HB2948

LRB10211004BMS16336b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB2948

Introduced 2/19/2021, by Rep. Bob Morgan

SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Insurance Code. Sets forth provisions concerning eligibility for health savings accounts. Provides that an HSA-eligible high deductible health plan is exempt from specified requirements but only until the deductible has been met and only to the extent necessary to allow the policy to satisfy specified federal criteria. Provides that for any HSA-eligible high deductible health plan issued, delivered, amended, or renewed on or after January 1, 2022, a company shall expressly identify the policy as HSA-eligible in all policy forms and in all sales and marketing materials. Provides that for high deductible non-HSA policies issued, delivered, amended, or renewed on or after January 1, 2022, the company shall use the term "non-HSA" in any name or title of the product found in its policy form, as well as in all sales and marketing materials. Provides that beginning January 1, 2022, if a company offers any HSA-eligible HDHP in the large group market, then it shall also offer in the same market at least one high-deductible non-HSA policy. Defines "HSA-eligible HDHP" and "high deductible non-HSA policy". In provisions concerning coverage for screening by low-dose mammography, provisions concerning coverage for contraceptives, and provisions concerning coverage for whole body skin examination, removes provisions stating that the mandates do not apply to required coverage to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to specified federal law. Makes a conforming change in the Health Maintenance Organization Act. Amends the Health Maintenance Organization Act and the Voluntary Health Services Plans Act to provide that health maintenance organizations and voluntary health services plans shall be subject to provisions of the Illinois Insurance Code concerning nonparticipating facility-based physicians and providers and provisions concerning eligibility for health savings accounts. Effective January 1, 2022.

LRB102 11004 BMS 16336 b

A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Illinois Insurance Code is amended by adding Section 355.5, by changing Sections 356g and 356z.4, and by renumbering and changing Section 356z.33 as added by Public Act 101-500 as follows:

(215 ILCS 5/355.5 new)

Sec. 355.5. Eligibility for health savings accounts.

(a) Definitions. As used in this Section:

"High deductible non-HSA policy" means a policy of individual or group accident and health insurance coverage that would have qualified as an HSA-eligible HDHP but for its conformity with any of the Illinois statutes subject to exemption under subsection (b).

"HSA-eligible HDHP" means a policy of individual or group accident and health insurance coverage that satisfies the criteria for a "high-deductible health plan" in 26 U.S.C. 223 as implemented and interpreted by the U.S. Department of the Treasury in the regulations and guidance in effect at the time of any transaction or occurrence addressed by this Section.

(b) Exemptions for an HSA-eligible HDHP.

(1) An HSA-eligible HDHP is exempt from the following

provisions of Illinois law, but only until the deductible has been met and only to the extent necessary to allow the policy to satisfy the criteria for a "high-deductible health plan" as implemented and interpreted by the U.S. Department of the Treasury under 26 U.S.C. 223:

(A) the prohibition on cost-sharing requirements for all coverages provided under subsection (a) of Section 356g of this Code and subsection (a) of Section 4-6.1 of the Health Maintenance Organization Act;

(B) the prohibition on cost-sharing requirements for coverage of voluntary male sterilization procedures under paragraph (4) of subsection (a) of Section 356z.4 of this Code;

(C) the prohibition on cost-sharing requirements for coverage of whole body skin examinations provided under Section 356z.37 of this Code;

(D) the requirements in subsection (d) of Section 30 of the Managed Care Reform and Patient Rights Act; notwithstanding any other provision of this Section, if any method of reducing an individual's out-of-pocket expenses addressed in subsection (d) of Section 30 does not fall within the scope of U.S. Department of the Treasury regulations or guidance about the criteria for a high deductible health plan under 26 U.S.C. 223, or if such regulations or

guidance indicate that the method of reduction is not prohibited for such a plan, then an HSA-eligible HDHP shall not be exempt from the requirements of subsection (d) of Section 30 relating to that method of reduction;

(E) other Illinois provisions that the Department may identify by rule; for such an exemption to be valid, the Department's rule must cite to the specific federal statute, regulation, or guidance within or under 26 U.S.C. 223 that would require a policy to be exempt from the Illinois statute in order to be an HSA-eligible HDHP; and

(F) other Illinois provisions that the Department may acknowledge at a company's request during the policy form filing process provided under Sections 143 and 355 of this Code. If a company requests an exemption from a statutory provision under this subparagraph, the Department may grant the exemption only if the company has cited a specific federal statute, regulation, or guidance within or under 26 U.S.C. 223 that would actually require such an exemption for the policy to be an HSA-eligible HDHP. Upon the first time granting the exemption to that Illinois provision, the Department shall publish a notification to companies indicating that it has done so and identifying its specific basis for granting the

exemption.

(2) Notwithstanding any other provision of this Section, if the U.S. Department of the Treasury determines by regulation or guidance that any coverage addressed by one of the above Illinois statutes pertains to preventive care as that term is used in 26 U.S.C. 223, an exemption shall not apply with respect to that Illinois statute for any HSA-eligible HDHP issued, delivered, amended, or renewed while such regulation or guidance is effective.

(c) For any HSA-eligible HDHP issued, delivered, amended, or renewed on or after January 1, 2022, a company shall expressly identify the policy as HSA-eligible in all policy forms and in all sales and marketing materials. Any name or title of a product that is an HSA-eligible HDHP shall include the term "HSA-eligible".

(d) For all policies issued, delivered, amended, or renewed on or after January 1, 2022, unless the policy is an HSA-eligible HDHP, no company shall use the terms "HSA-eligible", "HSA", "for HSAs", "high deductible health plan", "HDHP", or any substantially similar term or phrase, to describe a policy of individual or group accident and health insurance coverage in any policy form or related sales or marketing materials. For all policies in effect on or after the effective date of this amendatory Act of the 102nd General Assembly, a company or producer shall not in any way represent that a policy not satisfying the definition in subsection (a)

is an HSA-eligible HDHP.

(e) For high deductible non-HSA policies issued, delivered, amended, or renewed on or after January 1, 2022, the company shall use the term "non-HSA" in any name or title of the product found in its policy form, as well as in all sales and marketing materials. Any policy, certificate, evidence of coverage, or outline of coverage for a high deductible non-HSA policy shall include a statement substantially the same as the following within the first 2 pages of substantive text: "Pursuant to Section 355.5 of the Illinois Insurance Code, we are required to disclose that the coverage provided under this policy may not qualify as a "high-deductible health plan" under 26 U.S.C. 223. As a result, your enrollment under this policy may not qualify you as an "eligible individual" to contribute to a health savings account.".

(f) Beginning January 1, 2022, if a company offers any HSA-eligible HDHP in the large group market, then it shall also offer in the same market at least one high-deductible non-HSA policy. If a company offers any HSA-eligible HDHP in the individual or small group market, then it shall also offer in the same market at least one high-deductible non-HSA policy at each level of coverage defined in 45 CFR 156.140 for which the company offers an HSA-eligible HDHP. A company is not required to offer a high-deductible non-HSA policy version of every HSA-eligible HDHP that it offers in a market unless the

company only offers one HSA-eligible HDHP in the large group market or one HSA-eligible HDHP in each applicable level of coverage in the individual or small group market. No company is required to offer an HSA-eligible HDHP merely because it offers a high deductible non-HSA policy.

(g) If an applicant or policyholder obtains an HSA-eligible HDHP, any successive policy shall not be deemed a renewal policy unless it is issued as an HSA-eligible HDHP. Nothing in this subsection shall prevent a company from offering a policyholder a high deductible non-HSA policy as an alternative to renewing their HSA-eligible HDHP, nor from discontinuing to offer any HSA-eligible HDHP altogether in the Illinois individual, small group, or large group market.

(h) This Section does not apply to short-term, limited-duration health insurance coverage as defined in Section 5 of the Short-Term, Limited-Duration Health Insurance Coverage Act.

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

Sec. 356g. Mammograms; mastectomies.

(a) Every insurer shall provide in each group or individual policy, contract, or certificate of insurance issued or renewed for persons who are residents of this State, coverage for screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer within the provisions of the policy, contract, or

certificate. The coverage shall be as follows:

(1) A baseline mammogram for women 35 to 39 years of age.

(2) An annual mammogram for women 40 years of age or older.

(3) A mammogram at the age and intervals considered medically necessary by the woman's health care provider for women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.

(4) For an individual or group policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 101st General Assembly, a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when medically necessary as determined by a physician licensed to practice medicine in all of its branches.

(5) A screening MRI when medically necessary, as determined by a physician licensed to practice medicine in all of its branches.

(6) For an individual or group policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 101st General Assembly,

a diagnostic mammogram when medically necessary, as determined by a physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant.

A policy subject to this subsection shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided~~; except that this sentence does not apply to coverage of diagnostic mammograms to the extent such coverage would disqualify a high deductible health plan from eligibility for a health savings account pursuant to Section 223 of the Internal Revenue Code (26 U.S.C. 223)~~.

For purposes of this Section:

"Diagnostic mammogram" means a mammogram obtained using diagnostic mammography.

"Diagnostic mammography" means a method of screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.

"Low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast

tomosynthesis. As used in this Section, the term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

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 for breast tomosynthesis outlined in this subsection, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage 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 breast tomosynthesis set forth in this subsection.

(a-5) Coverage as described by subsection (a) shall be provided at no cost to the insured and shall not be applied to an annual or lifetime maximum benefit.

(a-10) When health care services are available through contracted providers and a person does not comply with plan

provisions specific to the use of contracted providers, the requirements of subsection (a-5) are not applicable. When a person does not comply with plan provisions specific to the use of contracted providers, plan provisions specific to the use of non-contracted providers must be applied without distinction for coverage required by this Section and shall be at least as favorable as for other radiological examinations covered by the policy or contract.

(b) No policy of accident or health insurance that provides for the surgical procedure known as a mastectomy shall be issued, amended, delivered, or renewed in this State unless that coverage also provides for prosthetic devices or reconstructive surgery incident to the mastectomy. Coverage for breast reconstruction in connection with a mastectomy shall include:

(1) reconstruction of the breast upon which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and treatment for physical complications at all stages of mastectomy, including lymphedemas.

Care shall be determined in consultation with the attending physician and the patient. The offered coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the

mastectomy, and all other terms and conditions applicable to other benefits. When a mastectomy is performed and there is no evidence of malignancy then the offered coverage may be limited to the provision of prosthetic devices and reconstructive surgery to within 2 years after the date of the mastectomy. As used in this Section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician.

Written notice of the availability of coverage under this Section shall be delivered to the insured upon enrollment and annually thereafter. An insurer may not deny to an insured eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this Section. An insurer may not penalize or reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with this Section.

(c) 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. 100-395, eff. 1-1-18; 101-580, eff. 1-1-20.)

(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) (Blank).

(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. 100-1102, eff. 1-1-19; 101-13, eff. 6-12-19.)

(215 ILCS 5/356z.37)

Sec. 356z.37 ~~356z.33~~. Whole body skin examination. An individual or group policy of accident and health insurance shall cover, without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement upon the insured patient, one annual office visit, using appropriate routine evaluation and management Current Procedural Terminology codes or any successor codes, for a whole body skin examination for lesions suspicious for skin cancer. The whole body skin examination shall be indicated using an appropriate International Statistical Classification of Diseases and Related Health Problems code or any successor codes. ~~The provisions of this Section do not apply to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. 223.~~

(Source: P.A. 101-500, eff. 1-1-20; revised 10-16-19.)

Section 10. The Health Maintenance Organization Act is amended by changing Sections 4-6.1 and 5-3 as follows:

(215 ILCS 125/4-6.1) (from Ch. 111 1/2, par. 1408.7)

Sec. 4-6.1. Mammograms; mastectomies.

(a) Every contract or evidence of coverage issued by a Health Maintenance Organization for persons who are residents of this State shall contain coverage for screening by low-dose

mammography for all women 35 years of age or older for the presence of occult breast cancer. The coverage shall be as follows:

(1) A baseline mammogram for women 35 to 39 years of age.

(2) An annual mammogram for women 40 years of age or older.

(3) A mammogram at the age and intervals considered medically necessary by the woman's health care provider for women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.

(4) For an individual or group policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 101st General Assembly, a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when medically necessary as determined by a physician licensed to practice medicine in all of its branches.

(5) For an individual or group policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 101st General Assembly, a diagnostic mammogram when medically necessary, as

determined by a physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant.

A policy subject to this subsection shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided~~; except that this sentence does not apply to coverage of diagnostic mammograms to the extent such coverage would disqualify a high deductible health plan from eligibility for a health savings account pursuant to Section 223 of the Internal Revenue Code (26 U.S.C. 223)~~.

For purposes of this Section:

"Diagnostic mammogram" means a mammogram obtained using diagnostic mammography.

"Diagnostic mammography" means a method of screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.

"Low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis.

"Breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

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 for breast tomosynthesis outlined in this subsection, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage 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 breast tomosynthesis set forth in this subsection.

(a-5) Coverage as described in subsection (a) shall be provided at no cost to the enrollee and shall not be applied to an annual or lifetime maximum benefit.

(b) No contract or evidence of coverage issued by a health maintenance organization that provides for the surgical procedure known as a mastectomy shall be issued, amended,

delivered, or renewed in this State on or after the effective date of this amendatory Act of the 92nd General Assembly unless that coverage also provides for prosthetic devices or reconstructive surgery incident to the mastectomy, providing that the mastectomy is performed after the effective date of this amendatory Act. Coverage for breast reconstruction in connection with a mastectomy shall include:

(1) reconstruction of the breast upon which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and treatment for physical complications at all stages of mastectomy, including lymphedemas.

Care shall be determined in consultation with the attending physician and the patient. The offered coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits. When a mastectomy is performed and there is no evidence of malignancy, then the offered coverage may be limited to the provision of prosthetic devices and reconstructive surgery to within 2 years after the date of the mastectomy. As used in this Section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician.

Written notice of the availability of coverage under this Section shall be delivered to the enrollee upon enrollment and annually thereafter. A health maintenance organization may not deny to an enrollee eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this Section. A health maintenance organization may not penalize or reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with this Section.

(c) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, 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. 100-395, eff. 1-1-18; 101-580, eff. 1-1-20.)

(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, 355.5, 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.3a, 356z.4, 356z.4a, 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, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.35, 356z.36, 356z.41, 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, XXVI, and XXXIIB 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. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1026, eff. 8-22-18; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21.)

Section 15. 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, 355.5, 355b, 356g, 356g.5, 356g.5-1, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.3a, 356z.4, 356z.4a, 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, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.41, 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; 100-863, eff. 8-14-18; 100-1026, eff. 8-22-18; 100-1057, eff.

1-1-19; 100-1102, eff. 1-1-19; 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-625, eff. 1-1-21.)

Section 99. Effective date. This Act takes effect January 1, 2022.

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