Sen. David Koehler

Filed: 5/13/2009

AMENDMENT TO SENATE BILL 1331

AMENDMENT NO. _____. Amend Senate Bill 1331, AS AMENDED, by replacing everything after the enacting clause with the following:

"ARTICLE 1. SHORT TITLE; LEGISLATIVE INTENT

Section 1-1. Short title. This Act may be cited as the Illinois Family and Employers Health Care Act.

Section 1-5. Legislative intent. The General Assembly finds that, for the economic and social benefit of all residents of the State it is vital to enable all Illinoisans to access affordable health insurance that provides comprehensive coverage. Therefore, the General Assembly established the Adequate Healthcare Taskforce to develop a comprehensive plan to provide all Illinoisans with access to comprehensive, high quality, affordable healthcare.

The Taskforce through extensive research and town hall meetings across the state found that not only are many working families uninsured but numerous others struggle with the high cost of healthcare. Health insurance premiums for Illinois's working families skyrocketed over the last eight years, increasing by 73.1 percent between 2000 - 2007. In addition, the employer's portion of annual premiums for family health coverage in the state rose from $5,581 to $9,587. Health care costs are consuming ever-larger portions of family budgets and causing substantial hardships for individuals and small businesses. If this trend continues, more and more families will inevitably join the ranks of the uninsured and underinsured, small businesses will not be able to provide health care for their workers and Illinoisans will face diminishing economic and health security.

It is, therefore, the intent of the Illinois Family and Employers Health Care Act to implement findings from the Adequate Healthcare Task Force to provide access to affordable, comprehensive health insurance to all Illinoisans in a cost-effective manner.

It is also the intent of this legislation to maximize the coordination of state policy with comprehensive federal healthcare system reforms, to maximize federal funds, ensure the earliest possible access to federal funds, and make the policy and system changes in the Illinois health insurance markets and industry that will facilitate coordination with

federal reform.

ARTICLE 10. AFFORDABLE HEALTHCARE FOR ALL SMALL BUSINESSES AND INDIVIDUALS

Section 10-1. Short title. This Article may be cited as the Illinois Guaranteed Option Act. All references in this Article to "this Act" mean this Article.

Section 10-5. Purpose. The General Assembly recognizes that small businesses and individuals struggle every day to pay the costs of meaningful health insurance coverage. Individuals with healthcare needs are frequently denied coverage or offered coverage they cannot afford. Small businesses too receive unaffordable offers of coverage, and always pay more for coverage than larger firms. Even small businesses that struggle to pay health insurance premiums for years can quickly be priced out of the market -- premiums skyrocket after just one small business employee gets sick. In essence, the Illinois health insurance market for small businesses and individuals provides affordable coverage for those who need healthcare services the least. Businesses and individuals who need healthcare the most can no longer afford it or are denied coverage. The General Assembly acknowledges that the high cost of health care for individuals and small groups can be driven by unpredictable and high cost catastrophic medical events.

Therefore, the General Assembly, in order to provide access to affordable health insurance for every Illinoisan, seeks to reduce the impact of high-cost medical events by enacting this Act.

Section 10-10. Definitions. In this Act:

"Department" means the Department of Healthcare and Family Services.

"Division" means the Division of Insurance within the Department of Financial and Professional Regulation.

"Federal poverty level" means the federal poverty level income guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

"Full-time employee" means a full-time employee as defined by Section 5-5 of the Economic Development for a Growing Economy Tax Credit Act.

"Health maintenance organization" means commercial health maintenance organizations as defined by Section 1-2 of the Health Maintenance Organization Act and shall not include health maintenance organizations which participate solely in government-sponsored programs.

"Illinois Comprehensive Health Insurance Plan" means the Illinois Comprehensive Health Insurance Plan established by the Comprehensive Health Insurance Plan Act.

"Illinois Guaranteed Option" means the program established

under this Act.

"Individual market" means the individual market as defined by the Illinois Health Insurance Portability and Accountability Act.

"Insurer" means any insurance company authorized to sell group or individual policies of hospital, surgical, or major medical insurance coverage, or any combination thereof, that contains agreements or arrangements with providers relating to health care services that may be rendered to beneficiaries as defined by the Health Care Reimbursement Reform Act of 1985 in Sections 370f and following of the Illinois Insurance Code (215 ILCS 5/370f and following) and its accompanying regulation (50 Illinois Administrative Code 2051). The term "insurer" does not include insurers that sell only policies of hospital indemnity, accidental death and dismemberment, workers' compensation, credit accident and health, short-term accident and health, accident only, long term care, Medicare supplement, student blanket, stand-alone policies, dental, vision care, prescription drug benefits, disability income, specified disease, or similar supplementary benefits.

"Illinois Guaranteed Option entity" means any health maintenance organization or insurer, as those terms are defined in this Section, whose gross Illinois premium equals or exceeds 1% of the applicable market share.

"Risk-based capital" means the minimum amount of required capital or net worth to be maintained by an insurer or Illinois

Guaranteed Option entity as prescribed by Article IIA of the Insurance Code (215 ILCS 5/35A-1 and following).

"Small employer", for purposes of the Illinois Guaranteed Option Act only, means an employer that employs not more than 50 employees who receive compensation for at least 25 hours of work per week.

"Small group market" means small group market as defined by the Illinois Health Insurance Portability and Accountability Act.

Section 10-15. Illinois Guaranteed Option plans for eligible small employers and individuals.

(a) The State hereby establishes a program for the purpose of making health insurance plans and health maintenance organizations affordable and accessible to small employers and individuals as defined in this Section. The program is designed to encourage small employers to offer affordable health insurance to employees and to make affordable health insurance available to eligible Illinoisans, including individuals whose employers do not offer or sponsor group health insurance.

(b) Participation in this program is limited to Illinois Guaranteed Option entities as defined by Section 10-10 of this Act. Participation by all insurers and health maintenance organizations in the Illinois Guaranteed Option program is mandatory. On July 1, 2011, all insurers and health maintenance organizations offering health insurance coverage in the small

group market shall offer one or more group Illinois Guaranteed Option plans to eligible small employers as defined in subsection (c) of this Section. All insurers and health maintenance organizations offering health insurance coverage in the individual market shall offer one or more individual Illinois Guaranteed Option plans. For purposes of this Section and Section 10-20 of this Act, all Illinois Guaranteed Option entities that comply with the program requirements shall be eligible for reimbursement from the stop loss funds created pursuant to Section 10-20 of this Act.

(c) For purposes of this Act, an eligible small employer is a small employer that:

(1) employs not more than 50 eligible employees; and

(2) contributes towards the group health insurance plan at least 50% of an individual employee's premium and at least 50% of an employee's family premium; and

(3) uses Illinois as its principal place of business, management, and administration. For purposes of small employer eligibility, there shall be no income limit, except for limitations made necessary by the funds appropriated and available in the "Illinois Shared Responsibility and Shared Opportunities Trust Fund" for this purpose.

(d) For purposes of this Section, "eligible employee" shall include any individual who receives compensation from the eligible employer for at least 25 hours of work per week.

(e) An Illinois Guaranteed Option entity may enter into an agreement with an employer to offer an Illinois Guaranteed Option plan pursuant to this Section only if that employer offers that plan to all eligible employees.

(f) The pro-rated employer premium contribution levels for non-full-time employees shall be based upon employer premium contribution levels required by subdivision (c)(2) of this Section. An eligible small employer shall contribute at least the pro-rated premium contribution amount towards an individual part-time employee's premium. An eligible small employer shall contribute at least the pro-rated premium contribution amount towards an individual part-time employee's family premium. The pro-rated premium contribution must be the same percentage for all similarly situated employees and may not vary based on class of employee.

(g) Illinois-based chambers of commerce or other associations, including bona fide associations as defined by the Illinois Health Insurance Portability and Accountability Act, may be eligible to participate in Illinois Guaranteed Option policies subject to approval by the Department, as permitted by law, and limitations made necessary by the funds appropriated and available in the Illinois Shared Responsibility and Shared Opportunities Trust Fund.

(h) An eligible small employer shall elect whether to make coverage under the Illinois Guaranteed Option plan available to dependents of employees. Any employee or dependent who is

enrolled in Medicare is ineligible for coverage, unless required by federal law. Dependents of an employee who is enrolled in Medicare shall be eligible for dependent coverage provided the dependent is not also enrolled in Medicare.

(i) An Illinois Guaranteed Option plan must provide the benefits set forth in subsection (o) of this Section. The contract, independently or in combination with other group Illinois Guaranteed Option plans, must insure not less than 50% of the eligible employees.

(j) For purposes of this Act, an eligible individual is an individual:

(1) who is unemployed, not an eligible employee as defined by subsection (d) of Section 10-15, or solely self-employed, or whose employer does not sponsor group health insurance and has not sponsored group health insurance with benefits on an expense-reimbursed or prepaid basis covering employees in effect during the 12-month period prior to the individual's application for health insurance under the program established by this Section;

(2) who for the first year of operation of the program resides in a household having a household income at or below 400% of the federal poverty level; thereafter, income and asset limits shall be determined by the Health Care Justice Commission established under the Illinois Health Care Justice Commission Act;

(3) who is ineligible for Medicare or medical assistance, except that the Department may determine that it shall require an individual who is eligible under subdivision 2(b) of Section 5-2 of the Illinois Public Aid Code to participate as an eligible individual; and

(4) who is a resident of Illinois.

(l) The requirements set forth in subdivision (j)(1) of this Section shall not be applicable to individuals who had health insurance coverage terminated due to:

(1) death of a family member that results in termination of coverage under a health insurance contract under which the individual is covered;

(2) change of residence so that no employer-based health insurance with benefits on an expense-reimbursed or prepaid basis is available; or

(3) legal separation, dissolution of marriage, or declaration of invalidity of marriage that results in termination of coverage under a health insurance contract under which the individual is covered.

(m) The 12-month period set forth in item (1) of subsection (j) of this Section may be adjusted by the Division from 12 months to an alternative duration if the Healthcare Justice Commission determines that the alternative period sufficiently prevents inappropriate substitution.

(o) The contracts issued pursuant to this Section by participating Illinois Guaranteed Option entities and approved

by the Department shall provide for a distinct product known as "Guaranteed Option". The insurance product will provide for major medical, mental health, pharmacy, dental and vision benefits that contains in and out of network benefits.

(p) Illinois Guaranteed Option entities shall propose the following for approval by the Department:

(1) Benefit designs provided in plans created for this Section.

(2) Co-pays and deductible amounts applicable to plans, which shall not exceed the maximum allowable amount under the Illinois Insurance Code.

(q) Under the Guaranteed Option product hospitals shall be reimbursed by Illinois Guaranteed Option entities in an amount that equals 110 percent of Medicare for Critical Access hospitals and equals the actuarial equivalent of 135 percent of Medicare for all other hospitals as prescribed for the hospital's designated region. "All other hospitals" includes Sole Community Hospitals, Medicare Dependent Hospitals and Rural Referral Centers. "Medicare" refers to the appropriate, Medicare federal standardized rate which is adjusted for the individual DRG weighting factors used by Medicare, the hospital's specific area wage index, capital costs, outlier payments, disproportionate share hospital payments, direct and indirect medical education payments, the costs of nursing and allied health education programs, and organ procurement costs. For hospital services provided for which a Medicare rate is not

prescribed or cannot be calculated, the hospital shall be reimbursed 90% of the lowest rate paid by the applicable insurer under its contract with that hospital for that same type of product and applicable service.

(r) On and after January 1, 2010, all providers that contract with an insurer or health maintenance organization must participate as a network provider under the same Illinois Guaranteed Option entity's Guaranteed Option product.

(s) Nothing in this Act shall be used by any private or public Illinois Guaranteed Option entity as a basis for reducing the Illinois Guaranteed Option entity's rates or policies with any hospital. Illinois Guaranteed Option entities are prohibited from using contractual provisions in provider contracts that would require the provider or providers to accept the rates under subsection (c) as the payment rates for any other type of product or service of the Illinois Guaranteed Option entity. Notwithstanding any other provision of law, rates authorized under this Act shall not be used by any private or public Illinois Guaranteed Option entities to determine a hospital's usual and customary charges for any health care service.

(t) Other non-hospital providers shall be reimbursed at a rate no less than the Medicare rate for that geographic area if payment is capitated at a per-member per-month amount and at 120% of the Medicare rate if reimbursement is fee-for-service.

(u) No Illinois Guaranteed Option entity shall issue a

group Illinois Guaranteed Option plan or individual Illinois Guaranteed Option plan until the plan has been certified as such by the Department.

(v) A participating Illinois Guaranteed Option plan shall obtain from the employer or individual, on forms approved by the Department or in a manner prescribed by the Department, written certification at the time of initial application and annually thereafter 90 days prior to the contract renewal date that the employer or individual meets and expects to continue to meet the requirements of an eligible small employer or an eligible individual pursuant to this Section. A participating Illinois Guaranteed Option plan may require the submission of appropriate documentation in support of the certification, including proof of income status.

(w) Applications to enroll in group Illinois Guaranteed Option plans and individual Illinois Guaranteed Option plans must be received and processed from any eligible individual and any eligible small employer during the open enrollment period each year. This provision does not restrict open enrollment guidelines set by Illinois Guaranteed Option plan contracts, but every such contract must include standard employer group open enrollment guidelines.

(x) All coverage under group Illinois Guaranteed Option plans and individual Illinois Guaranteed Option plans must be subject to a pre-existing condition limitation provision, including the crediting requirements thereunder. Pre-existing

conditions may be evaluated and considered by the Department when determining appropriate co-pay amounts, deductible levels, and benefit levels. Prenatal care shall be available without consideration of pregnancy as a preexisting condition. Waiver of deductibles and other cost-sharing payments by insurer may be made for individuals participating in chronic care management or wellness and prevention programs.

(y) In order to arrive at the actual premium charged to any particular group or individual, a participating Illinois Guaranteed Option entity may adjust its base rate.

(1) Adjustments to base rates may be made using only the following factors:

(A) geographic area;

(B) age;

(C) smoking or non-smoking status; and

(D) participation in wellness or chronic disease management activities.

(2) The adjustment for age in item (1) of this subsection may not use age brackets smaller than 5-year increments, which shall begin with age 20 and end with age 65. Eligible individuals, sole proprietors, and employees under the age of 20 shall be treated as those age 20.

(3) Permitted rates for any age group shall not exceed the rate for any other age group by more than 25%.

(4) If geographic rating areas are utilized, such geographic areas must be reasonable and in a given case may

include a single county. The geographic areas utilized must be the same for the contracts issued to eligible small employers and to eligible individuals. The Division shall not require the inclusion of any specific geographic region within the proposed region selected by the participating Illinois Guaranteed Option entity, but the participating Illinois Guaranteed Option entity's proposed regions shall not contain configurations designed to avoid or segregate particular areas within a county covered by the participating Illinois Guaranteed Option plan's community rates. Rates from one geographic region to another may not vary by more than 30% and must be actuarially supported.

(5) Permitted rates for any small employer shall not exceed the rate for any other small employer by more than 25%.

(6) A discount of up to 10% for participation in wellness or chronic disease management activities shall be permitted if based upon actuarially justified differences in utilization or cost attributed to such programs.

(7) Claims experience under contracts issued to eligible small employers and to eligible individuals must be combined for rate setting purposes.

(8) Rate-based provisions in this subsection may be modified due to claims experience and subject to limitations made necessary by funds appropriated and available in the Illinois Shared Opportunity and Shared

Responsibility Trust Fund.

(z) Participating Illinois Guaranteed Option entities shall submit reports to the Department in such form and such media as the Department shall prescribe. The reports shall be submitted at times as may be reasonably required by the Department to evaluate the operations and results of Illinois Guaranteed Option plans established by this Section. The Department shall make such reports available to the Division.

(aa) The Department shall conduct public education and outreach to facilitate enrollment of small employers, eligible employees, and eligible individuals in the Program.

Section 10-20. Stop loss funding for Illinois Guaranteed Option contracts issued to eligible small employers and eligible individuals.

(a) The Department shall provide a claims reimbursement program for eligible Illinois Guaranteed Option entities and shall annually seek appropriations to support the program. Eligibility for the program shall be determined by the Division of Insurance, in consultation with the Health Care Justice Commission.

(b) The claims reimbursement program, also known as "Illinois Stop Loss Protection", shall operate as a stop loss program for participating Illinois Guaranteed Option entities and shall reimburse participating Illinois Guaranteed Option entities for a certain percentage of health care claims above a

certain attachment amount or within certain attachment amounts. The stop loss attachment amount or amounts shall be determined by the Division, in consultation with the Health Care Justice Commission, consistent with the purpose of the Illinois Program and subject to limitations made necessary by the amount appropriated and available in the Illinois Shared Opportunity and Shared Responsibility Trust Fund.

(c) Based on pre-determined attachment amounts, verified claims paid for members covered under eligible Illinois Guaranteed Option plans shall be reimbursable from the Illinois Stop Loss Protection Program. For purposes of this Section, claims shall include health care claims paid by or on behalf of a covered member pursuant to such contracts.

(d) Consistent with the purpose of Illinois Act and subject to limitations made necessary by the amount appropriated and available in the Illinois Shared Opportunity and Shared Responsibility Trust Fund, the Department shall set forth procedures for operation of the Illinois Stop Loss Protection Program and distribution of monies therefrom.

(e) Claims shall be reported and funds shall be distributed by the Department on a calendar year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims are paid.

(f) Each participating Illinois Guaranteed Option entity shall submit a request for reimbursement from the Illinois Stop Loss Protection Program on forms prescribed by the Department.

Each request for reimbursement shall be submitted no later than April 1 following the end of the calendar year for which the reimbursement requests are being made. In connection with reimbursement requests, the Department may require participating Illinois Guaranteed Option entities to submit such claims data deemed necessary to enable proper distribution of funds and to oversee the effective operation of the Illinois Stop Loss Protection Program. The Department may require that such data be submitted on a per-member, aggregate, or categorical basis, or any combination of those. Data shall be reported separately for group Illinois Guaranteed Option plans and individual Illinois Guaranteed Option plans issued pursuant to Section 10-15 of this Act.

(f-5) In each request for reimbursement from the Illinois Stop Loss Protection Program, Illinois Guaranteed Option entities shall certify that provider reimbursement rates are consistent with the reimbursement rates as defined by subdivision (r)(3) of Section 10-15 of this Act. The Department, in collaboration with the Division, shall audit, as necessary, claims data submitted pursuant to subsection (f) of this Section to ensure that reimbursement rates paid by Illinois Guaranteed Option entities are consistent with reimbursement rates as defined by subsection (m) of Section 10-15.

(g) At all times, the Illinois Stop Loss Protection Program shall be implemented and operated subject to the limitations

made necessary by the funds appropriated and available in the Illinois Shared Opportunity and Shared Responsibility Trust Fund. The Department shall calculate the total claims reimbursement amount for all participating Illinois Guaranteed Option entities for the calendar year for which claims are being reported. In the event that the total amount requested for reimbursement for a calendar year exceeds appropriations available for distribution for claims paid during that same calendar year, the Department shall provide for the pro-rata distribution of the available funds. Each participating Illinois Guaranteed Option entity shall be eligible to receive only such proportionate amount of the available appropriations as the individual participating Illinois Guaranteed Option entity's total eligible claims paid bears to the total eligible claims paid by all participating Illinois Guaranteed Option entities.

(h) Each participating Illinois Guaranteed Option entity shall provide the Department with monthly reports of the total enrollment under the group Illinois Guaranteed Option plans and individual Illinois Guaranteed Option plans issued pursuant to Section 10-15 of this Act. The reports shall be in a form prescribed by the Department.

(i) The Department shall separately estimate the per member annual cost of total claims reimbursement from each stop loss program for group Illinois Guaranteed Option plans and individual Illinois Guaranteed Option plans based upon

available data and appropriate actuarial assumptions. Upon request, each participating Illinois Guaranteed Option plan shall furnish to the Department claims experience data for use in such estimations.

(j) Every participating Illinois Guaranteed Option entity shall file with the Division the base rates and rating schedules it uses to provide group Illinois Guaranteed Option plans and individual Illinois Guaranteed Option plans. All rates proposed for Illinois Guaranteed Option plans are subject to the prior regulatory review of the Division and shall be effective only upon approval by the Division. The Division has authority to approve, reject, or modify the proposed base rate subject to the following:

(1) Rates for Illinois Guaranteed Option plans must account for the availability of reimbursement pursuant to this Section.

(2) Rates must not be excessive or inadequate nor shall the rates be unfairly discriminatory.

(3) Consideration shall be given, to the extent applicable and among other factors, to the Illinois Guaranteed Option entity's past and prospective medical loss experience within the State for the product for which the base rate is proposed, to past and prospective expenses both countrywide and those especially applicable to this State, and to all other factors, including judgment factors, deemed relevant within and outside the State.

(4) Consideration shall be given to the Illinois Guaranteed Option entity's actuarial support, enrollment levels, premium volume, risk-based capital, and the ratio of incurred claims to earned premiums.

(k) If the Department deems it appropriate for the proper administration of the program, the Department shall be authorized to purchase stop loss insurance or reinsurance, or both, from an insurance company licensed to write such type of insurance in Illinois.

(k-5) Nothing in this Section 10-20 shall require modification of stop loss provisions of an existing contract between the Illinois Guaranteed Option entity and a healthcare provider.

(l) The Division shall assess insurers as defined in Section 12 of the Comprehensive Health Insurance Plan Act in accordance with the provisions of this subsection:

(1) By March 1, 2010, the Illinois Comprehensive Health Insurance Plan shall report to the Division the total assessment paid pursuant to subsection d of Section 12 of the Comprehensive Health Insurance Plan Act for fiscal years 2004 through 2009. By March 1, 2010, the Division shall determine the total direct Illinois premiums for calendar years 2004 through 2009 for the kinds of business described in clause (b) of Class 1 or clause (a) of Class 2 of Section 4 of the Illinois Insurance Code, and direct premium income of a health maintenance organization or a

voluntary health services plan, except that it shall not include credit health insurance as defined in Article IX 1/2 of the Illinois Insurance Code. The Division shall create a fraction, the numerator of which equals the total assessment as reported by the Illinois Comprehensive Health Insurance Plan pursuant to this subsection, and the denominator of which equals the total direct Illinois premiums determined by the Division pursuant to this subsection. The resulting percentage shall be the "baseline percentage assessment".

(2) For purposes of the program, and to the extent that in any fiscal year the Illinois Comprehensive Health Insurance Plan does not collect an amount equal to or greater than the equivalent dollar amount of the baseline percentage assessment to cover deficits established pursuant to subsection d of Section 12 of the Comprehensive Health Insurance Plan Act, the Division shall impose the "baseline assessment" in accordance with paragraph (3) of this subsection.

(3) An insurer's assessment shall be determined by multiplying the equivalent dollar amount of the baseline percentage assessment, as determined by paragraph (1), by a fraction, the numerator of which equals that insurer's direct Illinois premiums during the preceding calendar year and the denominator of which equals the total of all insurers' direct Illinois premiums for the preceding

calendar year. The Division may exempt those insurers whose share as determined under this subsection would be so minimal as to not exceed the estimated cost of levying the assessment.

(4) The Division shall charge and collect from each insurer the amounts determined to be due under this subsection.

(5) The difference between the total assessments paid pursuant to imposition of the baseline assessment and the total assessments paid to cover deficits established pursuant to subsection d of Section 12 of the Comprehensive Health Insurance Plan Act shall be paid to the Illinois Shared Opportunity and Shared Responsibility Trust Fund.

(6) When used in this subsection (l), "insurer" means "insurer" as defined in Section 2 of the Comprehensive Health Insurance Plan Act.

Section 10-25. Program publicity duties of Illinois Guaranteed Option entities and Department.

(a) In conjunction with the Department, all Illinois Guaranteed Option entities shall participate in and share the cost of annually publishing and disseminating a consumer's shopping guide or guides for group Illinois Guaranteed Option plans and individual Illinois Guaranteed Option plans issued pursuant to Section 10-15 of this Act. The contents of all consumer shopping guides published pursuant to this Section

shall be subject to review and approval by the Department.

(b) Participating Illinois Guaranteed Option entities may distribute additional sales or marketing brochures describing group Illinois Guaranteed Option plans and individual Illinois Guaranteed Option plans subject to review and approval by the Department.

(c) Commissions available to insurance producers from Illinois Guaranteed Option entities for sales of plans under the Illinois Program shall not be less than those available for sale of plans other than plans issued pursuant to the Illinois Guaranteed Option Program. Information on such commissions shall be reported to the Division in the rate approval process.

Section 10-30. Data reporting.

(a) The Department, in consultation with the Division and other State agencies, shall report on the program established pursuant to Sections 10-15 and 10-20 of this Act. The report shall examine:

(1) employer and individual participation, including an income profile of covered employees and individuals and an estimate of the per-member annual cost of total claims reimbursement as required by subsection (i) of Section 10-20 of this Act;

(2) claims experience and the program's projected costs through December 31, 2015;

(3) the impact of the program on the uninsured

population in Illinois and the impact of the program on health insurance rates paid by Illinois residents; and

(4) the amount of funds in the Illinois Shared Opportunity and Shared Responsibility Trust Fund generated by the Illinois Shared Opportunity and Shared Responsibility Assessment Act, by category of employer.

(b) The study shall be completed and a report submitted by October 1, 2011 to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 10-35. Duties assigned to the Department. Unless otherwise specified, all duties assigned to the Department by this Act shall be carried out in consultation with the Division.

Section 10-40. Applicability of other Illinois Insurance Code provisions. Unless otherwise specified in this Section, policies for all group Illinois Guaranteed Option plans and individual Illinois Guaranteed Option plans must meet all other applicable provisions of the Illinois Insurance Code.

ARTICLE 12. ILLINOIS HEALTHCARE JUSTICE COMMISSION

Section 12-1. Short title. This Article may be cited as the Illinois Health Care Justice Commission Act. All references in this Article to "this Act" means this Article.

Section 12-5. Purpose. This Act creates the bipartisan Illinois Health Care Justice Commission (HCJC). The purpose of the HCJC is to carry out the functions given to it elsewhere by law and to monitor and oversee generally the reforms of the Illinois healthcare system and the coordination of those reforms with federal reforms, to create regular opportunities to report to the public and learn public reaction through forums and otherwise, to report annually on the progress and status of healthcare reform to the General Assembly, and to generate recommendations for improvements to the system as the implementation proceeds.

Section 12-10. Makeup of Commission.

(a) The Illinois Health Care Justice Commission shall consist of 29 voting members appointed as follows: 5 shall be appointed by the Governor; 6 shall be appointed by the President of the Senate; 6 shall be appointed by the Minority Leader of the Senate; 6 shall be appointed by the Speaker of the House of Representatives; and 6 shall be appointed by the Minority Leader of the House of Representatives. Appointed members shall include representatives from state healthcare associations, advocacy organizations, providers, organized labor, and businesses with a primary focus that includes chronic disease prevention, public health delivery, medicine, mental health, oral health, health care and disease management,

consumer advocacy or community health, minority healthcare, and quality healthcare improvement. Members of the HCJC shall serve without compensation and be reimbursed for expenses.

(b) The members of the Commission shall be appointed within 30 days after the effective date of this Act. The Commission shall have a chairperson and a vice-chairperson who shall be elected by the voting members at the first meeting of the Commission. The Director of the Department of Healthcare and Family Services or his or her designee, the Director of the Department of Public Health or his or her designee, the Director of Aging or his or her designee, the Director of Insurance or his or her designee, and the Secretary of the Department of Human Services or his or her designee shall represent their respective departments and shall be invited to attend Commission meetings, but shall not be voting members of the Commission. The departments of State government represented on the Commission shall work cooperatively to provide administrative support for the Commission; the Department of Healthcare and Family Services shall be the primary agency in providing that administrative support.

(c) Voting members of the Commission shall serve for a term of 3 years or until a replacement is named. Of the initial appointees, as determined by lot, 9 members shall serve a term of one year; 9 shall serve for a term of 2 years; and 11 shall serve for a term of 3 years. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which

his or her predecessor was appointed shall be appointed for the remainder of that term. In the event of a vacancy on the Commission, the replacement commissioner shall satisfy the same criteria specified in subsection (a) for appointment (as to who appoints the commissioner and which interest group the commissioner represents) as the prior commissioner being replaced. The Commission shall adopt its own operating rules for matters such as quorums, executive committees, and scheduling of meetings.

Section 12-15. Public forums and reports. The Illinois Health Care Justice Commission shall provide opportunities for 6 regional public hearings annually beginning during its first year of operation. In addition, on January 1, 2011 and each January 1 thereafter, the Commission shall issue a report to the General Assembly on progress in complying with the Illinois Family and Employers Health Care Act, impediments thereto, recommendations of the Commission, and any recommendations for legislative changes necessary to implement the Illinois Family and Employers Health Care Act.

Section 12-20. Powers. The responsibilities of the Illinois Health Care Justice Commission shall include:

(1) Making decisions regarding eligibility and premium assistance for the new health insurance product (Illinois Guaranteed Option).

(2) Making decisions regarding the structure of the employer tax, credit and exemption scenarios outlined in Sections 50-301, 50-302, and 50-303 of the Illinois Shared Responsibility and Shared Opportunity Assessment Act.

(3) Responding to federal and state partnership opportunities regarding health care reform and expansion.

(4) In consultation with the Governor, helping to appoint members of the Illinois Shared Responsibility and Shared Opportunity Trust Fund Financial Oversight Panel, as established in Section 50-703 of the Illinois Shared Responsibility and Shared Opportunity Assessment Act.

(5) Establishing ad hoc commissions to consider the following health care workforce and cost containment issues:

(A) Assessment of state healthcare workforce trends, training issues and financing policies including workforce supply and distribution, cultural competence and minority participation in health professions education, primary care training and practice.

(B) Assessment of loan repayment assistance for physicians, dentists and allied health professionals.

(C) Creation of a strategic plan to implement a statewide system of chronic care infrastructure, prevention of chronic conditions and chronic care management.

(D) Lowering of administrative costs by simplifying the claims administration process for consumers, healthcare providers, and others and where possible, harmonizing the claims processing system for state healthcare programs with those used by private insurers.

Section 12-25. Funding. The Illinois Health Care Justice Commission shall be funded, in part, through the budget of the Illinois Department of Healthcare and Family Services and funds designated to the State of Illinois through federal economic stimulus plan of 2009.

ARTICLE 15. HELPING FAMILIES AFFORD HEALTH INSURANCE

Section 15-1. Short title. This Article may be cited as the Illinois Guaranteed Option Premium Assistance Program Act. All references in this Article to "this Act" mean this Article.

Section 15-80. The Illinois Public Aid Code is amended by adding Sections 1-12 and 1-13 as follows:

(305 ILCS 5/1-12 new)

Sec. 1-12. Premium Assistance.

(a) Subject to the availability of funds, the Department may provide premium assistance for eligible persons under this

Section to assist such persons or families in affording qualified private health insurance including employer-sponsored health insurance for themselves or their family members. Such premium assistance will be based on financial need with greater levels of assistance being provided to those with lowest income. Based on the availability of funding, the Department in consultation with the Illinois Health Care Justice Commission will determine the level of premium assistance available to individuals and families. If necessary to maximize receipt of federal matching funds, the Department may by rule make modifications to the premium assistance program.

(b) To be eligible for premium assistance, a person must:

(1) be a resident of Illinois,

(2) reside legally in the United States, and

(3) have family income at or below the level set by the Department based on the availability of funds but in no instance will such income threshold be above 400% of the federal poverty income guidelines.

(c) Premium assistance payments will commence only after a person is actually enrolled in qualified health insurance.

(d) The Department shall coordinate eligibility for premium assistance with eligibility for other public healthcare benefit programs.

(e) The following definitions shall apply to this Section:

(1) "Department" means the Department of Healthcare

and Family Services.

(2) "Employer-sponsored health insurance" means health insurance obtained as a benefit of employment.

(3) "Qualified health insurance" means any health insurance coverage as defined in Section 2 of the Comprehensive Health Insurance Plan Act.

(4) "Premium assistance" means payments made on behalf of an individual to offset the costs of paying premiums to secure qualified health insurance for that individual or that individual's family under family coverage.

(f) The Department may promulgate rules to implement this Section.

(305 ILCS 5/1-13 new)

Sec. 1-13. Exchange of information. The Director of Revenue may exchange information with the Department of Healthcare and Family Services and the Department of Human Services for the purpose of determining eligibility for health benefit programs administered by those departments, for verifying sources and amounts of income, and for other purposes directly connected with the administration of those programs.

ARTICLE 18. INSURANCE FAIRNESS ACT

Section 18-5. The Illinois Insurance Code is amended by changing Sections 359a and 370c, by adding Section 352b, and by

adding the heading of Article XLV and Sections 1500-5, 1500-10, 1500-15, 1500-20, 1500-25, and 1500-30 as follows:

(215 ILCS 5/352b new)

Sec. 352b. Group health plan non-discrimination requirement. On and after June 1, 2010, no group policy or certificate of accident and health insurance otherwise subject to applicable provisions of this Code shall be delivered or issued for delivery to an employer group in this State unless such policy or certificate is offered by that employer to all full-time employees who live in Illinois; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each policy or certificate of accident and health insurance for all employees. Notwithstanding any provision of this Section, an insurer may deliver or issue a group policy or certificate of accident and health insurance to an employer group that establishes separate contribution percentages for employees covered by collective bargaining agreements as negotiated in those agreements.

(215 ILCS 5/359a) (from Ch. 73, par. 971a)

Sec. 359a. Application.

(1) ~~No~~ On and after June 1, 2010, no individual or group policy or certificate of insurance except an Industrial

Accident and Health Policy provided for by this article shall be issued, except upon the signed application of the person or persons sought to be insured. Any information or statement of the applicant shall plainly appear upon such application in the form of interrogatories by the insurer and answers by the applicant. The insured shall not be bound by any statement made in an application for any policy, including an Industrial Accident and Health Policy, unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within fifteen days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal. On and after June 1, 2010, all individual and group applications for insurance that require health information or questions shall comply with the following standards:

(A) Insurers may ask diagnostic questions on applications for insurance.

(B) Application questions shall be formed in a manner designed to elicit specific medical information and not other inferential information.

(C) Questions which are vague, subjective, unfairly discriminatory, or so technical as to inhibit a clear understanding by the applicant are prohibited.

(D) Questions that ask an applicant to verify diagnosis or treatment for specific diseases or conditions must stipulate that such diagnoses must have been made and such treatment must have been performed by an appropriately licensed health care service provider.

(E) All underwriting shall be based on individual review of specific health information furnished on the application, any reports provided as a result of medical examinations performed at the company's request, medical record information obtained from the applicant's health care providers, or any combination of the foregoing. Adverse underwriting decisions shall not be based on ambiguous responses to application questions.

(F) Preexisting condition exclusions imposed based solely on responses to an application question may exclude only a condition that was specifically elicited in the application and may not be broadened to similar, but separate conditions that were not specifically identified by an application question.

(2) No alteration of any written application for any such

policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(3) On and after June 1, 2010, the falsity of any statement in the application for any policy covered by this Act may not bar the right to recovery thereunder unless such false statement has actually contributed to the contingency or event on which the policy is to become due and payable and unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer. Provided, however, that any recovery resulting from the operation of this Section shall not bar the right to render the policy void in accordance with its provisions. ~~The falsity of any statement in the application for any policy covered by this act may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.~~

(Source: Laws 1951, p. 611.)

(215 ILCS 5/370c) (from Ch. 73, par. 982c)

(Text of Section before amendment by P.A. 95-1049)

Sec. 370c. Mental and emotional disorders.

(a) (1) On and after the effective date of this Section, every insurer which delivers, issues for delivery or renews or

modifies group A&H policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall offer to the applicant or group policyholder subject to the insurers standards of insurability, coverage for reasonable and necessary treatment and services for mental, emotional or nervous disorders or conditions, other than serious mental illnesses as defined in item (2) of subsection (b), up to the limits provided in the policy for other disorders or conditions, except (i) the insured may be required to pay up to 50% of expenses incurred as a result of the treatment or services, and (ii) the annual benefit limit may be limited to the lesser of $10,000 or 25% of the lifetime policy limit.

(2) Each insured that is covered for mental, emotional or nervous disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist of his choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed

psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his profession.

(3) Insofar as this Section applies solely to licensed clinical social workers, licensed clinical professional counselors, and licensed marriage and family therapists, those persons who may provide services to individuals shall do so after the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist has informed the patient of the desirability of the patient conferring with the patient's primary care physician and the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist has provided written notification to the patient's primary care physician, if any, that services are being provided to the patient. That notification may, however, be waived by the patient on a written form. Those forms shall be retained by the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist for a period of not less than 5 years.

(b) (1) An insurer that provides coverage for hospital or medical expenses under a group policy of accident and health insurance or health care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the

92nd General Assembly shall provide coverage under the policy for treatment of serious mental illness under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. The coverage required under this Section must provide for same durational limits, amount limits, deductibles, and co-insurance requirements for serious mental illness as are provided for other illnesses and diseases. This subsection does not apply to coverage provided to employees by employers who have 50 or fewer employees.

(2) "Serious mental illness" means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

(A) schizophrenia;

(B) paranoid and other psychotic disorders;

(C) bipolar disorders (hypomanic, manic, depressive, and mixed);

(D) major depressive disorders (single episode or recurrent);

(E) schizoaffective disorders (bipolar or depressive);

(F) pervasive developmental disorders;

(G) obsessive-compulsive disorders;

(H) depression in childhood and adolescence;

(I) panic disorder;

(J) post-traumatic stress disorders (acute, chronic, or with delayed onset); and

(K) anorexia nervosa and bulimia nervosa.

(3) Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. An insurer shall provide a mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or herself), the patient's provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity of a treatment proposed by a patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for serous mental illness, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process.

(4) A group health benefit plan:

(A) shall provide coverage based upon medical necessity for the following treatment of mental illness in each calendar year:

(i) 45 days of inpatient treatment; and

(ii) beginning on June 26, 2006 (the effective date of Public Act 94-921), 60 visits for outpatient treatment including group and individual outpatient treatment; and

(iii) for plans or policies delivered, issued for delivery, renewed, or modified after January 1, 2007 (the effective date of Public Act 94-906), 20 additional outpatient visits for speech therapy for treatment of pervasive developmental disorders that will be in addition to speech therapy provided pursuant to item (ii) of this subparagraph (A);

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and

(C) shall include the same amount limits, deductibles, copayments, and coinsurance factors for serious mental illness as for physical illness.

(5) An issuer of a group health benefit plan may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of medication management and shall cover the outpatient visits

under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

(6) An issuer of a group health benefit plan may provide or offer coverage required under this Section through a managed care plan.

(7) This Section shall not be interpreted to require a group health benefit plan to provide coverage for treatment of:

(A) an addiction to a controlled substance or cannabis that is used in violation of law; or

(B) mental illness resulting from the use of a controlled substance or cannabis in violation of law.

(8) (Blank).

(Source: P.A. 94-402, eff. 8-2-05; 94-584, eff. 8-15-05; 94-906, eff. 1-1-07; 94-921, eff. 6-26-06; 95-331, eff. 8-21-07; 95-972, eff. 9-22-08; 95-973, eff. 1-1-09; revised 10-14-08.)

(Text of Section after amendment by P.A. 95-1049)

Sec. 370c. Mental and emotional disorders.

(a) (1) On and after the effective date of this Section, every insurer which delivers, issues for delivery or renews or modifies group A&H policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall offer to the applicant or group policyholder subject to the insurers standards of insurability, coverage for reasonable and necessary treatment

and services for mental, emotional or nervous disorders or conditions, other than serious mental illnesses as defined in item (2) of subsection (b), up to the limits provided in the policy for other disorders or conditions, except (i) the insured may be required to pay up to 50% of expenses incurred as a result of the treatment or services, and (ii) the annual benefit limit may be limited to the lesser of $10,000 or 25% of the lifetime policy limit.

(2) Each insured that is covered for mental, emotional or nervous disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist of his choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his profession.

(3) Insofar as this Section applies solely to licensed clinical social workers, licensed clinical professional counselors, and licensed marriage and family therapists, those persons who may provide services to individuals shall do so after the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist has informed the patient of the desirability of the patient conferring with the patient's primary care physician and the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist has provided written notification to the patient's primary care physician, if any, that services are being provided to the patient. That notification may, however, be waived by the patient on a written form. Those forms shall be retained by the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist for a period of not less than 5 years.

(b) (1) An insurer that provides coverage for hospital or medical expenses under a group policy of accident and health insurance ~~or health care plan~~ amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 92nd General Assembly shall provide coverage under the policy for treatment of serious mental illness under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. The coverage required under this Section must provide for same durational limits,

amount limits, deductibles, and co-insurance requirements for serious mental illness as are provided for other illnesses and diseases. This subsection does not apply to coverage provided to employees by employers who have 50 or fewer employees.

(2) "Serious mental illness" means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

(A) schizophrenia;

(B) paranoid and other psychotic disorders;

(C) bipolar disorders (hypomanic, manic, depressive, and mixed);

(D) major depressive disorders (single episode or recurrent);

(E) schizoaffective disorders (bipolar or depressive);

(F) pervasive developmental disorders;

(G) obsessive-compulsive disorders;

(H) depression in childhood and adolescence;

(I) panic disorder;

(J) post-traumatic stress disorders (acute, chronic, or with delayed onset); and

(K) anorexia nervosa and bulimia nervosa.

(3) (Blank). ~~Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically~~

~~necessary. An insurer shall provide a mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or herself), the patient's provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity of a treatment proposed by a patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for serous mental illness, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process.~~

(4) A group health benefit plan:

(A) shall provide coverage based upon medical necessity for the following treatment of mental illness in each calendar year:

(i) 45 days of inpatient treatment; and

(ii) beginning on June 26, 2006 (the effective date of Public Act 94-921), 60 visits for outpatient treatment including group and individual outpatient treatment; and

(iii) for plans or policies delivered, issued for delivery, renewed, or modified after July 1, 2010 ~~January 1, 2007 (the effective date of Public Act 94-906)~~, 20 additional outpatient visits for speech therapy for treatment of pervasive developmental disorders that will be in addition to speech therapy provided pursuant to item (ii) of this subparagraph (A);

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and

(C) shall include the same amount limits, deductibles, copayments, and coinsurance factors for serious mental illness as for physical illness.

(5) An issuer of a group health benefit plan may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

(6) An issuer of a group health benefit plan may provide or offer coverage required under this Section through a managed

care plan.

(7) This Section shall not be interpreted to require a group health benefit plan to provide coverage for treatment of:

(A) an addiction to a controlled substance or cannabis that is used in violation of law; or

(B) mental illness resulting from the use of a controlled substance or cannabis in violation of law.

(8) (Blank).

(c) This Section shall not be interpreted to require coverage for speech therapy or other habilitative services for those individuals covered under Section 356z.15 ~~356z.14~~ of this Code.

(c)(1) On and after June 1, 2010, coverage for the treatment of mental and emotional disorders as provided by subsections (a) and (b) shall not be denied under the policy provided that services are medically necessary as determined by the insured's treating physician. For purposes of this subsection, "medically necessary" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must be intended to either help restore or maintain the enrollee's

health or prevent deterioration of the enrollee's condition. Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary.

(2) On and after January 1, 2010, all of the provisions for the treatment of and services for mental, emotional, or nervous disorders or conditions, including the treatment of serious mental illness, contained in subsections (a) and (b), and the requirements relating to determinations based on medical necessity contained in subdivision (c)(1) of this Section must be contained in all group and individual Illinois Guaranteed Option plans as defined by the Illinois Guaranteed Option Act.

(Source: P.A. 94-402, eff. 8-2-05; 94-584, eff. 8-15-05; 94-906, eff. 1-1-07; 94-921, eff. 6-26-06; 95-331, eff. 8-21-07; 95-972, eff. 9-22-08; 95-973, eff. 1-1-09; 95-1049, eff. 1-1-10; revised 4-10-09.)

(215 ILCS 5/Art. XLV heading new)

ARTICLE XLV.

(215 ILCS 5/1500-5 new)

Sec. 1500-5. Office of Patient Protection. There is hereby established within the Division of Insurance an Office of Patient Protection to ensure that persons covered by health insurance companies are provided the benefits due them under

this Code and related statutes and are protected from health insurance company actions or policy provisions that are unjust, unfair, inequitable, ambiguous, misleading, inconsistent, deceptive, or contrary to law or to the public policy of this State or that unreasonably or deceptively affect the risk purported to be assumed.

(215 ILCS 5/1500-10 new)

Sec. 1500-10. Powers of Office of Patient Protection. Acting under the authority of the Director, the Office of Patient Protection shall:

(1) have the power as established by Section 401 of this Code to institute such actions or other lawful proceedings as may be necessary for the enforcement of this Code; and

(2) oversee the responsibilities of the Office of Consumer Health, including, but not limited to, responding to consumer questions relating to health insurance.

(215 ILCS 5/1500-15 new)

Sec. 1500-15. Responsibility of Office of Patient Protection. The Office of Patient Protection shall assist health insurance company consumers with respect to the exercise of the grievance and appeals rights established by Section 45 of the Managed Care Reform and Patient Rights Act.

(215 ILCS 5/1500-20 new)

Sec. 1500-20. Health insurance oversight. The responsibilities of the Office of Patient Protection shall include, but not be limited to, the oversight of health insurance companies with respect to:

(1) Improper claims practices (Sections 154.5 and 154.6 of this Code).

(2) Emergency services.

(3) Compliance with the Managed Care Reform and Patient Rights Act.

(4) Requiring health insurance companies to pay claims when internal appeal time frames exceed requirements established by the Managed Care Reform and Patient Rights Act.

(5) Ensuring coverage for mental health treatment, including insurance company procedures for internal and external review of denials for mental health coverage as provided by Section 370c of this Code.

(6) Reviewing health insurance company eligibility, underwriting, and claims practices.

(215 ILCS 5/1500-25 new)

Sec. 1500-25. Powers of the Director.

(a) The Director, in his or her discretion, may issue a Notice of Hearing requiring a health insurance company to appear at a hearing for the purpose of determining the health insurance company's compliance with the duties and responsibilities listed in Section 1500-15.

(b) Nothing in this Article XLV shall diminish or affect the powers and authority of the Director of Insurance otherwise set forth in this Code.

(215 ILCS 5/1500-30 new)

Sec. 1500-30. Operative date. This Article XLV is operative on and after January 1, 2010.

Section 18-10. 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)

(Text of Section before amendment by P.A. 95-958 and 95-1049)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 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, 355.2, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.13, 356z.14, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 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 ~~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. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; revised 4-10-09.)

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 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, 355.2, 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, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 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 ~~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. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; revised 4-10-09.)

(Text of Section after amendment by P.A. 95-1049)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 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, 355.2, 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, 359a ~~356z.14~~, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 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 ~~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. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; revised 4-10-09.)

Section 18-15. The Managed Care Reform and Patient Rights Act is amended by changing Section 45 as follows:

(215 ILCS 134/45)

Sec. 45. Health care services appeals, complaints, and external independent reviews.

(a) A health insurance ~~care~~ plan shall establish and

maintain an appeals procedure as outlined in this Act. Compliance with this Act's appeals procedures shall satisfy a health insurance ~~care~~ plan's obligation to provide appeal procedures under any other State law or rules. All appeals of a health insurance ~~care~~ plan's administrative determinations and complaints regarding its administrative decisions shall be handled as required under Section 50.

(b) Internal appeals.

(1) When an appeal concerns a decision or action by a health insurance ~~care~~ plan, its employees, or its subcontractors that relates to (i) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, or (ii) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, the health insurance ~~care~~ plan must allow for the filing of an appeal either orally or in writing.

(2) On and after June 1, 2010, a health plan must prominently display a brief summary of its appeal requirements as established by this Section, including the manner in which an enrollee may initiate such appeals, in all of its printed material sent to the enrollee as well as on its website.

(3) Upon submission of the appeal, a health insurance ~~care~~ plan must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the plan requires to evaluate the appeal.

(4) The health insurance ~~care~~ plan shall render a decision on the appeal within 24 hours after receipt of the required information.

(5) The health insurance ~~care~~ plan shall notify the party filing the appeal and the enrollee, enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal of its decision orally followed-up by a written notice of the determination.

(6) For all denials of treatment for mental and emotional disorders on and after June 1, 2010, the following requirements shall apply:

(A) A plan's determination that care rendered or to be rendered is inappropriate shall not be made until the plan has communicated with the enrollee's attending mental health professional concerning that medical care. The review shall be made prior to or concurrent with the treatment.

(B) A determination that care rendered or to be rendered is inappropriate shall include the written evaluation and findings of the mental health

professional whose training and expertise is at least comparable to that of the treating clinician.

(C) Any determination regarding services rendered or to be rendered for the treatment of mental and emotional disorders for an enrollee which may result in a denial of reimbursement or a denial of pre-certification for that service shall, at the request of the affected enrollee or provider as defined by Section 370c of the Illinois Insurance Code, include the specific review criteria, the procedures and methods used in evaluating proposed or delivered mental health care services, and the credentials of the peer reviewer.

(D) In making any communication, a plan shall ensure that all applicable State and federal laws to protect the confidentiality of individual mental health records are followed.

(E) A plan shall ensure that it provides appropriate notification to and receives concurrence from enrollees and their attending mental health professional before any enrollee interviews are conducted by the plan.

(7) On and after June 1, 2010, if the enrollee, the enrollee's treating physician, and the health insurance plan agree, or if the Office of Patient Protection established under Section 1500-5 of the Illinois Insurance

Code explicitly allows, the claim determination may be appealed directly to the external independent review as described under subsection (f).

(8) On and after June 1, 2010, except as provided in paragraph (7), an enrollee must exhaust the internal appeal process prior to requesting an external independent review.

(c) For all appeals related to health care services including, but not limited to, procedures or treatments for an enrollee and not covered by subsection (b) above, the health care plan shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection, a health insurance ~~care~~ plan must notify the party filing an appeal, within 3 business days, of all information that the plan requires to evaluate the appeal. The health insurance ~~care~~ plan shall render a decision on the appeal within 15 business days after receipt of the required information. The health insurance ~~care~~ plan shall notify the party filing the appeal, the enrollee, the enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal orally of its decision followed-up by a written notice of the determination.

(d) An appeal under subsection (b) or (c) may be filed by the enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health care provider. A health insurance ~~care~~ plan shall designate a

clinical peer to review appeals, because these appeals pertain to medical or clinical matters and such an appeal must be reviewed by an appropriate health care professional. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal. The written notice of determination required under subsections (b) and (c) shall include (i) clear and detailed reasons for the determination, (ii) the medical or clinical criteria for the determination, which shall be based upon sound clinical evidence and reviewed on a periodic basis, and (iii) in the case of an adverse determination, the procedures for requesting an external independent review under subsection (f).

(e) If an appeal filed under subsection (b) or (c) is denied for a reason including, but not limited to, the service, procedure, or treatment is not viewed as medically necessary, denial of specific tests or procedures, denial of referral to specialist physicians or denial of hospitalization requests or length of stay requests, and on and after June 1, 2010, if the amount of the denial exceeds $250, any involved party may request an external independent review under subsection (f) of the adverse determination.

(f) External independent review.

(1) The party seeking an external independent review shall so notify the health insurance ~~care~~ plan. The health insurance ~~care~~ plan shall seek to resolve all external independent reviews in the most expeditious manner and

shall make a determination and provide notice of the determination no more than 24 hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health or when extended health care services for an enrollee undergoing a course of treatment prescribed by a health care provider are at issue.

(2) On and after June 1, 2010, within 180 ~~Within 30~~ days after the enrollee receives written notice of an adverse determination, if the enrollee decides to initiate an external independent review, the enrollee shall send to the health insurance ~~care~~ plan a written request for an external independent review, including any information or documentation to support the enrollee's request for the covered service or claim for a covered service.

(3) Within 30 days after the health insurance ~~care~~ plan receives a request for an external independent review from an enrollee, the health insurance ~~care~~ plan shall:

(A) provide a mechanism for joint selection of an external independent reviewer by the enrollee, the enrollee's physician or other health care provider, and the health insurance ~~care~~ plan; and

(B) forward to the independent reviewer all medical records and supporting documentation pertaining to the case, a summary description of the applicable issues including a statement of the health

care plan's decision, the criteria used, and the medical and clinical reasons for that decision.

(4) Within 5 days after receipt of all necessary information, the independent reviewer shall evaluate and analyze the case and render a decision that is based on whether or not the health care service or claim for the health care service is medically appropriate. The decision by the independent reviewer is final. If the external independent reviewer determines the health care service to be medically appropriate, the health insurance ~~care~~ plan shall pay for the health care service. On and after June 1, 2010, an external independent review decision may be appealed to the Office of Patient Protection established under Section 1500-5 of the Illinois Insurance Code. In cases in which the Division finds the external independent review determination to have been arbitrary and capricious, the Division, through the Office of Patient Protection, may reverse the external independent review determination.

(5) The health insurance ~~care~~ plan shall be solely responsible for paying the fees of the external independent reviewer who is selected to perform the review.

(6) An external independent reviewer who acts in good faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external independent review,

unless the acts or omissions constitute wilful and wanton misconduct. For purposes of any proceeding, the good faith of the person participating shall be presumed.

(7) Future contractual or employment action by the health insurance ~~care~~ plan regarding the patient's physician or other health care provider shall not be based solely on the physician's or other health care provider's participation in this procedure.

(8) For the purposes of this Section, an external independent reviewer shall:

(A) be a clinical peer;

(B) have no direct financial interest in connection with the case; and

(C) have not been informed of the specific identity of the enrollee.

(g) Nothing in this Section shall be construed to require a health insurance ~~care~~ plan to pay for a health care service not covered under the enrollee's certificate of coverage or policy. (Source: P.A. 91-617, eff. 1-1-00.)

ARTICLE 30. COMMUNITY HEALTH CENTER CONSTRUCTION ACT

Section 30-1. Short title. This Article may be cited as the Community Health Center Construction Act. All references in this Article to "this Act" mean this Article.

Section 30-5. Definitions. In this Act:

"Board" means the Illinois Capital Development Board.

"Community health center site" means a new physical site where a community health center will provide primary health care services either to a medically underserved population or area or to the uninsured population of this State.

"Community provider" means a Federally Qualified Health Center (FQHC) or FQHC Look-Alike (Community Health Center or health center), designated as such by the Secretary of the United States Department of Health and Human Services, that operates at least one federally designated primary health care delivery site in the State of Illinois.

"Department" means the Illinois Department of Public Health.

"Medically underserved area" means an urban or rural area designated by the Secretary of the United States Department of Health and Human Services as an area with a shortage of personal health services.

"Medically underserved population" means (i) the population of an urban or rural area designated by the Secretary of the United States Department of Health and Human Services as an area with a shortage of personal health services or (ii) a population group designated by the Secretary as having a shortage of those services.

"Primary health care services" means the following:

(1) Basic health services consisting of the following:

(A) Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and, if appropriate, physician assistants, nurse practitioners, and nurse midwives.

(B) Diagnostic laboratory and radiologic services.

(C) Preventive health services, including the following:

(i) Prenatal and perinatal services.

(ii) Screenings for breast, ovarian, and cervical cancer.

(iii) Well-child services.

(iv) Immunizations against vaccine-preventable diseases.

(v) Screenings for elevated blood lead levels, communicable diseases, and cholesterol.

(vi) Pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care.

(vii) Voluntary family planning services.

(viii) Preventive dental services.

(D) Emergency medical services.

(E) Pharmaceutical services as appropriate for particular health centers.

(2) Referrals to providers of medical services and other health-related services (including substance abuse

and mental health services).

(3) Patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to federal, State, and local programs that provide or financially support the provision of medical, social, educational, or other related services.

(4) Services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of those individuals).

(5) Education of patients and the general population served by the health center regarding the availability and proper use of health services.

(6) Additional health services consisting of services that are appropriate to meet the health needs of the population served by the health center involved and that may include the following:

(A) Environmental health services, including the following:

(i) Detection and alleviation of unhealthful conditions associated with water supply.

(ii) Sewage treatment.

(iii) Solid waste disposal.

(iv) Detection and alleviation of rodent and parasite infestation.

(v) Field sanitation.

(vi) Housing.

(vii) Other environmental factors related to health.

(B) Special occupation-related health services for migratory and seasonal agricultural workers, including the following:

(i) Screening for and control of infectious diseases, including parasitic diseases.

(ii) Injury prevention programs, which may include prevention of exposure to unsafe levels of agricultural chemicals, including pesticides.

"Uninsured population" means persons who do not own private health care insurance, are not part of a group insurance plan, and are not eligible for any State or federal government-sponsored health care program.

Section 30-10. Operation of the grant program.

(a) The Board, in consultation with the Department, shall establish the Community Health Center Construction Grant Program and may make grants to eligible community providers subject to appropriations out of funds reserved for capital

improvements or expenditures as provided for in this Act. The Program shall operate in a manner so that the estimated cost of the Program during the fiscal year will not exceed the total appropriation for the Program. The grants shall be for the purpose of constructing or renovating new community health center sites, renovating existing community health center sites, and purchasing equipment to provide primary health care services to medically underserved populations or areas as defined in Section 30-5 of this Act or providing primary health care services to the uninsured population of Illinois.

(b) A recipient of a grant to establish a new community health center site must add each such site to the recipient's established service area for the purpose of extending federal FQHC or FQHC Look Alike status to the new site in accordance with federal regulations.

Section 30-15. Eligibility for grant. To be eligible for a grant under this Act, a recipient must be a community provider as defined in Section 30-5 of this Act.

Section 30-20. Use of grant moneys. A recipient of a grant under this Act may use the grant moneys to do any one or more of the following:

(1) Purchase equipment.

(2) Acquire a new physical location for the purpose of delivering primary health care services.

(3) Construct or renovate new or existing community health center sites.

Section 30-25. Reporting. Within 60 days after the first year of a grant under this Act, the grant recipient must submit a progress report to the Department. The Department may assist each grant recipient in meeting the goals and objectives stated in the original grant proposal submitted by the recipient, that grant moneys are being used for appropriate purposes, and that residents of the community are being served by the new community health center sites established with grant moneys.

ARTICLE 50. PROMOTING RESPONSIBILITY FOR HEALTH INSURANCE AND HEALTHCARE COSTS

Section 50-5. Findings. A majority of Illinoisans receive their healthcare through employer sponsored health insurance. The cost of such healthcare has been rising faster than wage inflation. A majority of businesses offer and subsidize such health insurance. However, a growing number of businesses are not offering health insurance. When a business does not offer subsidized health insurance, employees are far more likely to be uninsured and the costs of their healthcare are borne by other payors including other businesses. Likewise, when individuals choose to forgo paying for health insurance, they may still experience illness or be involved in an accident

resulting in high medical costs that are borne by others. This cost shifting is driving up the cost of insurance for responsible businesses who are offering health insurance and other individuals who are purchasing health insurance in the non-group market. It is also shifting costs to State government, and therefore taxpayers, by expanding the costs of current State healthcare programs. Therefore, the General Assembly finds that it is equitable to assess businesses a fee to offset such costs when such a business is not contributing adequately to the cost of healthcare insurance and services for its employees.

PART 1. SHORT TITLE AND CONSTRUCTION

Section 50-101. Short title. This Article may be cited as the Illinois Shared Responsibility and Shared Opportunity Assessment Act. References in this Article to "this Act" mean this Article.

Section 50-105. Construction. Except as otherwise expressly provided or clearly appearing from the context, any term used in this Act shall have the same meaning as when used in a comparable context in the Illinois Income Tax Act as in effect for the taxable year.

PART 2. DEFINITIONS AND MISCELLANEOUS PROVISIONS

Section 50-201. Definitions.

(a) When used in this Act, where not otherwise distinctly expressed or manifestly incompatible with the intent thereof:

"Department" means the Department of Revenue.

"Director" means the Director of Revenue.

"Employer" means any individual, partnership, association, corporation or other legal entity who employs 2 or more full time equivalent employees during the taxable year. The word "employer" shall not include nonprofit entities, as defined by the Internal Revenue Code, that are exclusively staffed by volunteers. The term "employer" does not include the government of the United States, of any foreign country, or of any of the states, or of any agency, instrumentality, or political subdivision of any such government. In the case of a unitary business group, as defined in Section 1501(a)(27) of the Illinois Income Tax Act, the employer is the unitary business group.

"Expenditures for health care" means any amount paid by an employer to provide health care to its employees or their families or reimburse its employees or their families for health care, including but not limited to amounts paid or reimbursed for health insurance premiums where the underlying policy provides or has provided coverage to employees of such employer or their families. Such expenditures include but are not limited to payment or reimbursement for medical care,

prescription drugs, vision care, medical savings accounts, and any other costs to provide health care to an employer's employees or their families.

"Full-time equivalent employees". The number of "full-time equivalent employees" employed by an employer during a taxable year shall be the lesser of (i) the number of persons who were employees of the employer at any time during the taxable year and (ii) the total number of hours worked by all employees of the employer during the taxable year, divided by 1500. In the case of a short taxable year, the denominator shall be 1500 multiplied by the number of days in the taxable year, divided by the number of days in the calendar year.

"Illinois employee" means an employee who is an Illinois resident during the time he or she is performing services for the employer or who has compensation from the employer that is "paid in this State" during the taxable year within the meaning of Section 304(a)(2)(B) of the Illinois Income Tax Act. For purposes of computing the liability under Section 50-301 for a taxable year and the credit under Section 50-302 of this Act, an employee with health care coverage provided by another employer of that employee, or with health care coverage as a dependent through another employer, is not an "Illinois employee" for that taxable year.

"Wages" means wages as defined in Section 3401(a) of the Internal Revenue Code, without regard to the exceptions contained in that Section and without reduction for exemptions

allowed in computing withholding.

(b) Other definitions.

(1) Words denoting number, gender, and so forth, when used in this Act, where not otherwise distinctly expressed or manifestly incompatible with the intent thereof:

(A) Words importing the singular include and apply to several persons, parties or things;

(B) Words importing the plural include the singular; and

(C) Words importing the masculine gender include the feminine as well.

(2) "Company" or "association" as including successors and assigns. The word "company" or "association", when used in reference to a corporation, shall be deemed to embrace the words "successors and assigns of such company or association", and in like manner as if these last-named words, or words of similar import, were expressed.

(3) Other terms. Any term used in any Section of this Act with respect to the application of, or in connection with, the provisions of any other Section of this Act shall have the same meaning as in such other Section.

Section 50-202. Applicable Sections of the Illinois Income Tax Act. All of the provisions of Articles 5, 6, 9, 10, 11, 12, 13 and 14 of the Illinois Income Tax Act which are not inconsistent with this Act shall apply, as far as practicable,

to the subject matter of this Act to the same extent as if such provisions were included herein.

Section 50-203. Severability. It is the purpose of Section 50-301 of this Act to impose a tax upon the privilege of doing business in this State, so far as the same may be done under the Constitution and statutes of the United States and the Constitution of the State of Illinois. If any clause, sentence, Section, provision, part, or credit included in this Act, or the application thereof to any person or circumstance, is adjudged to be unconstitutional, then it is the intent of the General Assembly that the tax imposed and the remainder of this Act, or its application to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

PART 3. TAX IMPOSED

Section 50-301. Tax imposed.

(a) A tax is hereby imposed on each employer for the privilege of doing business in this State at the rate of 1.5% of the wages paid to Illinois employees by the employer during the taxable year for firms with fewer than 10 full-time equivalent employees; at the rate of 3.0% of the wages paid to Illinois full-time equivalent employees by the employer during the taxable year for employers with between 10 and 24 full-time

equivalent employees; at the rate of 4.0% of the wages paid to Illinois full-time equivalent employees by the employer during the taxable year for firms with between 25 and 99 full-time equivalent employees; at the rate of 5.0% of the wages paid to Illinois full-time equivalent employees by the employer during the taxable year for firms with between 100 and 999 full-time equivalent employees; and at the rate of 6% of the wages paid to Illinois full-time equivalent employees by the employer during the taxable year for firms with 1000 or more full-time equivalent employees, provided that the tax on wages paid by the employer to any single full-time equivalent employee shall not exceed $15,000 for the taxable year.

(b) The tax imposed under this Act shall apply to wages paid on or after January 1, 2010 and shall be paid beginning July 1, 2010 as set forth in Part 4 of this Act and thereafter.

(c) The tax imposed under this Act is a tax on the employer, and shall not be withheld from wages paid to employees or otherwise be collected from employees or reduce the compensation paid to employees.

(d) The tax collected pursuant to this Section shall be deposited in the Illinois Shared Responsibility and Shared Opportunity Trust Fund established by Section 50-701 of this Act.

Section 50-302. Credits.

(a) For each taxable year, an employer whose total

expenditures for health care for Illinois employees equal or exceed 4% of the wages paid to Illinois employees for that taxable year shall be entitled to a full credit against the tax imposed under Section 50-301.

(b) For each taxable year, an employer whose total expenditures for health care for Illinois employees are less than 4% of the wages paid to Illinois employees for that taxable year shall be entitled to a partial credit against the tax imposed under Section 50-301. The partial credit shall be determined by the Illinois Health Care Justice Commission.

(c) If the tax otherwise due under subsection (a) of Section 50-301 of this Act with respect to the wages of any employee of the employer is $15,000, the credit allowed in subsection (a) of this Section shall be computed without taking into account any wages paid to that employee or any expenditures for health care incurred with respect to that Employee.

(d) For purposes of determining whether total expenditures for health care for Illinois employees equal or exceed 4% of the wages paid to Illinois employees for a taxable year, the wages paid to and expenditures for health care for any Illinois employee with health care coverage provided by another employer of that employee, or with health care coverage as a dependent through another employer, shall be disregarded.

Section 50-303. Exemptions. Start-up businesses with 5 or

fewer full-time equivalent employees will be exempt from paying this tax during their first 3 tax years of operation.

PART 4. PAYMENT OF ESTIMATED TAX

Section 50-401. Returns and notices.

(a) In General. Except as provided by the Department by regulation, every employer qualified to do business in this State at any time during a taxable year shall make a return under this Act for that taxable year.

(b) Every employer shall keep such records, render such statements, make such returns and notices, and comply with such rules and regulations as the Department may from time to time prescribe. Whenever in the judgment of the Director it is necessary, he or she may require any person, by notice served upon such person or by regulations, to make such returns and notices, render such statements, or keep such records, as the Director deems sufficient to show whether or not such person is liable for the tax under this Act.

Section 50-402. Payment on due date of return. Every employer required to file a return under this Act shall, without assessment, notice, or demand, pay any tax due thereon to the Department, at the place fixed for filing, on or before the date fixed for filing such return pursuant to regulations prescribed by the Department. In making payment as provided in

this Section, there shall remain payable only the balance of such tax remaining due after giving effect to payments of estimated tax made by the employer under Section 50-403 of this Act for the taxable year, which payments shall be deemed to have been paid on account of the tax imposed by this Act for the taxable year.

Section 50-403. Payment of estimated tax.

(a) Each taxpayer is required to pay estimated tax in installments for each taxable year in the form and manner that the Department requires by rule.

(b) Payment of an installment of estimated tax is due no later than each due date during the taxable year under Article 7 of the Illinois Income Tax Act for payment of amounts withheld from employee compensation by the employer.

(c) The amount of each installment shall be (1) the percentage of employees' wages outlined in Section 50-301 during the period during which the employer withheld the amount of Illinois income withholding that is due on the same date as the installment, minus (2) the credit allowed for the taxable year under Section 50-302 of this Act, multiplied by the number of days during the period in clause (1), divided by 365.

(d) For purposes of Section 3-3 of the Uniform Penalty and Interest Act, a taxpayer shall be deemed to have failed to make timely payment of an installment of estimated taxes due under this Section only if the amount timely paid for that

installment is less than 90% of the amount due under subsection (c) of this Section.

PART 7. ILLINOIS SHARED RESPONSIBILITY AND SHARED OPPORTUNITY TRUST FUND

Section 50-701. Establishment of Fund.

(a) There is hereby established a fund to be known as the Illinois Shared Responsibility and Shared Opportunity Trust Fund. There shall be credited to this Fund all taxes collected pursuant to this Act. The Illinois Shared Responsibility and Shared Opportunity Trust Fund shall not be subject to sweeps, administrative charges, or charge-backs, including but not limited to those authorized under Section 8h of the State Finance Act or any other fiscal or budgeting transfer that would in any way transfer any funds from the Illinois Shared Responsibility and Shared Opportunity Trust Fund into any other fund of the State, except to repay funds transferred into this Fund.

(b) Interest earnings, income from investments, and other income earned by the Fund shall be credited to and deposited into the Fund.

Section 50-702. Use of Fund.

(a) Amounts credited to the Illinois Shared Responsibility and Shared Opportunity Trust Fund shall be available

exclusively for providing affordable health care coverage for working families and employers in Illinois, including, without limitation, premium assistance, establishing and maintaining reinsurance to keep health care affordable, and administering and enforcing insurance market reforms, as well as providing additional improvements to the healthcare system. Moneys that have been deposited in the Trust Fund may be used to maximize federal funds, so long as all moneys are expended in a manner fully consistent with the purposes set forth in this Section.

(b) Not later than December 31 of each fiscal year, the Governor's Office of Management and Budget shall prepare estimates of the revenues to be credited to the Trust Fund in the subsequent fiscal year and shall provide this report to the General Assembly. In order to maintain the integrity of the Illinois Shared Responsibility and Shared Opportunity Trust Fund, for fiscal year 2010 through fiscal year 2012, the total amount of expenditures from the Illinois Shared Responsibility and Shared Opportunity Trust Fund shall be limited to each fiscal year in relation to 90% of revenues generated during such fiscal year.

(c) Beginning on or after July 1 of Fiscal Year 2010, the General Assembly shall make appropriations of such estimated revenues to the various programs authorized to be funded. If revenues credited to the Illinois Shared Responsibility and Shared Opportunity Trust Fund are less than the amounts estimated, the Governor's Office of Management and Budget shall

notify the General Assembly of such deficiency and shall notify the Departments administering the programs funded from the Trust Fund that the revenue deficiency shall require proportionate reductions in expenditures from the revenues available to support programs appropriated from the Illinois Shared Responsibility and Shared Opportunity Trust Fund.

Section 50-703. The Illinois Shared Responsibility and Shared Opportunity Trust Fund Financial Oversight Panel.

(a) Creation. In order to maintain the integrity of the Illinois Shared Responsibility and Shared Opportunity Trust Fund, prior to July 1, 2010, the Department shall create the Illinois Shared Responsibility and Shared Opportunity Trust Fund Financial Oversight Panel to monitor the revenues and expenditures of the Trust Fund and to furnish information regarding the Illinois programs to the Governor and the members of the General Assembly.

(b) Membership. The Oversight Panel shall consist of 7 non-State employee members appointed by the Governor in consultation with the Healthcare Justice Commission. Each Panel member shall possess knowledge, skill, and experience in at least one of the following areas of expertise: accounting, actuarial practice, risk management, investment management, management and accounting practices specific to health insurance administration, administration of public aid public programs, or public sector fiscal management. Panel members

shall serve 3-year terms. If appropriate, the terms may be modified at the Panel's inception to ensure a quorum. The Governor shall bi-annually appoint a Chairman and Vice-Chairman. Any person appointed to fill a vacancy on the Panel shall be appointed in a like manner and shall serve only the unexpired term. Panel members shall be eligible for reappointment. Panel members shall serve without compensation and be reimbursed for expenses.

(c) Statements of economic interest. Before being installed as a member of the Panel, each appointee shall file verified statements of economic interest with the Secretary of State as required by the Illinois Governmental Ethics Act and with the Board of Ethics as required by the Executive Order of the Governor.

(d) Advice and review. The Panel shall offer advice and counsel regarding the Illinois Shared Responsibility and Shared Opportunity Trust Fund with the objective of expanding access to affordable health care within the financial constraints of the Trust Fund. The Panel is required to review, and advise the Department, the General Assembly, and the Governor on, the financial condition of the Trust Fund.

(e) Management. Upon the vote of a majority of the Panel, the Panel shall have the authority to compensate for professional services rendered with respect to its duties and shall also have the authority to compensate for accounting, computing, and other necessary services.

(f) Semi-annual accounting and audit. The Panel shall semi-annually prepare or cause to be prepared a semi-annual report setting forth in appropriate detail an accounting of the Trust Fund and a description of the financial condition of the Trust Fund at the close of each fiscal year, including: semi-annual revenues to the Trust Fund, semi-annual expenditures from the Trust Fund, implementation and results of cost-saving measures, program utilization, and projections for program development.

If the Panel determines that insufficient funds exist in the Trust Fund to pay anticipated obligations in the next succeeding fiscal year, the Panel shall so certify in the semi-annual report the amount necessary to meet the anticipated obligations. The Panel's semi-annual report shall be directed to the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, and the Minority Leader of the House of Representatives.

PART 8. SEVERABILITY

Section 50-801. Severability. It is the purpose of Section 50-301 of this Act to impose a tax upon the privilege of doing business in this State, so far as the same may be done under the Constitution and statutes of the United States and the Constitution of the State of Illinois. If any clause, sentence, Section, provision, part, or credit included in this Act, or

the application thereof to any person or circumstance, is adjudged to be unconstitutional, then it is the intent of the General Assembly that the tax imposed and the remainder of this Act, or its application to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

ARTICLE 95. NO ACCELERATION OR DELAY

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