AN ACT concerning insurance.

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

Section 1. Short title. This Act may be cited as the Health Insurance Rate Review Act.

Section 5. Definitions. For the purposes of this Act:

"Board" means the Health Insurance Rate Review Board.

"Director" means the Director of Insurance.

"Health benefit plan" means a policy, contract, certificate, plan, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, or any other entity providing a plan of health insurance, health benefits, or health care services. "Health

carrier" also means Limited Health Service Organizations and Voluntary Health Service Plans.

"Insured" means an individual who is enrolled in or otherwise participating in a health benefit plan.

"Rate" means premium, deductible, co-payment, or any other amount that the health carrier requires its policyholders to pay.

"Supplementary rating information" means any manual, rating schedule, plan of rules, rating rules, classification systems, territory codes and descriptions, rating plans, and other similar information used by the insurer or health maintenance organization to determine the applicable rates for an insured. The term includes factors and relativities, including increased limits factors, classification relativities, deductible relativities, premium discount, and other similar factors and rating plans such as experience, schedule, and retrospective rating.

Section 10. Health Insurance Rate Review Board.

(a) There is created the Health Insurance Rate Review Board independent of the Department of Insurance to ensure insurance rates are reasonable and justified. The Board shall be a quasi-judicial body. The Board shall consist of 5 persons appointed, with the advice and consent of the Senate, by the Governor with the assistance of a Nomination Panel. The term of each member of the Board shall be 4 years.

(b) No member of the Board shall be involved in the operation or management of, have a pecuniary interest or a direct financial interest in, or be otherwise employed by a health carrier or any other organization or entity regulated by the Department of Insurance.

(c) Each member of the Board shall devote his or her entire time to the duties of his or her office, and shall hold no other office or position of profit, or engage in any other business, employment, or vocation.

(d) No member of the Board or person employed by the Board shall solicit or accept any gift, gratuity, emolument, or employment from any person or corporation subject to the supervision of the Board, or from any officer, agent, or employee thereof; nor solicit, request from, or recommend, directly or indirectly, to any such person or corporation, and every officer, agent, or employee thereof, the appointment of any persons to any place or position. If any Board member or person employed by the Board violates any provisions of this subsection (d), then he or she shall be removed from the Board or employment. Every person violating the provisions of this subsection (d) shall be guilty of a Class A misdemeanor.

(e) No former member of the Board or person formerly employed by the Board may represent any person before the Board in any capacity with respect to any particular Board proceeding in which he or she participated personally and substantially as a member or employee of the Board.

(f) No former member of the Board may appear before the Board in connection with any Board proceeding for a period of 2 years following the termination of service with the Board.

(g) No former member of the Board may accept any employment for 2 years following the termination of services with the Board with any entity subject to Board regulation or with any industry trade association that (1) receives a majority of its funding from entities regulated by the Board or (ii) has a majority of members regulated by the Board.

(h) No entity subject to Board regulation or trade association that (i) receives a majority of its funding from entities regulated by the Board or (ii) has a majority of members regulated by the Board shall offer a former member of the Board employment for a period of 2 years following the termination of member's services with the Board, or otherwise hire such person as an agent, consultant, or attorney where such employment or contractual relation would be in violation of this Act.

(i) The Board shall employ employees as may be necessary to carry out the provisions of this Act or to perform duties and exercise the powers conferred by law upon the Board.

(j) The Board shall adopt rules that the Board considers necessary to carry out the provisions of this Act or to perform duties and exercise the powers conferred by law upon the Board.

Section 15. Nomination panel.

(a) The Health Insurance Rate Review Board Nomination Panel is established to provide a list of nominees to the Governor for appointment to the Health Insurance Rate Review Board.

The Panel shall consist of 5 members. Members of the Panel must be appointed by majority vote of the following appointing authorities: the Governor, the Director, and the Attorney General. The term of each member of the Panel shall be 4 years. The Panel shall solicit recommendations from consumer advocates, health providers, insurers, and business advocates.

Candidates for nomination to the Health Insurance Rate Review Board may apply or be nominated. The Panel has 30 days after it is established to accept applications and nominations. All candidates must fill out a written application and submit to a background investigation to be eligible for consideration. The written application must include a sworn statement signed by the candidate disclosing communications relating to the regulation of health insurance, managed care plans, and health maintenance organizations that the applicant has engaged in within the last year with a constitutional officer, a member of the General Assembly, an officer or other employee of the executive branch of the State, or an employee of the legislative branch of this State.

A person who provides false or misleading information on the application or fails to disclose a communication required to be disclosed in the sworn statement under this Section is guilty of a Class 4 felony.

Once an application is submitted to the Nomination Panel and until (i) the candidate is rejected by the Nomination Panel, (ii) the candidate is rejected by the Governor, (iii) the candidate is rejected by the Senate, or (iv) the candidate is confirmed by the Senate, whichever is applicable, a candidate may not engage in ex parte communications.

Within 60 days after the Nomination Panel is established, the Nomination Panel must review written applications, determine eligibility for oral interviews, confirm satisfactory background investigations, and hold public hearings on qualifications of the candidates. Initial interviews of candidates need not be held in meetings subject to the Open Meetings Act; members or staff may arrange for informal interviews. Prior to recommendation, however, the Nomination Panel must question candidates under oath in a meeting subject to the Open Meetings Act.

The Nomination Panel must recommend 10 nominees for appointment to the Health Insurance Rate Review Board within 60 days after the Nomination Panel is established. The Governor may choose only from these nominations. The Nomination Panel shall deliver a list of the nominees, including a memorandum detailing the nominees' qualifications, to the Governor. After submitting the list to the Governor, the Nomination Panel shall file a copy along with a statement confirming delivery of the list and memorandum to the Governor with the Secretary of State. The Secretary of State shall indicate the date and time

of filing.

After reviewing the nominations, the Governor may select 5 nominees, including the chairperson, for appointment to the Health Insurance Rate Review Board, to be confirmed by the Senate. The Governor shall file the names of his or her appointments with the Senate and the Secretary of State. The Secretary of State shall indicate the date and time of filing.

The Governor shall have 30 days from the date the Nomination Panel files its list of nominees with the Secretary of State to make appointments to be confirmed by the Senate. If the Governor does not select all appointees within the 30 days, the Nomination Panel may appoint those members not yet selected for appointment by the Governor. The Nomination Panel shall file the names of its appointments with the Senate and the Secretary of State. The Secretary of State shall indicate the date and time of filing.

Appointments by the Governor or Nomination Panel must be confirmed by the Senate by two-thirds of its members by record vote. Any appointment not acted upon within 30 calendar days after the date of filing the names of appointments with the Secretary of State shall be deemed to have received the advice and consent of the Senate.

(b) When a vacancy occurs on the Health Insurance Rate Review Board, the Nomination Panel shall accept applications and nominations of candidates for 30 days from the date the vacancy occurs. All candidates must fill out a written

application and submit to a background investigation to be eligible for consideration. The written application must include a sworn statement signed by the candidate disclosing communications relating to the regulation of health insurance, managed care plans, and health maintenance organizations that the applicant engaged in within the last year with a constitutional officer, a member of the General Assembly, an officer or other employee of the executive branch of this State, or an employee of the legislative branch of this State.

A person who provides false or misleading information on the application or fails to disclose a communication required to be disclosed in the sworn statement under this Section is guilty of a Class 4 felony.

Once an application is submitted to the Nomination Panel and until (i) the candidate is rejected by the Nomination Panel, (ii) the candidate is rejected by the Governor, (iii) the candidate is rejected by the Senate, or (iv) the candidate is confirmed by the Senate, whichever is applicable, a candidate may not engage in ex parte communications.

The Nomination Panel must review written applications, determine eligibility for oral interviews, confirm satisfactory background investigations, and hold public hearings on the qualifications of the candidates. Initial interviews of candidates need not be held in meetings subject to the Open Meetings Act; members or staff may arrange for informal interviews. Prior to recommendation, however, the

Nomination Panel must question candidates under oath in a meeting subject to the Open Meetings Act.

The Nomination Panel must recommend 2 nominees for the vacancy within 60 days after the vacancy occurs. Within 30 days after the Nomination Panel's recommendation, the Governor shall appoint one of the nominees to fill the vacancy for the remainder of the unexpired term. If the Governor does not fill the vacancy within the 30 days, the Nomination Panel may make the appointment. Vacancies shall be confirmed by the Senate in the same manner as full-term appointments

Section 20. Filing and approval of rates and rate schedules.

(a) Notwithstanding any law to the contrary, a health carrier may not deliver or issue for delivery any health benefit plan after the effective date of this Act unless:

(1) the health carrier has filed with the Health Insurance Rate Review Board:

(a) all current and proposed rates and rate schedules of the health benefit plan; and

(b) if filing changes to a previously approved rate or rate schedule:

(i) proposed changes to the rate or rate schedule;

(ii) an explanation of the changes;

(iii) financial information describing the

basis for the proposed changes;

(iv) the rate of return anticipated if the rate or rate schedule is approved;

(v) the average rate increase or decrease anticipated per insured;

(vi) the medical loss ratio reserves and surpluses anticipated if the rate or rate schedule is approved;

(vii) a summary of the health carrier's nonmedical expenses for the most recent fiscal year;

(viii) supplementary rating information;

(ix) any other information required by the Board by rule; and

(2) the Board has approved the rates and rate schedules of the health benefit plan.

(b) The Board shall review and approve or disapprove all rates and rate schedules filed or used by a health carrier or filed by a rating or advisory organization on behalf of a health carrier.

(c) Within 30 days after the date a rate or rate schedule is filed with the Board, the Board shall:

(1) approve the rate or rate schedule if the Board determines that the rate or rate schedule is not excessive, inadequate, or unfairly discriminatory; or

(2) disapprove the rate or rate schedule if the Board

determines the rate or rate schedule is excessive, inadequate, or unfairly discriminatory.

(d) Except as provided in subsection (e), if a rate or rate schedule has not been approved or disapproved by the Board before the expiration of the 30-day period, the rate or rate schedule is considered approved and the rate or rate schedule may be used.

(e) For good cause, the Board may, on expiration of the 30-day period, extend the period for approval or disapproval of a rate or rate schedule for one additional 30-day period.

(f) If the Board determines that the information filed by a health carrier under this Section is incomplete or otherwise deficient, the Board may request additional information from the health carrier. If the Board requests additional information from the insurer during the 30-day period provided in subsection (c) or under a second 30-day period provided under subsection (e), then the time between the date the that Board submits the request to the health carrier and the date that the Board receives the information requested is not included in the computation of the first 30-day period or the second 30-day period, as applicable.

Section 25. Rate standards.

(a) A rate or rate schedule is excessive if the rate or rate schedule is likely to produce a long-term profit that is unreasonably high in relation to the insurance coverage

provided.

(b) A rate or rate schedule is inadequate if:

(1) the rate or rate schedule is insufficient to sustain projected losses and expenses to which the rate applies; and

(2) the continued use of the rate or rate schedule:

(a) endangers the solvency of an insurer using the rate or rate schedule; or

(b) has the effect of substantially lessening competition or creating a monopoly in a market.

(c) A rate or rate schedule is unfairly discriminatory if the rate or rate schedule:

(1) is not based on sound actuarial principles;

(2) does not bear a reasonable relationship to the expected loss and expense experience among risks; or

(3) is based wholly or partly on the race, creed, color, ethnicity, or national origin of the policyholder or an insured.

Section 30. Public notice of filing.

(a) The Board must issue a notice to the public within 7 days after a filing for approval of a rate or rate schedule is received by the Board. The notice must include:

(1) the filing health carrier;

(2) the current rate or rate schedule;

(3) the proposed rate or rate schedule;

(4) notice that a consumer who is aggrieved by the rate change may request a hearing on the proposed change within 30 days after the proposed change has been filed; and

(5) address and contact information of the Board.

Section 35. Hearings on proposed changes.

(a) Within 30 days after the proposed change to a rate or rate schedule has been filed, the Board may request a hearing on the filing to hear testimony on the filing.

(b) Within 30 days after the proposed change has been filed, any person who is aggrieved with respect to any filing under this Act, the Director, or any public official charged with protecting insurance consumers may submit a request in writing to the Board for a hearing on the filing. The request must specify the grounds for the requester's grievance.

(c) The Board must hold a hearing as requested under subsection (b) not later than 30 days after the date the Board receives the request for hearing if the Board determines that:

(1) the request is made in good faith;

(2) the requester would be aggrieved as alleged if the grounds specified in request were established; and

(3) the grounds specified in the request otherwise justify holding the hearing.

(d) The Board must provide written notice of a hearing to the requester, if any, and each affected health carrier not later than 10 days before the date of the hearing. The Board

shall also provide public notice of the hearing not later than 10 days before the date of the hearing.

(e) If, after the hearing, the Board disapproves of the filing, the Board shall issue an order:

(1) specifying in what respects the filing fails to meet those requirements; and

(2) stating the date on which the filing is no longer in effect, which must be within a reasonable period after the order date.

The Board must send copies of the order to the requester, if any, and each affected health carrier.

Section 40. Hearings on filings in effect.

(a) The Board may disapprove a rate or rate schedule that is in effect only after a hearing. The Board must provide the filer at least 20 days written notice of the hearing.

The Board must issue an order disapproving a rate or rate schedule under this subsection (a) within 15 days after the close of the hearing. The order must:

(1) specify in what respects the filing fails to meet those requirements; and

(2) state the date on which further use of the rate or rate schedule is prohibited.

(b) Any person who is aggrieved with respect to any filing under this Act that is in effect, the Director, or any public official charged with protecting insurance consumers may apply

to the Board in writing for a hearing on the filing. The request must specify the grounds for the requester's grievance.

(c) The Board must hold a hearing as requested under subsection (b) not later than 30 days after the date the Board receives the request for hearing if the Board determines that:

(1) the request is made in good faith;

(2) the requester would be aggrieved as alleged if the grounds specified in request were established; and

(3) the grounds specified in the request otherwise justify holding the hearing.

(d) The Board must provide written notice of a hearing to the requester, if any, and each affected health carrier not later than 10 days before the date of the hearing. The Board shall also provide public notice of the hearing not later than 10 days before the date of the hearing.

(e) If, after the hearing, the Board disapproves of the filing, the Board shall issue an order:

(1) specifying in what respects the filing fails to meet those requirements; and

(2) stating the date on which the filing is no longer in effect, which must be within a reasonable period after the order date.

The Board must send copies of the order to the requester, if any, and each affected health carrier.

Section 45. Disapproval of rate or rate schedule.

(a) If the Board disapproves a filing under this Act, then the Board shall issue an order specifying in what respects the filing fails to meet the requirements of this Act.

(b) The aggrieved filer is entitled to a hearing on written request made to the Board within 30 days after the date the order disapproving the rate or rate schedule filing takes effect.

Section 50. Approval of rate or rate schedule; use of the approved rate or rate schedule. If the board approves a rate or rate schedule filing under this Act, the Board shall provide the health carrier with a written or electronic notification of the approval. The health carrier may use the rate or rate schedule on receipt of the approval notice. The Board shall provide public notice of its approval or disapproval of all filings.