



102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

SB2410

Introduced 2/26/2021, by Sen. Napoleon Harris, III

SYNOPSIS AS INTRODUCED:

215 ILCS 5/107a.12
215 ILCS 5/130.4
215 ILCS 5/370c.1
215 ILCS 5/500-30
215 ILCS 5/500-130
215 ILCS 5/1510
215 ILCS 5/1565
215 ILCS 5/Art. XXXI.75 rep.

Amends the Illinois Insurance Code. Changes the filing due date applicable to actuarial opinions as to the sufficiency of the loss and loss adjustment expense reserves for group workers' compensation pools from June 1 to March 1 of each year. In provisions concerning the bond required of insurance producers, changes a reference from "agent contact" to "agency contract". Provides that the corporate governance annual disclosure must attest to the best of the signatory's belief and knowledge that the insurer has implemented the corporate governance practices (rather than the corporate governance practices required by the provisions concerning disclosure requirements) and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof. Provides that an insurer must ensure that it has complied with the financial requirements and treatment limitations applicable to mental, emotional, nervous, or substance use disorder or condition benefits prior to policy issuance. Provides that pre-licensing course of study hours required to be completed in a classroom setting in order to obtain an insurance producer license may also be completed in a webinar setting. Provides that 3 hours of classroom ethics instruction required for renewal of a public adjuster license may also be completed by webinar. Defines "webinar". Repeals an Article concerning public insurance adjusters and registered firms. Effective immediately, except that provisions concerning the filing due date applicable to actuarial opinions take effect January 1, 2022.

LRB102 16857 BMS 22263 b

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Insurance Code is amended by
5 changing Sections 107a.12, 130.4, 370c.1, 500-30, 500-130,
6 1510, and 1565 as follows:

7 (215 ILCS 5/107a.12)

8 Sec. 107a.12. Annual statement.

9 (a) A pool authorized to do business in this State shall
10 file with the Director by March 1st in each year 2 copies of
11 its financial statement for the year ending December 31st
12 immediately preceding on forms prescribed by the Director,
13 which shall conform substantially to the form of statement
14 adopted by the National Association of Insurance
15 Commissioners. Unless the Director provides otherwise, the
16 annual statement is to be prepared in accordance with the
17 annual statement instructions and the Accounting Practices and
18 Procedures Manual adopted by the National Association of
19 Insurance Commissioners. The Director may promulgate rules for
20 determining which portions of the annual statement
21 instructions and Accounting Practices and Procedures Manual
22 adopted by the National Association of Insurance Commissioners
23 are germane for the purpose of ascertaining the condition and

1 affairs of a pool.

2 (b) The Director shall have authority to extend the time
3 for filing any statement by any pool for reasons that he
4 considers good and sufficient. The admitted assets shall be
5 shown in the statement at the actual values as of the last day
6 of the preceding year, in accordance with Section 126.7 of
7 this Code. The statement shall be verified by oaths of a
8 majority of the trustees or directors of the pool. In
9 addition, when the Director considers it to be necessary and
10 appropriate for the protection of policyholders, creditors,
11 shareholders, or claimants, the Director may require the pool
12 to file, within 60 days after mailing to the pool a notice that
13 a supplemental summary statement is required, a supplemental
14 summary statement, as of the last day of any calendar month
15 occurring during the 100 days next preceding the mailing of
16 the notice, designated by him or her on forms prescribed and
17 furnished by the Director. The Director may require
18 supplemental summary statements to be certified by an
19 independent actuary deemed competent by the Director or by an
20 independent certified public accountant.

21 (c) On or before June 1 of each year, a pool shall file
22 with the Director an audited financial statement reporting the
23 financial condition of the pool as of the end of the most
24 recent calendar year and changes in the surplus funds for the
25 year then ending. The annual audited financial report shall
26 include the following:

1 (1) a report of an independent certified public
2 accountant;

3 (2) a balance sheet reporting assets, as defined in
4 this Article, liabilities, and surplus funds;

5 (3) a statement of gain and loss from operations;

6 (4) a statement of changes in financial position;

7 (5) a statement of changes in surplus funds; and

8 (6) the notes to financial statements.

9 (d) The Director shall require a pool to file an
10 independent actuarial opinion as to the sufficiency of the
11 loss and loss adjustment expense reserves. This opinion shall
12 be due on March ~~June~~ 1 of each year.

13 (Source: P.A. 91-757, eff. 1-1-01.)

14 (215 ILCS 5/130.4)

15 Sec. 130.4. Disclosure requirement.

16 (a) An insurer, or the insurance group of which the
17 insurer is a member, shall, no later than June 1 of each
18 calendar year, submit to the Director a corporate governance
19 annual disclosure that contains the information described in
20 subsection (b) of Section 130.5. Notwithstanding any request
21 from the Director made pursuant to subsection (c), if the
22 insurer is a member of an insurance group, the insurer shall
23 submit the report required by this Section to the Director of
24 the lead state for the insurance group, in accordance with the
25 laws of the lead state, as determined by the procedures

1 outlined in the most recent Financial Analysis Handbook
2 adopted by the National Association of Insurance
3 Commissioners.

4 (b) The corporate governance annual disclosure must
5 include a signature of the insurer's or insurance group's
6 chief executive officer or corporate secretary attesting to
7 the best of that individual's belief and knowledge that the
8 insurer has implemented the corporate governance practices
9 ~~required by this Section~~ and that a copy of the disclosure has
10 been provided to the insurer's board of directors or the
11 appropriate committee thereof.

12 (c) An insurer not required to submit a corporate
13 governance annual disclosure under this Section shall do so
14 upon the Director's request.

15 (d) For purposes of completing the corporate governance
16 annual disclosure, the insurer or insurance group may provide
17 information regarding corporate governance at the ultimate
18 controlling parent level, an intermediate holding company
19 level, or the individual legal entity level, depending upon
20 how the insurer or insurance group has structured its system
21 of corporate governance. The insurer or insurance group is
22 encouraged to make the corporate governance annual disclosure
23 at the level at which the insurer's or insurance group's risk
24 appetite is determined, the level at which the earnings,
25 capital, liquidity, operations, and reputation of the insurer
26 are overseen collectively and at which the supervision of

1 those factors is coordinated and exercised, or the level at
2 which legal liability for failure of general corporate
3 governance duties would be placed. If the insurer or insurance
4 group determines the level of reporting based on these
5 criteria, it shall indicate which of the 3 criteria was used to
6 determine the level of reporting and explain any subsequent
7 changes in the level of reporting.

8 (e) The review of the corporate governance annual
9 disclosure and any additional requests for information shall
10 be made through the lead state as determined by the procedures
11 within the most recent Financial Analysis Handbook adopted by
12 the National Association of Insurance Commissioners.

13 (f) Insurers providing information substantially similar
14 to the information required by this Article in other documents
15 provided to the Director, including proxy statements filed in
16 conjunction with the requirements of Section 131.13 or other
17 State or federal filings provided to the Department, are not
18 required to duplicate that information in the corporate
19 governance annual disclosure but are only required to
20 cross-reference the document in which the information is
21 included.

22 (Source: P.A. 101-600, eff. 12-6-19.)

23 (215 ILCS 5/370c.1)

24 Sec. 370c.1. Mental, emotional, nervous, or substance use
25 disorder or condition parity.

1 (a) On and after the effective date of this amendatory Act
2 of the 102nd General Assembly ~~this amendatory Act of the 99th~~
3 ~~General Assembly~~, every insurer that amends, delivers, issues,
4 or renews a group or individual policy of accident and health
5 insurance or a qualified health plan offered through the
6 Health Insurance Marketplace in this State providing coverage
7 for hospital or medical treatment and for the treatment of
8 mental, emotional, nervous, or substance use disorders or
9 conditions shall ensure prior to policy issuance that:

10 (1) the financial requirements applicable to such
11 mental, emotional, nervous, or substance use disorder or
12 condition benefits are no more restrictive than the
13 predominant financial requirements applied to
14 substantially all hospital and medical benefits covered by
15 the policy and that there are no separate cost-sharing
16 requirements that are applicable only with respect to
17 mental, emotional, nervous, or substance use disorder or
18 condition benefits; and

19 (2) the treatment limitations applicable to such
20 mental, emotional, nervous, or substance use disorder or
21 condition benefits are no more restrictive than the
22 predominant treatment limitations applied to substantially
23 all hospital and medical benefits covered by the policy
24 and that there are no separate treatment limitations that
25 are applicable only with respect to mental, emotional,
26 nervous, or substance use disorder or condition benefits.

1 (b) The following provisions shall apply concerning
2 aggregate lifetime limits:

3 (1) In the case of a group or individual policy of
4 accident and health insurance or a qualified health plan
5 offered through the Health Insurance Marketplace amended,
6 delivered, issued, or renewed in this State on or after
7 the effective date of this amendatory Act of the 99th
8 General Assembly that provides coverage for hospital or
9 medical treatment and for the treatment of mental,
10 emotional, nervous, or substance use disorders or
11 conditions the following provisions shall apply:

12 (A) if the policy does not include an aggregate
13 lifetime limit on substantially all hospital and
14 medical benefits, then the policy may not impose any
15 aggregate lifetime limit on mental, emotional,
16 nervous, or substance use disorder or condition
17 benefits; or

18 (B) if the policy includes an aggregate lifetime
19 limit on substantially all hospital and medical
20 benefits (in this subsection referred to as the
21 "applicable lifetime limit"), then the policy shall
22 either:

23 (i) apply the applicable lifetime limit both
24 to the hospital and medical benefits to which it
25 otherwise would apply and to mental, emotional,
26 nervous, or substance use disorder or condition

1 benefits and not distinguish in the application of
2 the limit between the hospital and medical
3 benefits and mental, emotional, nervous, or
4 substance use disorder or condition benefits; or

5 (ii) not include any aggregate lifetime limit
6 on mental, emotional, nervous, or substance use
7 disorder or condition benefits that is less than
8 the applicable lifetime limit.

9 (2) In the case of a policy that is not described in
10 paragraph (1) of subsection (b) of this Section and that
11 includes no or different aggregate lifetime limits on
12 different categories of hospital and medical benefits, the
13 Director shall establish rules under which subparagraph
14 (B) of paragraph (1) of subsection (b) of this Section is
15 applied to such policy with respect to mental, emotional,
16 nervous, or substance use disorder or condition benefits
17 by substituting for the applicable lifetime limit an
18 average aggregate lifetime limit that is computed taking
19 into account the weighted average of the aggregate
20 lifetime limits applicable to such categories.

21 (c) The following provisions shall apply concerning annual
22 limits:

23 (1) In the case of a group or individual policy of
24 accident and health insurance or a qualified health plan
25 offered through the Health Insurance Marketplace amended,
26 delivered, issued, or renewed in this State on or after

1 the effective date of this amendatory Act of the 99th
2 General Assembly that provides coverage for hospital or
3 medical treatment and for the treatment of mental,
4 emotional, nervous, or substance use disorders or
5 conditions the following provisions shall apply:

6 (A) if the policy does not include an annual limit
7 on substantially all hospital and medical benefits,
8 then the policy may not impose any annual limits on
9 mental, emotional, nervous, or substance use disorder
10 or condition benefits; or

11 (B) if the policy includes an annual limit on
12 substantially all hospital and medical benefits (in
13 this subsection referred to as the "applicable annual
14 limit"), then the policy shall either:

15 (i) apply the applicable annual limit both to
16 the hospital and medical benefits to which it
17 otherwise would apply and to mental, emotional,
18 nervous, or substance use disorder or condition
19 benefits and not distinguish in the application of
20 the limit between the hospital and medical
21 benefits and mental, emotional, nervous, or
22 substance use disorder or condition benefits; or

23 (ii) not include any annual limit on mental,
24 emotional, nervous, or substance use disorder or
25 condition benefits that is less than the
26 applicable annual limit.

1 (2) In the case of a policy that is not described in
2 paragraph (1) of subsection (c) of this Section and that
3 includes no or different annual limits on different
4 categories of hospital and medical benefits, the Director
5 shall establish rules under which subparagraph (B) of
6 paragraph (1) of subsection (c) of this Section is applied
7 to such policy with respect to mental, emotional, nervous,
8 or substance use disorder or condition benefits by
9 substituting for the applicable annual limit an average
10 annual limit that is computed taking into account the
11 weighted average of the annual limits applicable to such
12 categories.

13 (d) With respect to mental, emotional, nervous, or
14 substance use disorders or conditions, an insurer shall use
15 policies and procedures for the election and placement of
16 mental, emotional, nervous, or substance use disorder or
17 condition treatment drugs on their formulary that are no less
18 favorable to the insured as those policies and procedures the
19 insurer uses for the selection and placement of drugs for
20 medical or surgical conditions and shall follow the expedited
21 coverage determination requirements for substance abuse
22 treatment drugs set forth in Section 45.2 of the Managed Care
23 Reform and Patient Rights Act.

24 (e) This Section shall be interpreted in a manner
25 consistent with all applicable federal parity regulations
26 including, but not limited to, the Paul Wellstone and Pete

1 Domenici Mental Health Parity and Addiction Equity Act of
2 2008, final regulations issued under the Paul Wellstone and
3 Pete Domenici Mental Health Parity and Addiction Equity Act of
4 2008 and final regulations applying the Paul Wellstone and
5 Pete Domenici Mental Health Parity and Addiction Equity Act of
6 2008 to Medicaid managed care organizations, the Children's
7 Health Insurance Program, and alternative benefit plans.

8 (f) The provisions of subsections (b) and (c) of this
9 Section shall not be interpreted to allow the use of lifetime
10 or annual limits otherwise prohibited by State or federal law.

11 (g) As used in this Section:

12 "Financial requirement" includes deductibles, copayments,
13 coinsurance, and out-of-pocket maximums, but does not include
14 an aggregate lifetime limit or an annual limit subject to
15 subsections (b) and (c).

16 "Mental, emotional, nervous, or substance use disorder or
17 condition" means a condition or disorder that involves a
18 mental health condition or substance use disorder that falls
19 under any of the diagnostic categories listed in the mental
20 and behavioral disorders chapter of the current edition of the
21 International Classification of Disease or that is listed in
22 the most recent version of the Diagnostic and Statistical
23 Manual of Mental Disorders.

24 "Treatment limitation" includes limits on benefits based
25 on the frequency of treatment, number of visits, days of
26 coverage, days in a waiting period, or other similar limits on

1 the scope or duration of treatment. "Treatment limitation"
2 includes both quantitative treatment limitations, which are
3 expressed numerically (such as 50 outpatient visits per year),
4 and nonquantitative treatment limitations, which otherwise
5 limit the scope or duration of treatment. A permanent
6 exclusion of all benefits for a particular condition or
7 disorder shall not be considered a treatment limitation.

8 "Nonquantitative treatment" means those limitations as
9 described under federal regulations (26 CFR 54.9812-1).

10 "Nonquantitative treatment limitations" include, but are not
11 limited to, those limitations described under federal
12 regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR
13 146.136.

14 (h) The Department of Insurance shall implement the
15 following education initiatives:

16 (1) By January 1, 2016, the Department shall develop a
17 plan for a Consumer Education Campaign on parity. The
18 Consumer Education Campaign shall focus its efforts
19 throughout the State and include trainings in the
20 northern, southern, and central regions of the State, as
21 defined by the Department, as well as each of the 5 managed
22 care regions of the State as identified by the Department
23 of Healthcare and Family Services. Under this Consumer
24 Education Campaign, the Department shall: (1) by January
25 1, 2017, provide at least one live training in each region
26 on parity for consumers and providers and one webinar

1 training to be posted on the Department website and (2)
2 establish a consumer hotline to assist consumers in
3 navigating the parity process by March 1, 2017. By January
4 1, 2018 the Department shall issue a report to the General
5 Assembly on the success of the Consumer Education
6 Campaign, which shall indicate whether additional training
7 is necessary or would be recommended.

8 (2) The Department, in coordination with the
9 Department of Human Services and the Department of
10 Healthcare and Family Services, shall convene a working
11 group of health care insurance carriers, mental health
12 advocacy groups, substance abuse patient advocacy groups,
13 and mental health physician groups for the purpose of
14 discussing issues related to the treatment and coverage of
15 mental, emotional, nervous, or substance use disorders or
16 conditions and compliance with parity obligations under
17 State and federal law. Compliance shall be measured,
18 tracked, and shared during the meetings of the working
19 group. The working group shall meet once before January 1,
20 2016 and shall meet semiannually thereafter. The
21 Department shall issue an annual report to the General
22 Assembly that includes a list of the health care insurance
23 carriers, mental health advocacy groups, substance abuse
24 patient advocacy groups, and mental health physician
25 groups that participated in the working group meetings,
26 details on the issues and topics covered, and any

1 legislative recommendations developed by the working
2 group.

3 (3) Not later than August 1 of each year, the
4 Department, in conjunction with the Department of
5 Healthcare and Family Services, shall issue a joint report
6 to the General Assembly and provide an educational
7 presentation to the General Assembly. The report and
8 presentation shall:

9 (A) Cover the methodology the Departments use to
10 check for compliance with the federal Paul Wellstone
11 and Pete Domenici Mental Health Parity and Addiction
12 Equity Act of 2008, 42 U.S.C. 18031(j), and any
13 federal regulations or guidance relating to the
14 compliance and oversight of the federal Paul Wellstone
15 and Pete Domenici Mental Health Parity and Addiction
16 Equity Act of 2008 and 42 U.S.C. 18031(j).

17 (B) Cover the methodology the Departments use to
18 check for compliance with this Section and Sections
19 356z.23 and 370c of this Code.

20 (C) Identify market conduct examinations or, in
21 the case of the Department of Healthcare and Family
22 Services, audits conducted or completed during the
23 preceding 12-month period regarding compliance with
24 parity in mental, emotional, nervous, and substance
25 use disorder or condition benefits under State and
26 federal laws and summarize the results of such market

1 conduct examinations and audits. This shall include:

2 (i) the number of market conduct examinations
3 and audits initiated and completed;

4 (ii) the benefit classifications examined by
5 each market conduct examination and audit;

6 (iii) the subject matter of each market
7 conduct examination and audit, including
8 quantitative and nonquantitative treatment
9 limitations; and

10 (iv) a summary of the basis for the final
11 decision rendered in each market conduct
12 examination and audit.

13 Individually identifiable information shall be
14 excluded from the reports consistent with federal
15 privacy protections.

16 (D) Detail any educational or corrective actions
17 the Departments have taken to ensure compliance with
18 the federal Paul Wellstone and Pete Domenici Mental
19 Health Parity and Addiction Equity Act of 2008, 42
20 U.S.C. 18031(j), this Section, and Sections 356z.23
21 and 370c of this Code.

22 (E) The report must be written in non-technical,
23 readily understandable language and shall be made
24 available to the public by, among such other means as
25 the Departments find appropriate, posting the report
26 on the Departments' websites.

1 (i) The Parity Advancement Fund is created as a special
2 fund in the State treasury. Moneys from fines and penalties
3 collected from insurers for violations of this Section shall
4 be deposited into the Fund. Moneys deposited into the Fund for
5 appropriation by the General Assembly to the Department shall
6 be used for the purpose of providing financial support of the
7 Consumer Education Campaign, parity compliance advocacy, and
8 other initiatives that support parity implementation and
9 enforcement on behalf of consumers.

10 (j) The Department of Insurance and the Department of
11 Healthcare and Family Services shall convene and provide
12 technical support to a workgroup of 11 members that shall be
13 comprised of 3 mental health parity experts recommended by an
14 organization advocating on behalf of mental health parity
15 appointed by the President of the Senate; 3 behavioral health
16 providers recommended by an organization that represents
17 behavioral health providers appointed by the Speaker of the
18 House of Representatives; 2 representing Medicaid managed care
19 organizations recommended by an organization that represents
20 Medicaid managed care plans appointed by the Minority Leader
21 of the House of Representatives; 2 representing commercial
22 insurers recommended by an organization that represents
23 insurers appointed by the Minority Leader of the Senate; and a
24 representative of an organization that represents Medicaid
25 managed care plans appointed by the Governor.

26 The workgroup shall provide recommendations to the General

1 Assembly on health plan data reporting requirements that
2 separately break out data on mental, emotional, nervous, or
3 substance use disorder or condition benefits and data on other
4 medical benefits, including physical health and related health
5 services no later than December 31, 2019. The recommendations
6 to the General Assembly shall be filed with the Clerk of the
7 House of Representatives and the Secretary of the Senate in
8 electronic form only, in the manner that the Clerk and the
9 Secretary shall direct. This workgroup shall take into account
10 federal requirements and recommendations on mental health
11 parity reporting for the Medicaid program. This workgroup
12 shall also develop the format and provide any needed
13 definitions for reporting requirements in subsection (k). The
14 research and evaluation of the working group shall include,
15 but not be limited to:

16 (1) claims denials due to benefit limits, if
17 applicable;

18 (2) administrative denials for no prior authorization;

19 (3) denials due to not meeting medical necessity;

20 (4) denials that went to external review and whether
21 they were upheld or overturned for medical necessity;

22 (5) out-of-network claims;

23 (6) emergency care claims;

24 (7) network directory providers in the outpatient
25 benefits classification who filed no claims in the last 6
26 months, if applicable;

1 (8) the impact of existing and pertinent limitations
2 and restrictions related to approved services, licensed
3 providers, reimbursement levels, and reimbursement
4 methodologies within the Division of Mental Health, the
5 Division of Substance Use Prevention and Recovery
6 programs, the Department of Healthcare and Family
7 Services, and, to the extent possible, federal regulations
8 and law; and

9 (9) when reporting and publishing should begin.

10 Representatives from the Department of Healthcare and
11 Family Services, representatives from the Division of Mental
12 Health, and representatives from the Division of Substance Use
13 Prevention and Recovery shall provide technical advice to the
14 workgroup.

15 (k) An insurer that amends, delivers, issues, or renews a
16 group or individual policy of accident and health insurance or
17 a qualified health plan offered through the health insurance
18 marketplace in this State providing coverage for hospital or
19 medical treatment and for the treatment of mental, emotional,
20 nervous, or substance use disorders or conditions shall submit
21 an annual report, the format and definitions for which will be
22 developed by the workgroup in subsection (j), to the
23 Department, or, with respect to medical assistance, the
24 Department of Healthcare and Family Services starting on or
25 before July 1, 2020 that contains the following information
26 separately for inpatient in-network benefits, inpatient

1 out-of-network benefits, outpatient in-network benefits,
2 outpatient out-of-network benefits, emergency care benefits,
3 and prescription drug benefits in the case of accident and
4 health insurance or qualified health plans, or inpatient,
5 outpatient, emergency care, and prescription drug benefits in
6 the case of medical assistance:

7 (1) A summary of the plan's pharmacy management
8 processes for mental, emotional, nervous, or substance use
9 disorder or condition benefits compared to those for other
10 medical benefits.

11 (2) A summary of the internal processes of review for
12 experimental benefits and unproven technology for mental,
13 emotional, nervous, or substance use disorder or condition
14 benefits and those for other medical benefits.

15 (3) A summary of how the plan's policies and
16 procedures for utilization management for mental,
17 emotional, nervous, or substance use disorder or condition
18 benefits compare to those for other medical benefits.

19 (4) A description of the process used to develop or
20 select the medical necessity criteria for mental,
21 emotional, nervous, or substance use disorder or condition
22 benefits and the process used to develop or select the
23 medical necessity criteria for medical and surgical
24 benefits.

25 (5) Identification of all nonquantitative treatment
26 limitations that are applied to both mental, emotional,

1 nervous, or substance use disorder or condition benefits
2 and medical and surgical benefits within each
3 classification of benefits.

4 (6) The results of an analysis that demonstrates that
5 for the medical necessity criteria described in
6 subparagraph (A) and for each nonquantitative treatment
7 limitation identified in subparagraph (B), as written and
8 in operation, the processes, strategies, evidentiary
9 standards, or other factors used in applying the medical
10 necessity criteria and each nonquantitative treatment
11 limitation to mental, emotional, nervous, or substance use
12 disorder or condition benefits within each classification
13 of benefits are comparable to, and are applied no more
14 stringently than, the processes, strategies, evidentiary
15 standards, or other factors used in applying the medical
16 necessity criteria and each nonquantitative treatment
17 limitation to medical and surgical benefits within the
18 corresponding classification of benefits; at a minimum,
19 the results of the analysis shall:

20 (A) identify the factors used to determine that a
21 nonquantitative treatment limitation applies to a
22 benefit, including factors that were considered but
23 rejected;

24 (B) identify and define the specific evidentiary
25 standards used to define the factors and any other
26 evidence relied upon in designing each nonquantitative

1 treatment limitation;

2 (C) provide the comparative analyses, including
3 the results of the analyses, performed to determine
4 that the processes and strategies used to design each
5 nonquantitative treatment limitation, as written, for
6 mental, emotional, nervous, or substance use disorder
7 or condition benefits are comparable to, and are
8 applied no more stringently than, the processes and
9 strategies used to design each nonquantitative
10 treatment limitation, as written, for medical and
11 surgical benefits;

12 (D) provide the comparative analyses, including
13 the results of the analyses, performed to determine
14 that the processes and strategies used to apply each
15 nonquantitative treatment limitation, in operation,
16 for mental, emotional, nervous, or substance use
17 disorder or condition benefits are comparable to, and
18 applied no more stringently than, the processes or
19 strategies used to apply each nonquantitative
20 treatment limitation, in operation, for medical and
21 surgical benefits; and

22 (E) disclose the specific findings and conclusions
23 reached by the insurer that the results of the
24 analyses described in subparagraphs (C) and (D)
25 indicate that the insurer is in compliance with this
26 Section and the Mental Health Parity and Addiction

1 Equity Act of 2008 and its implementing regulations,
2 which includes 42 CFR Parts 438, 440, and 457 and 45
3 CFR 146.136 and any other related federal regulations
4 found in the Code of Federal Regulations.

5 (7) Any other information necessary to clarify data
6 provided in accordance with this Section requested by the
7 Director, including information that may be proprietary or
8 have commercial value, under the requirements of Section
9 30 of the Viatical Settlements Act of 2009.

10 (1) An insurer that amends, delivers, issues, or renews a
11 group or individual policy of accident and health insurance or
12 a qualified health plan offered through the health insurance
13 marketplace in this State providing coverage for hospital or
14 medical treatment and for the treatment of mental, emotional,
15 nervous, or substance use disorders or conditions on or after
16 the effective date of this amendatory Act of the 100th General
17 Assembly shall, in advance of the plan year, make available to
18 the Department or, with respect to medical assistance, the
19 Department of Healthcare and Family Services and to all plan
20 participants and beneficiaries the information required in
21 subparagraphs (C) through (E) of paragraph (6) of subsection
22 (k). For plan participants and medical assistance
23 beneficiaries, the information required in subparagraphs (C)
24 through (E) of paragraph (6) of subsection (k) shall be made
25 available on a publicly-available website whose web address is
26 prominently displayed in plan and managed care organization

1 informational and marketing materials.

2 (m) In conjunction with its compliance examination program
3 conducted in accordance with the Illinois State Auditing Act,
4 the Auditor General shall undertake a review of compliance by
5 the Department and the Department of Healthcare and Family
6 Services with Section 370c and this Section. Any findings
7 resulting from the review conducted under this Section shall
8 be included in the applicable State agency's compliance
9 examination report. Each compliance examination report shall
10 be issued in accordance with Section 3-14 of the Illinois
11 State Auditing Act. A copy of each report shall also be
12 delivered to the head of the applicable State agency and
13 posted on the Auditor General's website.

14 (Source: P.A. 99-480, eff. 9-9-15; 100-1024, eff. 1-1-19.)

15 (215 ILCS 5/500-30)

16 (Section scheduled to be repealed on January 1, 2027)

17 Sec. 500-30. Application for license.

18 (a) An individual applying for a resident insurance
19 producer license must make application on a form specified by
20 the Director and declare under penalty of refusal, suspension,
21 or revocation of the license that the statements made in the
22 application are true, correct, and complete to the best of the
23 individual's knowledge and belief. Before approving the
24 application, the Director must find that the individual:

25 (1) is at least 18 years of age;

1 (2) is sufficiently rehabilitated in cases in which
2 the applicant has committed any act that is a ground for
3 denial, suspension, or revocation set forth in Section
4 500-70, other than convictions set forth in paragraph (6)
5 of subsection (a) of Section 500-70; with respect to
6 applicants with convictions set forth in paragraph (6) of
7 subsection (a) of Section 500-70, the Director shall
8 determine in accordance with Section 500-76 that the
9 conviction will not impair the ability of the applicant to
10 engage in the position for which a license is sought;

11 (3) has completed, if required by the Director, a
12 pre-licensing course of study before the insurance exam
13 for the lines of authority for which the individual has
14 applied (an individual who successfully completes the Fire
15 and Casualty pre-licensing courses also meets the
16 requirements for Personal Lines-Property and Casualty);

17 (4) has paid the fees set forth in Section 500-135;
18 and

19 (5) has successfully passed the examinations for the
20 lines of authority for which the person has applied.

21 (b) A pre-licensing course of study for each class of
22 insurance for which an insurance producer license is requested
23 must be established in accordance with rules prescribed by the
24 Director and must consist of the following minimum hours:

25 Class of Insurance	Number of
26	Hours

1	Life (Class 1(a))	20
2	Accident and Health (Class 1(b) or 2(a))	20
3	Fire (Class 3)	20
4	Casualty (Class 2)	20
5	Personal Lines-Property Casualty	20
6	Motor Vehicle (Class 2(b) or 3(e))	12.5

7 7.5 hours of each pre-licensing course must be completed
8 in a classroom or webinar setting, except Motor Vehicle, which
9 would require 5 hours in a classroom or webinar setting.

10 (c) A business entity acting as an insurance producer must
11 obtain an insurance producer license. Application must be made
12 using the Uniform Business Entity Application. Before
13 approving the application, the Director must find that:

14 (1) the business entity has paid the fees set forth in
15 Section 500-135; and

16 (2) the business entity has designated a licensed
17 producer responsible for the business entity's compliance
18 with the insurance laws and rules of this State.

19 (d) The Director may require any documents reasonably
20 necessary to verify the information contained in an
21 application.

22 (Source: P.A. 100-286, eff. 1-1-18.)

23 (215 ILCS 5/500-130)

24 (Section scheduled to be repealed on January 1, 2027)

25 Sec. 500-130. Bond required of insurance producers.

1 (a) An insurance producer who places insurance either
2 directly or indirectly with an insurer with which the
3 insurance producer does not have an agency contract ~~agent~~
4 ~~contract~~ must maintain in force while licensed a bond in favor
5 of the people of the State of Illinois executed by an
6 authorized surety company and payable to any party injured
7 under the terms of the bond. The bond shall be continuous in
8 form and in the amount of \$2,500 or 5% of the premiums brokered
9 in the previous calendar year, whichever is greater, but not
10 to exceed \$50,000 total aggregate liability. The bond shall be
11 conditioned upon full accounting and due payment to the person
12 or company entitled thereto, of funds coming into the
13 insurance producer's possession as an incident to insurance
14 transactions under the license or surplus line insurance
15 transactions under the license as a surplus line producer.

16 (b) Authorized insurance producers of a business entity
17 may meet the requirements of this Section with a bond in the
18 name of the business entity, continuous in form, and in the
19 amounts set forth in subsection (a) of this Section. Insurance
20 producers may meet the requirements of this Section with a
21 bond in the name of an association. An individual producer
22 remains responsible for assuring that a producer bond is in
23 effect and is for the correct amount. The association must
24 have been in existence for 5 years, have common membership,
25 and been formed for a purpose other than obtaining a bond.

26 (c) The surety may cancel the bond and be released from

1 further liability thereunder upon 30 days' written notice in
2 advance to the principal. The cancellation does not affect any
3 liability incurred or accrued under the bond before the
4 termination of the 30-day period.

5 (d) The producer's license may be revoked if the producer
6 acts without a bond that is required under this Section.

7 (e) If a party injured under the terms of the bond requests
8 the producer to provide the name of the surety and the bond
9 number, the producer must provide the information within 3
10 working days after receiving the request.

11 (f) An association may meet the requirements of this
12 Section for all of its members with a bond in the name of the
13 association that is continuous in form and in the amounts set
14 forth in subsection (a) of this Section.

15 (Source: P.A. 92-386, eff. 1-1-02.)

16 (215 ILCS 5/1510)

17 Sec. 1510. Definitions. In this Article:

18 "Adjusting a claim for loss or damage covered by an
19 insurance contract" means negotiating values, damages, or
20 depreciation or applying the loss circumstances to insurance
21 policy provisions.

22 "Business entity" means a corporation, association,
23 partnership, limited liability company, limited liability
24 partnership, or other legal entity.

25 "Department" means the Department of Insurance.

1 "Director" means the Director of Insurance.

2 "Fingerprints" means an impression of the lines on the
3 finger taken for the purpose of identification. The impression
4 may be electronic or in ink converted to electronic format.

5 "Home state" means the District of Columbia and any state
6 or territory of the United States where the public adjuster's
7 principal place of residence or principal place of business is
8 located. If neither the state in which the public adjuster
9 maintains the principal place of residence nor the state in
10 which the public adjuster maintains the principal place of
11 business has a substantially similar law governing public
12 adjusters, the public adjuster may declare another state in
13 which it becomes licensed and acts as a public adjuster to be
14 the home state.

15 "Individual" means a natural person.

16 "Person" means an individual or a business entity.

17 "Public adjuster" means any person who, for compensation
18 or any other thing of value on behalf of the insured:

19 (i) acts or aids, solely in relation to first party
20 claims arising under insurance contracts that insure the
21 real or personal property of the insured, on behalf of an
22 insured in adjusting a claim for loss or damage covered by
23 an insurance contract;

24 (ii) advertises for employment as a public adjuster of
25 insurance claims or solicits business or represents
26 himself or herself to the public as a public adjuster of

1 first party insurance claims for losses or damages arising
2 out of policies of insurance that insure real or personal
3 property; or

4 (iii) directly or indirectly solicits business,
5 investigates or adjusts losses, or advises an insured
6 about first party claims for losses or damages arising out
7 of policies of insurance that insure real or personal
8 property for another person engaged in the business of
9 adjusting losses or damages covered by an insurance policy
10 for the insured.

11 "Uniform individual application" means the current version
12 of the National Association of Directors (NAIC) Uniform
13 Individual Application for resident and nonresident
14 individuals.

15 "Uniform business entity application" means the current
16 version of the National Association of Insurance Commissioners
17 (NAIC) Uniform Business Entity Application for resident and
18 nonresident business entities.

19 "Webinar" means an online educational presentation during
20 which a live and participating instructor and participating
21 viewers, whose attendance is periodically verified throughout
22 the presentation, actively engage in discussion and in the
23 submission and answering of questions.

24 (Source: P.A. 96-1332, eff. 1-1-11.)

1 Sec. 1565. Continuing education.

2 (a) An individual who holds a public adjuster license and
3 who is not exempt under subsection (b) of this Section shall
4 satisfactorily complete a minimum of 24 hours of continuing
5 education courses, including 3 hours of classroom or webinar
6 ethics instruction, reported on a biennial basis in
7 conjunction with the license renewal cycle.

8 The Director may not approve a course of study unless the
9 course provides for classroom, seminar, or self-study
10 instruction methods. A course given in a combination
11 instruction method of classroom or seminar and self-study
12 shall be deemed to be a self-study course unless the classroom
13 or seminar certified hours meets or exceeds two-thirds of the
14 total hours certified for the course. The self-study material
15 used in the combination course must be directly related to and
16 complement the classroom portion of the course in order to be
17 considered for credit. An instruction method other than
18 classroom or seminar shall be considered as self-study
19 methodology. Self-study credit hours require the successful
20 completion of an examination covering the self-study material.
21 The examination may not be self-evaluated. However, if the
22 self-study material is completed through the use of an
23 approved computerized interactive format whereby the computer
24 validates the successful completion of the self-study
25 material, no additional examination is required. The
26 self-study credit hours contained in a certified course shall

1 be considered classroom hours when at least two-thirds of the
2 hours are given as classroom or seminar instruction.

3 The public adjuster must complete the course in advance of
4 the renewal date to allow the education provider time to
5 report the credit to the Department.

6 (b) This Section shall not apply to:

7 (1) licensees not licensed for one full year prior to
8 the end of the applicable continuing education biennium;
9 or

10 (2) licensees holding nonresident public adjuster
11 licenses who have met the continuing education
12 requirements of their home state and whose home state
13 gives credit to residents of this State on the same basis.

14 (c) Only continuing education courses approved by the
15 Director shall be used to satisfy the continuing education
16 requirement of subsection (a) of this Section.

17 (Source: P.A. 96-1332, eff. 1-1-11.)

18 (215 ILCS 5/Art. XXXI.75 rep.)

19 Section 10. The Illinois Insurance Code is amended by
20 repealing Article XXXI 3/4.

21 Section 99. Effective date. This Act takes effect upon
22 becoming law, except that the changes to Section 107a.12 of
23 the Illinois Insurance Code take effect January 1, 2022.