include financial incentives, for enrollees to use in-plan covered services;

(3) shall not offer services out-of-plan without providing those services on an in-plan basis;

(4) may limit or exclude specific types of services from coverage when obtained out-of-plan;

(5) may include annual out-of-pocket limits and lifetime maximum benefits allowances for out-of-plan services that are separate from any limits or allowances applied to in-plan services;

~~(6) shall include an annual maximum benefit allowance not to exceed $2,500 per year that is separate from any limits or allowances applied to in-plan services;~~

(6) ~~(7)~~ may limit the groups to which a POS product is offered, however, if a POS product is offered to a group, then it must be offered to all eligible members of that group, when an LHSO provider is available;

(7) ~~(8)~~ shall not consider emergency services, authorized referral services, or non-routine services

obtained out of the service area to be POS services; and

(8) ~~(9)~~ may treat as out-of-plan services those services that an enrollee obtains from a participating provider, but for which the proper authorization was not given by the LHSO.

(b) An LHSO offering a POS contract shall be subject to the following limitations:

(1) The LHSO shall not expend in any calendar quarter more than 20% of its total limited health services expenditures for all its members for out-of-plan covered services, unless otherwise allowed under this subsection.

(2) If the amount specified in paragraph (1) is exceeded by 2% in a quarter, the LHSO shall effect compliance with paragraph (1) by the end of the following quarter.

(3) If compliance with the amount specified in paragraph (1) is not demonstrated in the LHSO's next quarterly report, the LHSO may not offer the POS contract to new groups or include the POS option in the renewal of an existing group until compliance with the amount specified in paragraph (1) is demonstrated ~~or otherwise allowed by the Director~~.

(4) Any LHSO failing, without just cause, to comply with the provisions of this subsection shall be required, after notice and hearing, to pay a penalty of $250 for each day out of compliance, to be recovered by the Director of

Insurance. Any penalty recovered shall be paid into the General Revenue Fund. The Director may reduce the penalty if the LHSO demonstrates to the Director that the imposition of the penalty would constitute a financial hardship to the LHSO.

If an LHSO expends in any calendar quarter more than 20% of its total limited health services expenditures for all its members for out-of-plan covered services, then paragraphs (2), (3), and (4) shall not apply subject to the LHSO minimum capital and surplus requirements applicable to a life, accident, and health insurance company as outlined in Section 13 of the Illinois Insurance Code.

(c) Any LHSO that offers a POS product shall:

(1) File a quarterly financial statement detailing compliance with the requirements of subsection (b).

(2) Track out-of-plan POS utilization separately from in-plan or non-POS out-of-plan emergency care, referral care, and urgent care out of the service area utilization.

(3) Record out-of-plan utilization in a manner that will permit such utilization and cost reporting as the Director may, by regulation, require.

(4) Demonstrate to the Director's satisfaction that the LHSO has the fiscal, administrative, and marketing capacity to control its POS enrollment, utilization, and costs so as not to jeopardize the financial security of the LHSO.

(5) Maintain the deposit required by subsection (b) of Section 2006 in addition to any other deposit required under this Act.

(d) An LHSO shall not issue a POS contract until it has filed and had approved by the Director a plan to comply with the provisions of this Section. The compliance plan shall at a minimum include provisions demonstrating that the LHSO will do all of the following:

(1) Design the benefit levels and conditions of coverage for in-plan covered services and out-of-plan covered services as required by this Article.

(2) Provide or arrange for the provision of adequate systems to:

(A) process and pay claims for all out-of-plan covered services;

(B) meet the requirements for a POS contract set forth in this Section and any additional requirements that may be set forth by the Director; and

(C) generate accurate data and financial and regulatory reports on a timely basis so that the Department can evaluate the LHSO's experience with the POS contract and monitor compliance with POS contract provisions.

(3) Comply initially and on an ongoing basis with the requirements of subsections (b) and (c).

(e) A limited health service organization that offers a

POS contract must comply with Sections 356w and 356x of the Illinois Insurance Code.

(Source: P.A. 90-741, eff. 1-1-99.)