SB3862

LRB10120451BMS70010b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB3862

Introduced 2/14/2020, by Sen. Andy Manar

SYNOPSIS AS INTRODUCED:

215 ILCS 5/355.5 new	
215 ILCS 5/356g	from Ch. 73, par. 968g
215 ILCS 5/356z.4	
215 ILCS 5/356z.37	
215 ILCS 125/4-6.1	from Ch. 111 1/2, par. 1408.7
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2
215 ILCS 165/10	from Ch. 32, par. 604

Amends the Illinois Insurance Code, the Health Maintenance Organization Act, and the Voluntary Health Services Plans Act. Exempts HSA-eligible high deductible health plans from various cost-sharing provisions for insurance coverage under the Illinois Insurance Code, the Health Maintenance Organization Act, the Managed Care Reform and Patients Rights Act, and any other provision of Illinois law that the Department of Insurance may specify by rule or at an insurance company's request pursuant to the policy form filing process, but only until the plan's deductible has been met and only to the minimum extent necessary to allow the policy to satisfy specified federal criteria for health savings accounts. Provides that for insurance policies issued, delivered, amended, or renewed on or after January 1, 2021, companies must identify plans as "HSA-eligible" or "non-HSA". Provides form disclosure language. Provides that for any high deductible non-HSA insurance policy issued, delivered, amended, or renewed on or after January 1, 2020 and before December 31, 2020, insurance companies must offer applicants and policyholders the option to amend the policy to be an HSA-eligible plan by adopting all necessary exemptions. Provides Notice and Election form language which allows applicants or policyholders to adjust a policy's coverage to be eligible to contribute to a health savings account. Provides requirements for insurance companies concerning filing and receipt of Notice and Election forms, adjustments to terms of coverage, and issuance of riders or endorsements. Defines "HSA-eligible HDHP" and "high deductible non-HSA policy". Removes exemptions from prohibitions against imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on required insurance coverage. Effective immediately, except certain provisions take effect on January 1, 2021.

LRB101 20451 BMS 70010 b

A BILL FOR

AN ACT concerning regulation.

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

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

(215 ILCS 5/355.5 new)

Sec. 355.5. Eligibility for health savings accounts.

(a) In this Section:

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

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

(b) Exemptions for an HSA-eligible HDHP.

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

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

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

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

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

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

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

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

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

(2) Notwithstanding any other provision of this

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

(c) For any HSA-eligible HDHP issued, delivered, amended, or renewed on or after January 1, 2021, a company shall expressly identify the policy as HSA-eligible in all policy forms and in all sales and marketing materials. Any name or title of a product that is an HSA-eligible HDHP shall include the term "HSA-eligible".

(d) For all policies issued, delivered, amended, or renewed on or after January 1, 2021, unless the policy is an HSA-eligible HDHP, no company shall use the terms "HSA-eligible", "HSA", "for HSAs", "high deductible health plan", "HDHP", or any substantially similar term or phrase, to describe a policy of individual or group accident and health insurance coverage in any policy form or related sales or marketing materials. For all policies in effect on or after the effective date of this amendatory Act of the 101st General Assembly, a company or producer shall not in any way represent that a policy not satisfying the definition in subsection (a) is an HSA-eligible HDHP.

(e) For high deductible non-HSA policies issued, delivered, amended, or renewed on or after January 1, 2021, the company shall use the term "non-HSA" in any name or title of the product found in its policy form, as well as in all sales and marketing materials. Any policy, certificate, evidence of coverage, or outline of coverage for a high deductible non-HSA policy shall include a statement substantially the same as the following within the first 2 pages of substantive text: "Pursuant to Section 355.5 of the Illinois Insurance Code, we are required to disclose that the coverage provided under this policy may not qualify as a high deductible health plan under 26 U.S.C. 223. As a result, your enrollment under this policy may not qualify you as an eligible individual to contribute to a health savings account.".

(f) Except as provided in subsection (g), no company is required to offer an HSA-eligible HDHP merely because it offers a high deductible non-HSA policy, or vice versa.

(g)(1) This subsection shall apply only to the large group market and only with respect to large employer applicants for a group policy and large employer policyholders whose coverage a company will renew or offer to renew.

(2) For any high deductible non-HSA policy issued, delivered, amended, or renewed no later than December 31, 2020 based on an application or renewal notice issued at least 30 days after the effective date of this amendatory Act of the 101st General Assembly, the company shall offer all applicants

and policyholders of such policies the option to amend their coverage to be an HSA-eligible HDHP by adopting all necessary exemptions under subsection (b). With an application form or renewal notice issued or displayed at least 30 days after the effective date of this amendatory Act of the 101st General Assembly the company shall provide a Notice and Election form to the applicant or policyholder containing the following text in quotations. Brackets denote variable text, while parentheses enclose instructions about the use of the variable text:

"NOTICE AND ELECTION REGARDING ELIGIBILITY FOR HEALTH SAVINGS ACCOUNT

Under Section 355.5 of the Illinois Insurance Code, we are required to notify you that, because of temporary inconsistencies between state and federal laws, the coverage provided under this policy may not currently qualify any of your enrolled employees as an eligible individual to make contributions to a health savings account. A health savings account, also known as an HSA, is a specific type of account with federal tax advantages that can be used to pay for qualified medical expenses. An HSA is not the same as a flexible spending account, a health reimbursement arrangement, or some other arrangements that help consumers pay for their medical expenses. The State of Illinois has amended its laws so that health insurance coverage

issued, delivered, amended, or renewed in 2021 or later will not conflict with federal laws regarding HSAs.

For the meantime, though, if you want your coverage under this policy to allow employees to contribute to an HSA, then you MUST return this Notice and Election to us with your signature and a mark in the "YES" box below. You may also wish to return this Notice and Election if you or your employees have already contributed to an employee HSA at any time since January 1, 2020. By returning this form to us with your signature and a mark for "YES", you expressly will allow us to adjust the terms of your coverage as follows:

1. Your enrolled employees will be responsible to pay out-of-pocket for all costs associated with the benefits for a comprehensive ultrasound screening or MRI of an entire breast or breasts until before they have met their deductible. Once they have met their deductible, they will receive these benefits without any further cost-sharing.

2. For prescription drugs, we will NOT apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses toward your enrolled employees' deductible for this coverage. Only the payments that they make themselves will count toward the deductible.

IMPORTANT: Nothing here will prevent your enrolled employees from accepting or using these discounts, coupons, and other reductions in out-of-pocket expenses when they pay for their prescription. We simply will not be able to count toward their deductible any amounts that they do not pay for themselves. Once they have met the deductible, if they subsequently receive any of these discounts, coupons, or other reductions for prescription drugs during the current policy term, the amount of that reduction WILL be counted toward all other applicable cost-sharing requirements for their coverage, such as a copay, coinsurance, and out-of-pocket maximum.

[3. Your enrolled employees will be responsible to pay out-of-pocket for all costs associated with the benefit for a whole body skin examination until they have met their deductible. Once they have met the deductible, they will receive these benefits without any further cost-sharing. (This clause 3 must be included in the Notice and Election form if and only if the existing policy does not impose cost-sharing requirements for whole body skin examinations at least until the deductible is reached.)]

[[3.] [4.] Your enrolled employees will be responsible to pay out-of-pocket for all costs associated with the benefit for voluntary male

sterilization before they have met their deductible. Once they have met the deductible, they will receive these benefits without any further cost-sharing. (This clause 3 or 4 must be included in the Notice and Election form if and only if the existing policy does not impose cost-sharing requirements on voluntary male sterilization at least until the deductible is reached.)]

[If the company intends to adjust the premium) Based on these changes, the premium contributions for this policy term will be adjusted as follows:...]

Besides the [two/three/four] changes above [and the associated adjustment to your premium (if applicable)], returning this Notice and Election with your signature will not cause any other adjustments to be made to your coverage during the upcoming policy term. The adjustments to your policy will take effect on the first day of the term.

IF YOU WANT US TO ADJUST YOUR COVERAGE IN TIME TO ALLOW ELIGIBILITY TO CONTRIBUTE TO AN HSA DURING THE YEAR 2020, WE MUST RECEIVE YOUR SIGNED NOTICE AND ELECTION WITH A "YES" MARK NO LATER THAN THE BUSINESS DAY BEFORE YOUR POLICY TERM BEGINS, AND YOUR POLICY TERM MUST BEGIN NO LATER THAN DECEMBER 1, 2020. If you do not intend this coverage to be used for employee HSAs during the upscoming policy period, you may

disregard this Notice and Election.

Please mark this box if applicable:

"YES", adjust this coverage to allow eligibility to contribute to an HSA under this policy.

IMPORTANT: We are providing this Notice and Election as required under Illinois law. It is not intended to be tax advice or legal advice from us to you or your employees. The requirements for HSAs are based on the federal Internal Revenue Code and are enforced by the federal Internal Revenue Service. Even if you elect "YES" under this form, federal tax penalties may apply to some contributions to an HSA under some circumstances. If you need advice about how or whether to be eligible to contribute to an HSA, or how to avoid or minimize federal tax penalties with an HSA, please consult a qualified tax professional. The IRS also provides guidance about HSAs in its Publication 969, which may be found online at www.irs.gov.

Sincerely,

[Company Executive Officer Signature]

For the Group Applicant/Policyholder

Group Applicant/Policyholder Name:

Authorized Representative Name and Title:

Authorized Representative

Signature: ..... Date:]"

(3)(A) Within 30 days after the effective date of this amendatory Act of the 101st General Assembly, a company that offers or provides coverage under a high deductible non-HSA policy subject to this subsection (g) shall file its Notice and Election forms with the Director. In this filing, the company shall identify the System for Electronic Rates and Form Filing (SERFF) tracking numbers, form numbers, and dates of approval of the policies, certificates, and evidences of coverage that will be affected by a Notice and Election form. Besides the contents within the brackets, a company may modify the statutory text of the Notice and Election form to reflect defined terms from the underlying policy, certificate, or evidence of coverage. The company must submit a complete filing before issuing a Notice and Election form to any applicant or policyholder. If the Director finds that this filing does not comply with any requirements of this Section, he or she may order the company to discontinue its use and to resubmit a corrected form. No right to an administrative hearing shall apply to this order.

(B) Not later than 60 days after the effective date of this amendatory Act of the 101st General Assembly, a company that offers or provides coverage under a high deductible non-HSA policy subject to this subsection (g) shall file rider or endorsement policy forms with the

Director for approval. The rider or endorsement shall reflect only the changes that will be made to the terms and conditions of the policy, contract, certificate, evidence of coverage, or other policy form based on a "YES" election made under the Notice and Election form. The company shall identify in such filings the System for Electronic Rates and Form Filing (SERFF) tracking numbers, form numbers, and dates of approval of the policy forms whose terms and conditions will be amended. The Director shall have 45 days to approve or disapprove the rider or endorsement policy forms upon receipt of a complete filing. Failure to approve, disapprove, or take an extension by that deadline shall be deemed an approval.

(C) No signature of acceptance shall be required on the rider or endorsement form, provided that such rider or endorsement shall only be issued to a person who has returned a signed Notice and Election form that has been filed with the Director.

(D) If a company will simultameously adjust the premium of a large group policy based on an amendment elected under this subsection (g), the company shall submit a rate filing with the rider or endorsement policy form filing to demonstrate the calculation of the new rates.

(E) Except as modified by this paragraph (3), the provisions of subsection (1) of Section 143 and Section 355 of this Code, and the rules adopted thereunder, shall apply

to this form filing procedure.

(4)(A) Upon receipt of a Notice and Election signed by, or on behalf of, an applicant or policyholder under this subsection, a company shall apply the exemptions in subsection (b) of this Section as necessary to adjust the applicant or policyholder's coverage to become an HSA-eligible HDHP as reflected in the approved rider or endorsement for that policy. The changes to the terms and conditions of coverage shall be deemed effective on the date of the policy's inception or renewal, whichever is later.

(B) At the time of issuing the policy, certificate, or evidence of coverage or any renewal thereof or within 10 days after receiving the Director's approval under paragraph (3) above, whichever is later, the company shall issue a rider or endorsement to each group policyholder, and to each enrollee in a group policy, that specifies the changes to the terms of coverage. The company shall attach a copy of the signed Notice and Election to the rider or endorsement.

(C) The company's receipt of the signed Notice and Election shall be deemed to satisfy any Illinois requirement for a rider or endorsement to be signed by the enrollee.

(D) Other than the premium rate to be charged, the effective date of the adjustments in coverage shall not be

delayed by the absence of a rider or endorsement policy form with the Department's approval.

(5) A company may electronically issue and receive the Notice and Election form, as well as any resulting rider or endorsement, to the extent consistent with applicable law.

(6) If a company, in its policy forms or marketing materials, already expressly describes any of its policies in the Illinois large group market as pertaining to an HSA or a health savings account, or as being an HDHP or a high deductible health plan, then with respect to the company's coverage in that market, the company shall only be required to offer to amend high deductible non-HSA policies for which such express descriptions are used. However, on or after the effective date of this amendatory Act of the 101st General Assembly, if a company subject to this paragraph (6) also offers to amend any other high deductible non-HSA policy so that it becomes an HSA-eligible HDHP, then the company shall conform to the requirements of this subsection (g) for that amendment process.

(h) If an applicant or policyholder obtains an HSA-eligible HDHP, or if a large group applicant or policyholder elects to adjust their coverage under subsection (g), any successive policy shall not be deemed a renewal policy unless it is issued as an HSA-eligible HDHP. Nothing in this Section prevents a company from offering a policyholder a high deductible non-HSA

policy as an alternative to renewing their HSA-eligible HDHP, nor from discontinuing to offer any HSA-eligible HDHP altogether in the Illinois individual, small group, or large group market.

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

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

Sec. 356g. Mammograms; mastectomies.

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

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

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

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

positive genetic testing, or other risk factors.

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

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

(6) For an individual or group policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 101st General Assembly, a diagnostic mammogram when medically necessary, as determined by a physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant.

A policy subject to this subsection shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided~~; except that this sentence does not apply to coverage of diagnostic mammograms to the extent such coverage would disqualify a high deductible health~~

~~plan from eligibility for a health savings account pursuant to Section 223 of the Internal Revenue Code (26 U.S.C. 223)~~.

For purposes of this Section:

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

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

"Low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis. As used in this Section, the term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would

require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this subsection, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this subsection.

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

(a-10) When health care services are available through contracted providers and a person does not comply with plan provisions specific to the use of contracted providers, the requirements of subsection (a-5) are not applicable. When a person does not comply with plan provisions specific to the use of contracted providers, plan provisions specific to the use of non-contracted providers must be applied without distinction for coverage required by this Section and shall be at least as favorable as for other radiological examinations covered by the policy or contract.

(b) No policy of accident or health insurance that provides for the surgical procedure known as a mastectomy shall be issued, amended, delivered, or renewed in this State unless

that coverage also provides for prosthetic devices or reconstructive surgery incident to the mastectomy. Coverage for breast reconstruction in connection with a mastectomy shall include:

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

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

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

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

Written notice of the availability of coverage under this Section shall be delivered to the insured upon enrollment and annually thereafter. An insurer may not deny to an insured

eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this Section. An insurer may not penalize or reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with this Section.

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

(Source: P.A. 100-395, eff. 1-1-18; 101-580, eff. 1-1-20.)

(215 ILCS 5/356z.4)

Sec. 356z.4. Coverage for contraceptives.

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

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

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

(C) The General Assembly intends to build on existing State and federal law to promote gender equity and women's health and to ensure greater contraceptive coverage equity and timely access to all federal Food and Drug Administration approved methods of birth control for all individuals covered by an individual or group health insurance policy in Illinois.

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

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

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

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

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

general criteria:

(i) they are approved as safe and effective;

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

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

(iv) they are adequately labeled; and

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

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

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

(i) If the United States Food and Drug Administration has approved one or more therapeutic equivalent versions of a contraceptive drug, device, or product, a policy is not required to include all such therapeutic equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing and in accordance with this Section.

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

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

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

(B) Voluntary sterilization procedures.

(C) Contraceptive services, patient education, and

counseling on contraception.

(D) Follow-up services related to the drugs, devices, products, and procedures covered under this Section, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

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

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

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

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

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

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

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

As used in this subsection (b), "outpatient contraceptive

service" means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

(c) (Blank).

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

(Source: P.A. 100-1102, eff. 1-1-19; 101-13, eff. 6-12-19.)

(215 ILCS 5/356z.37)

Sec. 356z.37 ~~356z.33~~. Whole body skin examination. An individual or group policy of accident and health insurance shall cover, without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement upon the insured patient, one annual office visit, using appropriate routine evaluation and management Current Procedural Terminology codes or any successor codes, for a whole body skin examination for lesions suspicious for skin cancer. The whole body skin examination shall be indicated using an appropriate International Statistical Classification of Diseases and

Related Health Problems code or any successor codes. ~~The provisions of this Section do not apply to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. 223.~~

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

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

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

Sec. 4-6.1. Mammograms; mastectomies.

(a) Every contract or evidence of coverage issued by a Health Maintenance Organization for persons who are residents of this State shall contain coverage for screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer. The coverage shall be as follows:

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

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

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

positive genetic testing, or other risk factors.

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

(5) For an individual or group policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 101st General Assembly, a diagnostic mammogram when medically necessary, as determined by a physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant.

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

For purposes of this Section:

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

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

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

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

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

successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this subsection, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this subsection.

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

(b) No contract or evidence of coverage issued by a health maintenance organization that provides for the surgical procedure known as a mastectomy shall be issued, amended, delivered, or renewed in this State on or after the effective date of this amendatory Act of the 92nd General Assembly unless that coverage also provides for prosthetic devices or reconstructive surgery incident to the mastectomy, providing that the mastectomy is performed after the effective date of this amendatory Act. Coverage for breast reconstruction in connection with a mastectomy shall include:

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

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

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

lymphedemas.

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

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

(c) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, if any, is conditioned on the

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

(Source: P.A. 100-395, eff. 1-1-18; 101-580, eff. 1-1-20.)

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2, 355.3, 355.5, 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.35, 356z.36, 364, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are

deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

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

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance

Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional

premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

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

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1026, eff. 8-22-18; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; revised 10-16-19.)

Section 15. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

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

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355.5, 355b, 356g, 356g.5, 356g.5-1, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26,

356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

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

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1026, eff. 8-22-18; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; revised 10-16-19.)

Section 99. Effective date. This Act takes effect upon becoming law.