Sen. Laura Fine

Filed: 5/24/2023

1 AMENDMENT TO HOUSE BILL 2296

2 AMENDMENT NO. ______. Amend House Bill 2296, AS AMENDED,
3 by replacing everything after the enacting clause with the
4 following:

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

7 (20 ILCS 1405/1405-50 new)
8 Sec. 1405-50. Health insurance coverage, affordability,
9 and cost transparency annual report.
10 (a) On or before May 1, 2026, and each May 1 thereafter,
11 the Department of Insurance shall report to the Governor and
12 the General Assembly on health insurance coverage,
13 affordability, and cost trends, including:
14 (1) medical cost trends by major service category,
15 including prescription drugs;
16 (2) utilization patterns of services by major service

1 categories;
2 (3) impact of benefit changes, including essential
3 health benefits and non-essential health benefits;
4 (4) enrollment trends;
5 (5) demographic shifts;
6 (6) geographic factors and variations, including
7 changes in provider availability;
8 (7) health care quality improvement initiatives;
9 (8)inflation and other factors impacting this State's
10 economic condition;
11 (9) the availability of financial assistance and tax
12 credits to pay for health insurance coverage for
13 individuals and small businesses;
14 (10) trends in out-of-pocket costs for consumers; and
15 (11) factors contributing to costs that are not
16 otherwise specified in paragraphs (1) through (10) of this
17 subsection.
18 (b) This report shall not attribute any information or
19 trend to a specific company and shall not disclose any
20 information otherwise considered confidential or proprietary.

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

23 (215 ILCS 5/355) (from Ch. 73, par. 967)
24 Sec. 355. Accident and health policies; provisions.

1 ~~policies-Provisions.)~~
2 (a) As used in this Section:
3 "Inadequate rate" means a rate:
4 (1) that is insufficient to sustain projected losses
5 and expenses to which the rate applies; and
6 (2) the continued use of which endangers the solvency
7 of an insurer using that rate.
8 "Large employer" has the meaning provided in the Illinois
9 Health Insurance Portability and Accountability Act.
10 "Plain language" has the meaning provided in the federal
11 Plain Writing Act of 2010 and subsequent guidance documents,
12 including the Federal Plain Language Guidelines.
13 "Unreasonable rate increase" means a rate increase that
14 the Director determines to be excessive, unjustified, or
15 unfairly discriminatory in accordance with 45 CFR 154.205.
16 (b) No policy of insurance against loss or damage from the
17 sickness, or from the bodily injury or death of the insured by
18 accident shall be issued or delivered to any person in this
19 State until a copy of the form thereof and of the
20 classification of risks and the premium rates pertaining
21 thereto have been filed with the Director; nor shall it be so
22 issued or delivered until the Director shall have approved
23 such policy pursuant to the provisions of Section 143. If the
24 Director disapproves the policy form, he or she shall make a
25 written decision stating the respects in which such form does
26 not comply with the requirements of law and shall deliver a

1 copy thereof to the company and it shall be unlawful
2 thereafter for any such company to issue any policy in such
3 form. On and after January 1, 2025, any form filing submitted
4 for large employer group accident and health insurance shall
5 be automatically deemed approved within 90 days of the
6 submission date unless the Director extends by not more than
7 an additional 30 days the period within which the form shall be
8 approved or disapproved by giving written notice to the
9 insurer of such extension before the expiration of the 90
10 days. Any form in receipt of such an extension shall be
11 automatically deemed approved within 120 days of the
12 submission date. The Director may toll the filing due to a
13 conflict in legal interpretation of federal or State law as
14 long as the tolling is applied uniformly to all applicable
15 forms, written notification is provided to the insurer prior
16 to the tolling, the duration of the tolling is provided within
17 the notice to the insurer, and justification for the tolling
18 is posted to the Department's website. The Director may
19 disapprove the filing if the insurer fails to respond to an
20 objection or request for additional information within the
21 timeframe identified for response. As used in this subsection,
22 "large employer" has the meaning given in Section 5 of the
23 federal Health Insurance Portability and Accountability Act.
24 (c) For plan year 2026 and thereafter, premium rates for
25 all individual and small group accident and health insurance
26 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.

1 (f) After the close of the public comment period described
2 in subsection (e), the Department, beginning for plan year
3 2026, shall issue a decision to approve, disapprove, or modify
4 a rate filing within 60 days. Any rate filing or any rates
5 within a filing on which the Director does not issue a decision
6 within 60 days shall automatically be deemed approved. The
7 Director's decision shall take into account the actuarial
8 justifications and public comments. The Department shall
9 notify the insurer of the decision, make the decision
10 available to the public by posting it on the Department's
11 website, and include an explanation of the findings, actuarial
12 justifications, and rationale that are the basis for the
13 decision. Any company whose rate has been modified or
14 disapproved shall be allowed to request a hearing within 10
15 days after the action taken. The action of the Director in
16 disapproving a rate shall be subject to judicial review under
17 the Administrative Review Law.
18 (g) If, following the issuance of a decision but before
19 the effective date of the premium rates approved by the
20 decision, an event occurs that materially affects the
21 Director's decision to approve, deny, or modify the rates, the
22 Director may consider supplemental facts or data reasonably
23 related to the event.
24 (h) The Department shall adopt rules implementing the
25 procedures described in subsections (d) through (g) by March
26 31, 2024.

1 (i) Subsection (a) and subsections (c) through (h) of this
2 Section do not apply to grandfathered health plans as defined
3 in 45 CFR 147.140; excepted benefits as defined in 42 U.S.C.
4 300gg-91; student health insurance coverage as defined in 45
5 CFR 147.145; the large group market as defined in Section 5 of
6 the Illinois Health Insurance Portability and Accountability
7 Act; or short-term, limited-duration health insurance coverage
8 as defined in Section 5 of the Short-Term, Limited-Duration
9 Health Insurance Coverage Act. For a filing of premium rates
10 or classifications of risk for any of these types of coverage,
11 the Director's initial review period shall not exceed 60 days
12 to issue informal objections to the company that request
13 additional clarification, explanation, substantiating
14 documentation, or correction of concerns identified in the
15 filing before the company implements the premium rates,
16 classifications, or related rate-setting methodologies
17 described in the filing, except that the Director may extend
18 by not more than an additional 30 days the period of initial
19 review by giving written notice to the company of such
20 extension before the expiration of the initial 60-day period.
21 Nothing in this subsection shall confer authority upon the
22 Director to approve, modify, or disapprove rates where that
23 authority is not provided by other law. Nothing in this
24 subsection shall prohibit the Director from conducting any
25 investigation, examination, hearing, or other formal
26 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

1 the information required by Section 2001 if different from
2 that filed with the prepaid limited health service
3 organization's application. Issuance of such an amended
4 certificate of authority shall be subject to the conditions of
5 Section 2002 of this Act.
6 (c) In addition to any applicable provisions of this Act,
7 premium rate filings shall be subject to subsection (i) of
8 Section 355 of the Illinois Insurance Code.
9 (Source: P.A. 86-600.)".