AN ACT concerning regulation.

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

Section 5. The Department of Insurance Law is amended by adding Section 1405-50 as follows:

(20 ILCS 1405/1405-50 new)

Sec. 1405-50. Health insurance coverage, affordability, and cost transparency annual report.

(a) On or before May 1, 2026, and each May 1 thereafter, the Department of Insurance shall report to the Governor and the General Assembly on health insurance coverage, affordability, and cost trends, including:

(1) medical cost trends by major service category, including prescription drugs;

(2) utilization patterns of services by major service categories;

(3) impact of benefit changes, including essential health benefits and non-essential health benefits;

(4) enrollment trends;

(5) demographic shifts;

(6) geographic factors and variations, including changes in provider availability;

(7) health care quality improvement initiatives;

(8)inflation and other factors impacting this State's economic condition;

(9) the availability of financial assistance and tax credits to pay for health insurance coverage for individuals and small businesses;

(10) trends in out-of-pocket costs for consumers; and

(11) factors contributing to costs that are not otherwise specified in paragraphs (1) through (10) of this subsection.

(b) This report shall not attribute any information or trend to a specific company and shall not disclose any information otherwise considered confidential or proprietary.

Section 10. The Illinois Insurance Code is amended by changing Section 355 as follows:

(215 ILCS 5/355) (from Ch. 73, par. 967)

Sec. 355. Accident and health policies; provisions. ~~policies Provisions.)~~

(a) As used in this Section:

"Inadequate rate" means a rate:

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

(2) the continued use of which endangers the solvency of an insurer using that rate.

"Large employer" has the meaning provided in the Illinois

Health Insurance Portability and Accountability Act.

"Plain language" has the meaning provided in the federal Plain Writing Act of 2010 and subsequent guidance documents, including the Federal Plain Language Guidelines.

"Unreasonable rate increase" means a rate increase that the Director determines to be excessive, unjustified, or unfairly discriminatory in accordance with 45 CFR 154.205.

(b) No policy of insurance against loss or damage from the sickness, or from the bodily injury or death of the insured by accident shall be issued or delivered to any person in this State until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the Director; nor shall it be so issued or delivered until the Director shall have approved such policy pursuant to the provisions of Section 143. If the Director disapproves the policy form, he or she shall make a written decision stating the respects in which such form does not comply with the requirements of law and shall deliver a copy thereof to the company and it shall be unlawful thereafter for any such company to issue any policy in such form. On and after January 1, 2025, any form filing submitted for large employer group accident and health insurance shall be automatically deemed approved within 90 days of the submission date unless the Director extends by not more than an additional 30 days the period within which the form shall be approved or disapproved by giving written notice to the

insurer of such extension before the expiration of the 90 days. Any form in receipt of such an extension shall be automatically deemed approved within 120 days of the submission date. The Director may toll the filing due to a conflict in legal interpretation of federal or State law as long as the tolling is applied uniformly to all applicable forms, written notification is provided to the insurer prior to the tolling, the duration of the tolling is provided within the notice to the insurer, and justification for the tolling is posted to the Department's website. The Director may disapprove the filing if the insurer fails to respond to an objection or request for additional information within the timeframe identified for response. As used in this subsection, "large employer" has the meaning given in Section 5 of the federal Health Insurance Portability and Accountability Act.

(c) For plan year 2026 and thereafter, premium rates for all individual and small group accident and health insurance policies must be filed with the Department for approval. Unreasonable rate increases or inadequate rates shall be modified or disapproved. For any plan year during which the Illinois Health Benefits Exchange operates as a full State-based exchange, the Department shall provide insurers at least 30 days' notice of the deadline to submit rate filings.

(d) For plan year 2025 and thereafter, the Department shall post all insurers' rate filings and summaries on the Department's website 5 business days after the rate filing

deadline set by the Department in annual guidance. The rate filings and summaries posted to the Department's website shall exclude information that is proprietary or trade secret information protected under paragraph (g) of subsection (1) of Section 7 of the Freedom of Information Act or confidential or privileged under any applicable insurance law or rule. All summaries shall include a brief justification of any rate increase or decrease requested, including the number of individual members, the medical loss ratio, medical trend, administrative costs, and any other information required by rule. The plain writing summary shall include notification of the public comment period established in subsection (e).

(e) The Department shall open a 30-day public comment period on the rate filings beginning on the date that all of the rate filings are posted on the Department's website. The Department shall post all of the comments received to the Department's website within 5 business days after the comment period ends.

(f) After the close of the public comment period described in subsection (e), the Department, beginning for plan year 2026, shall issue a decision to approve, disapprove, or modify a rate filing within 60 days. Any rate filing or any rates within a filing on which the Director does not issue a decision within 60 days shall automatically be deemed approved. The Director's decision shall take into account the actuarial justifications and public comments. The Department shall

notify the insurer of the decision, make the decision available to the public by posting it on the Department's website, and include an explanation of the findings, actuarial justifications, and rationale that are the basis for the decision. Any company whose rate has been modified or disapproved shall be allowed to request a hearing within 10 days after the action taken. The action of the Director in disapproving a rate shall be subject to judicial review under the Administrative Review Law.

(g) If, following the issuance of a decision but before the effective date of the premium rates approved by the decision, an event occurs that materially affects the Director's decision to approve, deny, or modify the rates, the Director may consider supplemental facts or data reasonably related to the event.

(h) The Department shall adopt rules implementing the procedures described in subsections (d) through (g) by March 31, 2024.

(i) Subsection (a) and subsections (c) through (h) of this Section do not apply to grandfathered health plans as defined in 45 CFR 147.140; excepted benefits as defined in 42 U.S.C. 300gg-91; student health insurance coverage as defined in 45 CFR 147.145; the large group market as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act; or short-term, limited-duration health insurance coverage as defined in Section 5 of the Short-Term, Limited-Duration

Health Insurance Coverage Act. For a filing of premium rates or classifications of risk for any of these types of coverage, the Director's initial review period shall not exceed 60 days to issue informal objections to the company that request additional clarification, explanation, substantiating documentation, or correction of concerns identified in the filing before the company implements the premium rates, classifications, or related rate-setting methodologies described in the filing, except that the Director may extend by not more than an additional 30 days the period of initial review by giving written notice to the company of such extension before the expiration of the initial 60-day period. Nothing in this subsection shall confer authority upon the Director to approve, modify, or disapprove rates where that authority is not provided by other law. Nothing in this subsection shall prohibit the Director from conducting any investigation, examination, hearing, or other formal administrative or enforcement proceeding with respect to a company's rate filing or implementation thereof under applicable law at any time, including after the period of initial review.

(Source: P.A. 79-777.)

Section 15. The Health Maintenance Organization Act is amended by changing Section 4-12 as follows:

(215 ILCS 125/4-12) (from Ch. 111 1/2, par. 1409.5)

Sec. 4-12. Changes in Rate Methodology and Benefits, Material Modifications. A health maintenance organization shall file with the Director, prior to use, a notice of any change in rate methodology, or benefits and of any material modification of any matter or document furnished pursuant to Section 2-1, together with such supporting documents as are necessary to fully explain the change or modification.

(a) Contract modifications described in subsections (c)(5), (c)(6) and (c)(7) of Section 2-1 shall include all form agreements between the organization and enrollees, providers, administrators of services and insurers of health maintenance organizations.

(b) Material transactions or series of transactions other than those described in subsection (a) of this Section, the total annual value of which exceeds the greater of $100,000 or 5% of net earned subscription revenue for the most current 12-month ~~twelve month~~ period as determined from filed financial statements.

(c) Any agreement between the organization and an insurer shall be subject to the provisions of the laws of this State regarding reinsurance as provided in Article XI of the Illinois Insurance Code. All reinsurance agreements must be filed. Approval of the Director is required for all agreements except the following: individual stop loss, aggregate excess, hospitalization benefits or out-of-area of the participating

providers unless 20% or more of the organization's total risk is reinsured, in which case all reinsurance agreements require approval.

(d) In addition to any applicable provisions of this Act, premium rate filings shall be subject to subsections (a) and (c) through (i) of Section 355 of the Illinois Insurance Code.

(Source: P.A. 86-620.)

Section 20. The Limited Health Service Organization Act is amended by changing Section 3006 as follows:

(215 ILCS 130/3006) (from Ch. 73, par. 1503-6)

Sec. 3006. Changes in rate methodology and benefits; material modifications; addition of limited health services.

(a) A limited health service organization shall file with the Director prior to use, a notice of any change in rate methodology, charges or benefits and of any material modification of any matter or document furnished pursuant to Section 2001, together with such supporting documents as are necessary to fully explain the change or modification.

(1) Contract modifications described in paragraphs (5) and (6) of subsection (c) of Section 2001 shall include all agreements between the organization and enrollees, providers, administrators of services and insurers of limited health services; also other material transactions or series of transactions, the total annual value of which

exceeds the greater of $100,000 or 5% of net earned subscription revenue for the most current 12 month period as determined from filed financial statements.

(2) Contract modification for reinsurance. Any agreement between the organization and an insurer shall be subject to the provisions of Article XI of the Illinois Insurance Code, as now or hereafter amended. All reinsurance agreements must be filed with the Director. Approval of the Director in required agreements must be filed. Approval of the director is required for all agreements except individual stop loss, aggregate excess, hospitalization benefits or out-of-area of the participating providers, unless 20% or more of the organization's total risk is reinsured, in which case all reinsurance agreements shall require approval.

(b) If a limited health service organization desires to add one or more additional limited health services, it shall file a notice with the Director and, at the same time, submit the information required by Section 2001 if different from that filed with the prepaid limited health service organization's application. Issuance of such an amended certificate of authority shall be subject to the conditions of Section 2002 of this Act.

(c) In addition to any applicable provisions of this Act, premium rate filings shall be subject to subsection (i) of Section 355 of the Illinois Insurance Code.

(Source: P.A. 86-600.)