SB3926

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

SB3926

Introduced 1/21/2022, by Sen. Laura Fine

SYNOPSIS AS INTRODUCED:

215 ILCS 5/121-2.05	from Ch. 73, par. 733-2.05
215 ILCS 5/352c new	
215 ILCS 5/356z.18	
215 ILCS 5/367.3	from Ch. 73, par. 979.3
215 ILCS 5/367a	from Ch. 73, par. 979a
215 ILCS 5/368f	
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2
215 ILCS 130/4003	from Ch. 73, par. 1504-3
215 ILCS 190/Act rep.	

Amends the Illinois Insurance Code. Sets forth provisions concerning short-term, limited-duration insurance. Provides that on and after January 1, 2023, no company shall issue, deliver, amend, or renew short-term, limited-duration insurance to any natural or legal person that is a resident or domiciled in the State. Provides that the Department of Insurance may adopt rules as deemed necessary that prescribe specific standards for or restrictions on policy provisions, benefit design, disclosures, and sales and marketing practices for excepted benefits. Provides that the Director of Insurance's authority under specified provisions is extended to group and blanket excepted benefits. Provides that the language does not apply to limited-scope dental, limited-scope vision, long-term care, Medicare supplement, credit life, credit health, or any excepted benefits that are filed under specified provisions. Provides that nothing in the language shall be construed to limit the Director's authority under other statutes. Makes conforming changes in the Health Maintenance Organization Act and the Limited Health Service Organization Act. Repeals the Short-Term, Limited-Duration Health Insurance Coverage Act. Effective January 1, 2023.

LRB102 24061 BMS 34191 b

A BILL FOR

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 121-2.05, 356z.18, 367.3, 367a, and 368f and
6 by adding Section 352c as follows:

7 (215 ILCS 5/121-2.05) (from Ch. 73, par. 733-2.05)
8 Sec. 121-2.05. Group insurance policies issued and
9 delivered in other State-Transactions in this State. With the
10 exception of insurance transactions authorized under Sections
11 230.2 or 367.3 of this Code or transactions described under
12 Section 352c, transactions in this State involving group
13 legal, group life and group accident and health or blanket
14 accident and health insurance or group annuities where the
15 master policy of such groups was lawfully issued and delivered
16 in, and under the laws of, a State in which the insurer was
17 authorized to do an insurance business, to a group properly
18 established pursuant to law or regulation, and where the
19 policyholder is domiciled or otherwise has a bona fide situs.
20 (Source: P.A. 86-753.)

21 (215 ILCS 5/352c new)
22 Sec. 352c. Short-term, limited-duration insurance

1 prohibited; rules for excepted benefits.
2 (a) Definitions. As used in this Section:
3 "Excepted benefits" has the meaning given to that term in
4 42 U.S.C. 300gg-91 and implementing regulations. "Excepted
5 benefits" includes individual, group, or blanket coverage.
6 "Short-term, limited-duration insurance" means any type of
7 accident and health insurance offered or provided within this
8 State pursuant to a group or individual policy or individual
9 certificate by a company, regardless of the situs state of the
10 delivery of the policy, that has an expiration date specified
11 in the contract that is fewer than 365 days after the original
12 effective date. Regardless of the duration of coverage,
13 "short-term, limited-duration insurance" does not include
14 excepted benefits or any student health insurance coverage.
15 "Student health insurance coverage" has the meaning given
16 to that term in 45 CFR 147.145.
17 (b) On and after January 1, 2023, no company shall issue,
18 deliver, amend, or renew short-term, limited-duration
19 insurance to any natural or legal person that is a resident or
20 domiciled in this State.
21 (c) To prevent the use, design, and combination of
22 excepted benefits to circumvent State or federal requirements
23 for comprehensive forms of health insurance coverage, to
24 prevent confusion or misinformation of insureds about
25 duplicate or distinct types of coverage, and to ensure a
26 measure of consistency within product lines across the

individual, group, and blanket markets, the Department may adopt rules as deemed necessary that prescribe specific standards for or restrictions on policy provisions, benefit design, disclosures, and sales and marketing practices for excepted benefits. For purposes of these rules, the Director's authority under subsections (3) and (4) of Section 355a is extended to group and blanket excepted benefits. To ensure compliance with these rules, the Director may require policy forms and rates to be filed as provided in Sections 143 and 355 and rules thereunder with respect to excepted benefits coverage intended to be issued to residents of this State under a master contract issued to a group domiciled or otherwise with bona fide situs outside of this State. This subsection does not apply to limited-scope dental, limited-scope vision, long-term care, Medicare supplement, credit life, credit health, or any excepted benefits that are filed under subsections (b) through (l) of Class 2 or under Class 3 of Section 4. Nothing in this subsection shall be construed to limit the Director's authority under other statutes.

(215 ILCS 5/356z.18)

Sec. 356z.18. Prosthetic and customized orthotic devices.

(a) For the purposes of this Section:

"Customized orthotic device" means a supportive device for

1 the body or a part of the body, the head, neck, or extremities,
2 and includes the replacement or repair of the device based on
3 the patient's physical condition as medically necessary,
4 excluding foot orthotics defined as an in-shoe device designed
5 to support the structural components of the foot during
6 weight-bearing activities.

7 "Licensed provider" means a prosthetist, orthotist, or
8 pedorthist licensed to practice in this State.

9 "Prosthetic device" means an artificial device to replace,
10 in whole or in part, an arm or leg and includes accessories
11 essential to the effective use of the device and the
12 replacement or repair of the device based on the patient's
13 physical condition as medically necessary.

14 (b) This amendatory Act of the 96th General Assembly shall
15 provide benefits to any person covered thereunder for expenses
16 incurred in obtaining a prosthetic or custom orthotic device
17 from any Illinois licensed prosthetist, licensed orthotist, or
18 licensed pedorthist as required under the Orthotics,
19 Prosthetics, and Pedorthics Practice Act.

20 (c) A group or individual major medical policy of accident
21 or health insurance or managed care plan or medical, health,
22 or hospital service corporation contract that provides
23 coverage for prosthetic or custom orthotic care and is
24 amended, delivered, issued, or renewed 6 months after the
25 effective date of this amendatory Act of the 96th General
26 Assembly must provide coverage for prosthetic and orthotic

1 devices in accordance with this subsection (c). The coverage
2 required under this Section shall be subject to the other
3 general exclusions, limitations, and financial requirements of
4 the policy, including coordination of benefits, participating
5 provider requirements, utilization review of health care
6 services, including review of medical necessity, case
7 management, and experimental and investigational treatments,
8 and other managed care provisions under terms and conditions
9 that are no less favorable than the terms and conditions that
10 apply to substantially all medical and surgical benefits
11 provided under the plan or coverage.
12 (d) The policy or plan or contract may require prior
13 authorization for the prosthetic or orthotic devices in the
14 same manner that prior authorization is required for any other
15 covered benefit.
16 (e) Repairs and replacements of prosthetic and orthotic
17 devices are also covered, subject to the co-payments and
18 deductibles, unless necessitated by misuse or loss.
19 (f) A policy or plan or contract may require that, if
20 coverage is provided through a managed care plan, the benefits
21 mandated pursuant to this Section shall be covered benefits
22 only if the prosthetic or orthotic devices are provided by a
23 licensed provider employed by a provider service who contracts
24 with or is designated by the carrier, to the extent that the
25 carrier provides in-network and out-of-network service, the
26 coverage for the prosthetic or orthotic device shall be

offered no less extensively.

(g) The policy or plan or contract shall also meet adequacy requirements as established by the Health Care Reimbursement Reform Act of 1985 of the Illinois Insurance Code.

(h) This Section shall not apply to accident only, specified disease, short-term travel ~~hospital or medical~~, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation insurance, or automobile medical payment insurance.

(Source: P.A. 96-833, eff. 6-1-10.)

(215 ILCS 5/367.3) (from Ch. 73, par. 979.3)

Sec. 367.3. Group accident and health insurance; discretionary groups.

(a) No group health insurance offered to a resident of this State under a policy issued to a group, other than one specifically described in Section 367(1), shall be delivered or issued for delivery in this State unless the Director determines that:

(1) the issuance of the policy is not contrary to the public interest;

(2) the issuance of the policy will result in

1 economies of acquisition and administration; and
2 (3) the benefits under the policy are reasonable in
3 relation to the premium charged.
4 (b) No such group health insurance may be offered in this
5 State under a policy issued in another state unless this State
6 or the state in which the group policy is issued has made a
7 determination that the requirements of subsection (a) have
8 been met.
9 Where insurance is to be offered in this State under a
10 policy described in this subsection, the insurer shall file
11 for informational review purposes:
12 (1) a copy of the group master contract;
13 (2) a copy of the statute authorizing the issuance of
14 the group policy in the state of situs, which statute has
15 the same or similar requirements as this State, or in the
16 absence of such statute, a certification by an officer of
17 the company that the policy meets the Illinois minimum
18 standards required for individual accident and health
19 policies under authority of Section 401 of this Code, as
20 now or hereafter amended, as promulgated by rule at 50
21 Illinois Administrative Code, Ch. I, Sec. 2007, et seq.,
22 as now or hereafter amended, or by a successor rule;
23 (3) evidence of approval by the state of situs of the
24 group master policy; and
25 (4) copies of all supportive material furnished to the
26 state of situs to satisfy the criteria for approval.

(c) The Director may, at any time after receipt of the information required under subsection (b) and after finding that the standards of subsection (a) have not been met, order the insurer to cease the issuance or marketing of that coverage in this State.

(d) Notwithstanding subsections (a) and (b), group ~~Group~~ accident and health insurance subject to the provisions of this Section is also subject to the provisions of Sections 352c and ~~Section~~ 367i of this Code and rules thereunder.

(Source: P.A. 90-655, eff. 7-30-98.)

(215 ILCS 5/367a) (from Ch. 73, par. 979a)

Sec. 367a. Blanket accident and health insurance.

(1) Blanket accident and health insurance is the ~~that~~ form of accident and health insurance providing excepted benefits as defined in Section 352c that covers ~~covering~~ special groups of persons as enumerated in one of the following paragraphs (a) to (g), inclusive:

(a) Under a policy or contract issued to any carrier for hire, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on such carrier.

(b) Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering all employees or any group of employees defined by reference to exceptional hazards incident to such employment.

(c) Under a policy or contract issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers. However, except where inconsistent with 45 CFR 147.145, student health insurance coverage other than excepted benefits that is provided pursuant to a written agreement with an institution of higher education for the benefit of its enrolled students and their dependents shall remain subject to the standards and requirements for individual coverage.

(d) Under a policy or contract issued in the name of any volunteer fire department, first aid, or other such volunteer group, which shall be deemed the policyholder, covering all of the members of such department or group.

(e) Under a policy or contract issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditors; Provided, however, that in the case of a loan which is subject to the Small Loans Act, no insurance premium or other cost shall be directly or indirectly charged or assessed against, or collected or received from the borrower.

(f) Under a policy or contract issued to a sports team or to a camp, which team or camp sponsor shall be deemed the policyholder, covering members or campers.

(g) Under a policy or contract issued to any other substantially similar group which, in the discretion of the Director, may be subject to the issuance of a blanket accident

and health policy or contract.

(2) Any insurance company authorized to write accident and health insurance in this state shall have the power to issue blanket accident and health insurance. No such blanket policy may be issued or delivered in this State unless a copy of the form thereof shall have been filed in accordance with Section 355, and it contains in substance such of those provisions contained in Sections 357.1 through 357.30 as may be applicable to blanket accident and health insurance and the following provisions:

(a) A provision that the policy and the application shall constitute the entire contract between the parties, and that all statements made by the policyholder shall, in absence of fraud, be deemed representations and not warranties, and that no such statements shall be used in defense to a claim under the policy, unless it is contained in a written application.

(b) A provision that to the group or class thereof originally insured shall be added from time to time all new persons or individuals eligible for coverage.

(3) An individual application shall not be required from a person covered under a blanket accident or health policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

(4) All benefits under any blanket accident and health policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his or her

1 estate, except that if the person insured be a minor or person
2 under legal disability, such benefits may be made payable to
3 his or her parent, guardian, or other person actually
4 supporting him or her. Provided further, however, that the
5 policy may provide that all or any portion of any indemnities
6 provided by any such policy on account of hospital, nursing,
7 medical or surgical services may, at the insurer's option, be
8 paid directly to the hospital or person rendering such
9 services; but the policy may not require that the service be
10 rendered by a particular hospital or person. Payment so made
11 shall discharge the insurer's obligation with respect to the
12 amount of insurance so paid.

13 (5) Nothing contained in this section shall be deemed to
14 affect the legal liability of policyholders for the death of
15 or injury to, any such member of such group.

16 (Source: P.A. 83-1362.)

17 (215 ILCS 5/368f)

18 Sec. 368f. Military service member insurance
19 reinstatement.

20 (a) No Illinois resident activated for military service
21 and no spouse or dependent of the resident who becomes
22 eligible for a federal government-sponsored health insurance
23 program, including the TriCare program providing coverage for
24 civilian dependents of military personnel, as a result of the
25 activation shall be denied reinstatement into the same

individual health insurance coverage with the health insurer that the resident lapsed as a result of activation or becoming covered by the federal government-sponsored health insurance program. The resident shall have the right to reinstatement in the same individual health insurance coverage without medical underwriting, subject to payment of the current premium charged to other persons of the same age and gender that are covered under the same individual health coverage. Except in the case of birth or adoption that occurs during the period of activation, reinstatement must be into the same coverage type as the resident held prior to lapsing the individual health insurance coverage and at the same or, at the option of the resident, higher deductible level. The reinstatement rights provided under this subsection (a) are not available to a resident or dependents if the activated person is discharged from the military under other than honorable conditions.

(b) The health insurer with which the reinstatement is being requested must receive a request for reinstatement no later than 63 days following the later of (i) deactivation or (ii) loss of coverage under the federal government-sponsored health insurance program. The health insurer may request proof of loss of coverage and the timing of the loss of coverage of the government-sponsored coverage in order to determine eligibility for reinstatement into the individual coverage. The effective date of the reinstatement of individual health coverage shall be the first of the month following receipt of

the notice requesting reinstatement.

(c) All insurers must provide written notice to the policyholder of individual health coverage of the rights described in subsection (a) of this Section. In lieu of the inclusion of the notice in the individual health insurance policy, an insurance company may satisfy the notification requirement by providing a single written notice:

(1) in conjunction with the enrollment process for a policyholder initially enrolling in the individual coverage on or after the effective date of this amendatory Act of the 94th General Assembly; or

(2) by mailing written notice to policyholders whose coverage was effective prior to the effective date of this amendatory Act of the 94th General Assembly no later than 90 days following the effective date of this amendatory Act of the 94th General Assembly.

(d) The provisions of subsection (a) of this Section do not apply to any policy or certificate providing coverage for any specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care, Medicare supplement, vision care, or short-term travel ~~nonrenewable health policy~~ or other limited-benefit supplemental insurance, or any coverage issued as a supplement to any liability insurance, workers' compensation or similar insurance, or any insurance under which benefits are payable with or without regard to fault,

1 whether written on a group, blanket, or individual basis.
2 (e) Nothing in this Section shall require an insurer to
3 reinstate the resident if the insurer requires residency in an
4 enrollment area and those residency requirements are not met
5 after deactivation or loss of coverage under the
6 government-sponsored health insurance program.
7 (f) All terms, conditions, and limitations of the
8 individual coverage into which reinstatement is made apply
9 equally to all insureds enrolled in the coverage.
10 (g) The Secretary may adopt rules as may be necessary to
11 carry out the provisions of this Section.
12 (Source: P.A. 94-1037, eff. 7-20-06.)

13 Section 10. The Health Maintenance Organization Act is
14 amended by changing Section 5-3 as follows:

15 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)
16 Sec. 5-3. Insurance Code provisions.
17 (a) Health Maintenance Organizations shall be subject to
18 the provisions of Sections 133, 134, 136, 137, 139, 140,
19 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153,
20 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 352c, 355.2,
21 355.3, 355b, 356g.5-1, 356m, 356q, 356v, 356w, 356x, 356y,
22 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
23 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
24 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29,

1 356z.30, 356z.30a, 356z.32, 356z.33, 356z.35, 356z.36,
2 356z.40, 356z.41, 356z.43, 356z.46, 356z.47, 356z.48, 356z.50,
3 356z.51, 364, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c,
4 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408,
5 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection
6 (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2,
7 XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois
8 Insurance Code.

9 (b) For purposes of the Illinois Insurance Code, except
10 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
11 Health Maintenance Organizations in the following categories
12 are deemed to be "domestic companies":

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

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

17 (3) a corporation organized under the laws of another
18 state, 30% or more of the enrollees of which are residents
19 of this State, except a corporation subject to
20 substantially the same requirements in its state of
21 organization as is a "domestic company" under Article VIII
22 1/2 of the Illinois Insurance Code.

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

26 (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

1 acquired for a period of not less than 3 years; and
2 (D) such other information as the Director shall
3 require.
4 (d) The provisions of Article VIII 1/2 of the Illinois
5 Insurance Code and this Section 5-3 shall apply to the sale by
6 any health maintenance organization of greater than 10% of its
7 enrollee population (including without limitation the health
8 maintenance organization's right, title, and interest in and
9 to its health care certificates).
10 (e) In considering any management contract or service
11 agreement subject to Section 141.1 of the Illinois Insurance
12 Code, the Director (i) shall, in addition to the criteria
13 specified in Section 141.2 of the Illinois Insurance Code,
14 take into account the effect of the management contract or
15 service agreement on the continuation of benefits to enrollees
16 and the financial condition of the health maintenance
17 organization to be managed or serviced, and (ii) need not take
18 into account the effect of the management contract or service
19 agreement on competition.
20 (f) Except for small employer groups as defined in the
21 Small Employer Rating, Renewability and Portability Health
22 Insurance Act and except for medicare supplement policies as
23 defined in Section 363 of the Illinois Insurance Code, a
24 Health Maintenance Organization may by contract agree with a
25 group or other enrollment unit to effect refunds or charge
26 additional premiums under the following terms and conditions:

1 (i) the amount of, and other terms and conditions with
2 respect to, the refund or additional premium are set forth
3 in the group or enrollment unit contract agreed in advance
4 of the period for which a refund is to be paid or
5 additional premium is to be charged (which period shall
6 not be less than one year); and
7 (ii) the amount of the refund or additional premium
8 shall not exceed 20% of the Health Maintenance
9 Organization's profitable or unprofitable experience with
10 respect to the group or other enrollment unit for the
11 period (and, for purposes of a refund or additional
12 premium, the profitable or unprofitable experience shall
13 be calculated taking into account a pro rata share of the
14 Health Maintenance Organization's administrative and
15 marketing expenses, but shall not include any refund to be
16 made or additional premium to be paid pursuant to this
17 subsection (f)). The Health Maintenance Organization and
18 the group or enrollment unit may agree that the profitable
19 or unprofitable experience may be calculated taking into
20 account the refund period and the immediately preceding 2
21 plan years.
22 The Health Maintenance Organization shall include a
23 statement in the evidence of coverage issued to each enrollee
24 describing the possibility of a refund or additional premium,
25 and upon request of any group or enrollment unit, provide to
26 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. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; revised 10-27-21.)

Section 15. The Limited Health Service Organization Act is

amended by changing Section 4003 as follows:

(215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

Sec. 4003. Illinois Insurance Code provisions. Limited health service 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, 155.37, 352c, 355.2, 355.3, 355b, 356q, 356v, 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, ~~356z.43,~~ 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code. For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited health service organizations in the following categories are deemed to be domestic companies:

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

(2) 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.

(Source: P.A. 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff.

1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; revised 10-27-21.)

(215 ILCS 190/Act rep.)

Section 20. The Short-Term, Limited-Duration Health Insurance Coverage Act is repealed.

Section 99. Effective date. This Act takes effect January 1, 2023.