Health Healthcare Disparities Committee

Filed: 3/13/2008

1 AMENDMENT TO HOUSE BILL 5192

2 AMENDMENT NO. ______. Amend House Bill 5192 by replacing
3 everything after the enacting clause with the following:

4 "Article 1. Legislative Intent

5 Section 1-1. Legislative intent. The General Assembly
6 finds that the mortality associated with breast cancer for
7 minority women in Illinois is significantly higher compared to
8 non-minority women. This disparity has grown over the last 2
9 decades and is unacceptable. A recent New England Journal of
10 Medicine article found that even modest cost-sharing deters
11 women from getting a mammogram. The reduction was most
12 pronounced for those with lower income and less education. Many
13 other studies have found that women with lower family income
14 and those relying on public programs for healthcare access
15 mammography at a lower rate. It is, therefore, the intent of
16 this legislation to decrease health disparities as they relate

to breast cancer and to improve access for all women to quality breast cancer screening and treatment where necessary.

Article 5. Improving State Healthcare Programs
With Respect To
Mammography And Breast Cancer Treatment

Section 5-5. The Illinois Public Aid Code is amended by changing Section 5-5 as follows:

(305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women; (11) physical therapy and related services;

1 (12) prescribed drugs, dentures, and prosthetic devices; and
2 eyeglasses prescribed by a physician skilled in the diseases of
3 the eye, or by an optometrist, whichever the person may select;
4 (13) other diagnostic, screening, preventive, and
5 rehabilitative services; (14) transportation and such other
6 expenses as may be necessary; (15) medical treatment of sexual
7 assault survivors, as defined in Section 1a of the Sexual
8 Assault Survivors Emergency Treatment Act, for injuries
9 sustained as a result of the sexual assault, including
10 examinations and laboratory tests to discover evidence which
11 may be used in criminal proceedings arising from the sexual
12 assault; (16) the diagnosis and treatment of sickle cell
13 anemia; and (17) any other medical care, and any other type of
14 remedial care recognized under the laws of this State, but not
15 including abortions, or induced miscarriages or premature
16 births, unless, in the opinion of a physician, such procedures
17 are necessary for the preservation of the life of the woman
18 seeking such treatment, or except an induced premature birth
19 intended to produce a live viable child and such procedure is
20 necessary for the health of the mother or her unborn child. The
21 Illinois Department, by rule, shall prohibit any physician from
22 providing medical assistance to anyone eligible therefor under
23 this Code where such physician has been found guilty of
24 performing an abortion procedure in a wilful and wanton manner
25 upon a woman who was not pregnant at the time such abortion
26 procedure was performed. The term "any other type of remedial

care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

Notwithstanding any other provision of this Section, a comprehensive tobacco use cessation program that includes purchasing prescription drugs or prescription medical devices approved by the Food and Drug administration shall be covered under the medical assistance program under this Article for persons who are otherwise eligible for assistance under this Article.

Notwithstanding any other provision of this Code, the Illinois Department may not require, as a condition of payment for any laboratory test authorized under this Article, that a physician's handwritten signature appear on the laboratory test order form. The Illinois Department may, however, impose other appropriate requirements regarding laboratory test order documentation.

The Department of Healthcare and Family Services shall provide the following services to persons eligible for assistance under this Article who are participating in education, training or employment programs operated by the Department of Human Services as successor to the Department of Public Aid:

(1) dental services, which shall include but not be limited to prosthodontics; and

(2) eyeglasses prescribed by a physician skilled in the

diseases of the eye, or by an optometrist, whichever the person may select.

The Illinois Department, by rule, may distinguish and classify the medical services to be provided only in accordance with the classes of persons designated in Section 5-2.

The Department of Healthcare and Family Services must provide coverage and reimbursement for amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

The Illinois Department shall authorize the provision of, and shall authorize payment for, screening by low-dose mammography for the presence of occult breast cancer for women 35 years of age or older who are eligible for medical assistance under this Article, as follows:

(A) A ~~a~~ baseline mammogram for women 35 to 39 years of age. ~~and an~~

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

(C) A mammogram at the age and intervals considered medically necessary by the woman's health care provider for women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.

1 (D) A comprehensive ultrasound screening of an entire
2 breast or breasts if a mammogram demonstrates
3 heterogeneous or dense breast tissue, when medically
4 necessary as determined by a physician licensed to practice
5 medicine in all of its branches.
6 All screenings shall include a physical breast exam,
7 instruction on self-examination and information regarding the
8 frequency of self-examination and its value as a preventative
9 tool. For purposes of ~~As used in~~ this Section, "low-dose
10 mammography" means the x-ray examination of the breast using
11 equipment dedicated specifically for mammography, including
12 the x-ray tube, filter, compression device, and image receptor,
13 ~~and cassettes,~~ with an average radiation exposure delivery of
14 less than one rad per breast for ~~mid-breast, with~~ 2 views of an
15 average size ~~for each~~ breast. The term also includes digital
16 mammography.
17 On and after July 1, 2008, screening and diagnostic
18 mammography shall be reimbursed at the same rate as the
19 Medicare program's rates, including the increased
20 reimbursement for digital mammography.
21 The Department shall convene an expert panel including
22 representatives of hospitals, free-standing mammography
23 facilities, and doctors, including radiologists, to establish
24 quality standards. Based on these quality standards, the
25 Department shall provide for bonus payments to mammography
26 facilities meeting the standards for screening and diagnosis.

1 The bonus payments shall be at least 15% higher than the
2 Medicare rates for mammography.
3 Subject to federal approval, the Department shall
4 establish a rate methodology for mammography at federally
5 qualified health centers and other encounter-rate clinics.
6 These clinics or centers may also collaborate with other
7 hospital-based mammography facilities.
8 The Department shall establish a methodology to remind
9 women who are age-appropriate for screening mammography, but
10 who have not received a mammogram within the previous 18
11 months, of the importance and benefit of screening mammography.
12 The Department shall establish a performance goal for
13 primary care providers with respect to their female patients
14 over age 40 receiving an annual mammogram. This performance
15 goal shall be used to provide additional reimbursement in the
16 form of a quality performance bonus to primary care providers
17 who meet that goal.
18 The Department shall devise a means of case-managing or
19 patient navigation for beneficiaries diagnosed with breast
20 cancer. This program shall initially operate as a pilot program
21 in areas of the State with the highest incidence of mortality
22 related to breast cancer. At least one pilot program site shall
23 be in the metropolitan Chicago area and at least one site shall
24 be outside the metropolitan Chicago area. An evaluation of the
25 pilot program shall be carried out measuring health outcomes
26 and cost of care for those served by the pilot program compared

to similarly situated patients who are not served by the pilot program.

Any medical or health care provider shall immediately recommend, to any pregnant woman who is being provided prenatal services and is suspected of drug abuse or is addicted as defined in the Alcoholism and Other Drug Abuse and Dependency Act, referral to a local substance abuse treatment provider licensed by the Department of Human Services or to a licensed hospital which provides substance abuse treatment services. The Department of Healthcare and Family Services shall assure coverage for the cost of treatment of the drug abuse or addiction for pregnant recipients in accordance with the Illinois Medicaid Program in conjunction with the Department of Human Services.

All medical providers providing medical assistance to pregnant women under this Code shall receive information from the Department on the availability of services under the Drug Free Families with a Future or any comparable program providing case management services for addicted women, including information on appropriate referrals for other social services that may be needed by addicted women in addition to treatment for addiction.

The Illinois Department, in cooperation with the Departments of Human Services (as successor to the Department of Alcoholism and Substance Abuse) and Public Health, through a public awareness campaign, may provide information concerning

1 treatment for alcoholism and drug abuse and addiction, prenatal
2 health care, and other pertinent programs directed at reducing
3 the number of drug-affected infants born to recipients of
4 medical assistance.

5 Neither the Department of Healthcare and Family Services
6 nor the Department of Human Services shall sanction the
7 recipient solely on the basis of her substance abuse.

8 The Illinois Department shall establish such regulations
9 governing the dispensing of health services under this Article
10 as it shall deem appropriate. The Department should seek the
11 advice of formal professional advisory committees appointed by
12 the Director of the Illinois Department for the purpose of
13 providing regular advice on policy and administrative matters,
14 information dissemination and educational activities for
15 medical and health care providers, and consistency in
16 procedures to the Illinois Department.

17 The Illinois Department may develop and contract with
18 Partnerships of medical providers to arrange medical services
19 for persons eligible under Section 5-2 of this Code.
20 Implementation of this Section may be by demonstration projects
21 in certain geographic areas. The Partnership shall be
22 represented by a sponsor organization. The Department, by rule,
23 shall develop qualifications for sponsors of Partnerships.
24 Nothing in this Section shall be construed to require that the
25 sponsor organization be a medical organization.

26 The sponsor must negotiate formal written contracts with

medical providers for physician services, inpatient and outpatient hospital care, home health services, treatment for alcoholism and substance abuse, and other services determined necessary by the Illinois Department by rule for delivery by Partnerships. Physician services must include prenatal and obstetrical care. The Illinois Department shall reimburse medical services delivered by Partnership providers to clients in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

(1) Physicians participating in a Partnership and providing certain services, which shall be determined by the Illinois Department, to persons in areas covered by the Partnership may receive an additional surcharge for such services.

(2) The Department may elect to consider and negotiate financial incentives to encourage the development of Partnerships and the efficient delivery of medical care.

(3) Persons receiving medical services through Partnerships may receive medical and case management services above the level usually offered through the medical assistance program.

Medical providers shall be required to meet certain qualifications to participate in Partnerships to ensure the delivery of high quality medical services. These qualifications shall be determined by rule of the Illinois Department and may be higher than qualifications for

participation in the medical assistance program. Partnership sponsors may prescribe reasonable additional qualifications for participation by medical providers, only with the prior written approval of the Illinois Department.

Nothing in this Section shall limit the free choice of practitioners, hospitals, and other providers of medical services by clients. In order to ensure patient freedom of choice, the Illinois Department shall immediately promulgate all rules and take all other necessary actions so that provided services may be accessed from therapeutically certified optometrists to the full extent of the Illinois Optometric Practice Act of 1987 without discriminating between service providers.

The Department shall apply for a waiver from the United States Health Care Financing Administration to allow for the implementation of Partnerships under this Section.

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to

1 fully and accurately document the nature, scope, details and
2 receipt of the health care provided to persons eligible for
3 medical assistance under this Code, in accordance with
4 regulations promulgated by the Illinois Department. The rules
5 and regulations shall require that proof of the receipt of
6 prescription drugs, dentures, prosthetic devices and
7 eyeglasses by eligible persons under this Section accompany
8 each claim for reimbursement submitted by the dispenser of such
9 medical services. No such claims for reimbursement shall be
10 approved for payment by the Illinois Department without such
11 proof of receipt, unless the Illinois Department shall have put
12 into effect and shall be operating a system of post-payment
13 audit and review which shall, on a sampling basis, be deemed
14 adequate by the Illinois Department to assure that such drugs,
15 dentures, prosthetic devices and eyeglasses for which payment
16 is being made are actually being received by eligible
17 recipients. Within 90 days after the effective date of this
18 amendatory Act of 1984, the Illinois Department shall establish
19 a current list of acquisition costs for all prosthetic devices
20 and any other items recognized as medical equipment and
21 supplies reimbursable under this Article and shall update such
22 list on a quarterly basis, except that the acquisition costs of
23 all prescription drugs shall be updated no less frequently than
24 every 30 days as required by Section 5-5.12.
25 The rules and regulations of the Illinois Department shall
26 require that a written statement including the required opinion

of a physician shall accompany any claim for reimbursement for abortions, or induced miscarriages or premature births. This statement shall indicate what procedures were used in providing such medical services.

The Illinois Department shall require all dispensers of medical services, other than an individual practitioner or group of practitioners, desiring to participate in the Medical Assistance program established under this Article to disclose all financial, beneficial, ownership, equity, surety or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services in this State under this Article.

The Illinois Department may require that all dispensers of medical services desiring to participate in the medical assistance program established under this Article disclose, under such terms and conditions as the Illinois Department may by rule establish, all inquiries from clients and attorneys regarding medical bills paid by the Illinois Department, which inquiries could indicate potential existence of claims or liens for the Illinois Department.

Enrollment of a vendor that provides non-emergency medical transportation, defined by the Department by rule, shall be conditional for 180 days. During that time, the Department of Healthcare and Family Services may terminate the vendor's eligibility to participate in the medical assistance program

without cause. That termination of eligibility is not subject to the Department's hearing process.

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients without medical authorization; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of the recipient's needs, and the requirements and costs for maintaining such equipment. Such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department.

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped.

The Illinois Department shall develop and operate, in

1 cooperation with other State Departments and agencies and in
2 compliance with applicable federal laws and regulations,
3 appropriate and effective systems of health care evaluation and
4 programs for monitoring of utilization of health care services
5 and facilities, as it affects persons eligible for medical
6 assistance under this Code.

7 The Illinois Department shall report annually to the
8 General Assembly, no later than the second Friday in April of
9 1979 and each year thereafter, in regard to:

10 (a) actual statistics and trends in utilization of
11 medical services by public aid recipients;

12 (b) actual statistics and trends in the provision of
13 the various medical services by medical vendors;

14 (c) current rate structures and proposed changes in
15 those rate structures for the various medical vendors; and

16 (d) efforts at utilization review and control by the
17 Illinois Department.

18 The period covered by each report shall be the 3 years
19 ending on the June 30 prior to the report. The report shall
20 include suggested legislation for consideration by the General
21 Assembly. The filing of one copy of the report with the
22 Speaker, one copy with the Minority Leader and one copy with
23 the Clerk of the House of Representatives, one copy with the
24 President, one copy with the Minority Leader and one copy with
25 the Secretary of the Senate, one copy with the Legislative
26 Research Unit, and such additional copies with the State

1 Government Report Distribution Center for the General Assembly
2 as is required under paragraph (t) of Section 7 of the State
3 Library Act shall be deemed sufficient to comply with this
4 Section.
5 (Source: P.A. 95-331, eff. 8-21-07; 95-520, eff. 8-28-07.)

6 Article 10. Breast Cancer Patients'
7 Access To Pain Relief

8 Section 10-5. The Illinois Insurance Code is amended by
9 adding Section 356g.5-1 as follows:

10 (215 ILCS 5/356g.5-1 new)
11 Sec. 356g.5-1. Breast cancer pain medication and therapy. A
12 group or individual policy of accident and health insurance or
13 managed care plan that is amended, delivered, issued, or
14 renewed after the effective date of this amendatory Act of the
15 95th General Assembly must provide coverage for all medically
16 necessary pain medication and pain therapy related to the
17 treatment of breast cancer on the same terms and conditions
18 that are generally applicable to coverage for other conditions.
19 For purposes of this Section, "pain therapy" means pain therapy
20 that is medically based and includes reasonably defined goals,
21 including, but not limited to, stabilizing or reducing pain,
22 with periodic evaluations of the efficacy of the pain therapy
23 against these goals. The provisions of this Section do not

apply to short-term travel, accident-only, limited, or specified-disease policies, or to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under State or federal governmental plans.

Section 10-10. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, ~~and~~ 356z.9, and 356z.10 ~~356z.9~~ of the Illinois Insurance Code. The program of health benefits must comply with Section 155.37 of the Illinois Insurance Code.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 10-15. The Counties Code is amended by changing Section 5-1069.3 as follows:

1 (55 ILCS 5/5-1069.3)
2 Sec. 5-1069.3. Required health benefits. If a county,
3 including a home rule county, is a self-insurer for purposes of
4 providing health insurance coverage for its employees, the
5 coverage shall include coverage for the post-mastectomy care
6 benefits required to be covered by a policy of accident and
7 health insurance under Section 356t and the coverage required
8 under Sections 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, ~~and~~
9 356z.9, and 356z.10 ~~356z.9~~ of the Illinois Insurance Code. The
10 requirement that health benefits be covered as provided in this
11 Section is an exclusive power and function of the State and is
12 a denial and limitation under Article VII, Section 6,
13 subsection (h) of the Illinois Constitution. A home rule county
14 to which this Section applies must comply with every provision
15 of this Section.
16 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
17 95-520, eff. 8-28-07; revised 12-4-07.)

18 Section 10-20. The Illinois Municipal Code is amended by
19 changing Section 10-4-2.3 as follows:

20 (65 ILCS 5/10-4-2.3)
21 Sec. 10-4-2.3. Required health benefits. If a
22 municipality, including a home rule municipality, is a
23 self-insurer for purposes of providing health insurance

coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, ~~and~~ 356z.9, and 356z.10 ~~356z.9~~ of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 10-25. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, and 356z.9 of the Illinois Insurance Code.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; revised 12-4-07.)

Section 10-30. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 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, 355.2, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10 ~~356z.9~~, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

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

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

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

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents

1 of this State, except a corporation subject to
2 substantially the same requirements in its state of
3 organization as is a "domestic company" under Article VIII
4 1/2 of the Illinois Insurance Code.
5 (c) In considering the merger, consolidation, or other
6 acquisition of control of a Health Maintenance Organization
7 pursuant to Article VIII 1/2 of the Illinois Insurance Code,
8 (1) the Director shall give primary consideration to
9 the continuation of benefits to enrollees and the financial
10 conditions of the acquired Health Maintenance Organization
11 after the merger, consolidation, or other acquisition of
12 control takes effect;
13 (2)(i) the criteria specified in subsection (1)(b) of
14 Section 131.8 of the Illinois Insurance Code shall not
15 apply and (ii) the Director, in making his determination
16 with respect to the merger, consolidation, or other
17 acquisition of control, need not take into account the
18 effect on competition of the merger, consolidation, or
19 other acquisition of control;
20 (3) the Director shall have the power to require the
21 following information:
22 (A) certification by an independent actuary of the
23 adequacy of the reserves of the Health Maintenance
24 Organization sought to be acquired;
25 (B) pro forma financial statements reflecting the
26 combined balance sheets of the acquiring company and

1 the Health Maintenance Organization sought to be
2 acquired as of the end of the preceding year and as of
3 a date 90 days prior to the acquisition, as well as pro
4 forma financial statements reflecting projected
5 combined operation for a period of 2 years;
6 (C) a pro forma business plan detailing an
7 acquiring party's plans with respect to the operation
8 of the Health Maintenance Organization sought to be
9 acquired for a period of not less than 3 years; and
10 (D) such other information as the Director shall
11 require.
12 (d) The provisions of Article VIII 1/2 of the Illinois
13 Insurance Code and this Section 5-3 shall apply to the sale by
14 any health maintenance organization of greater than 10% of its
15 enrollee population (including without limitation the health
16 maintenance organization's right, title, and interest in and to
17 its health care certificates).
18 (e) In considering any management contract or service
19 agreement subject to Section 141.1 of the Illinois Insurance
20 Code, the Director (i) shall, in addition to the criteria
21 specified in Section 141.2 of the Illinois Insurance Code, take
22 into account the effect of the management contract or service
23 agreement on the continuation of benefits to enrollees and the
24 financial condition of the health maintenance organization to
25 be managed or serviced, and (ii) need not take into account the
26 effect of the management contract or service agreement on

competition.

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

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

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable

1 or unprofitable experience may be calculated taking into
2 account the refund period and the immediately preceding 2
3 plan years.
4 The Health Maintenance Organization shall include a
5 statement in the evidence of coverage issued to each enrollee
6 describing the possibility of a refund or additional premium,
7 and upon request of any group or enrollment unit, provide to
8 the group or enrollment unit a description of the method used
9 to calculate (1) the Health Maintenance Organization's
10 profitable experience with respect to the group or enrollment
11 unit and the resulting refund to the group or enrollment unit
12 or (2) the Health Maintenance Organization's unprofitable
13 experience with respect to the group or enrollment unit and the
14 resulting additional premium to be paid by the group or
15 enrollment unit.
16 In no event shall the Illinois Health Maintenance
17 Organization Guaranty Association be liable to pay any
18 contractual obligation of an insolvent organization to pay any
19 refund authorized under this Section.
20 (Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06;
21 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

22 Section 10-35. The Voluntary Health Services Plans Act is
23 amended by changing Section 10 as follows:

24 (215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c, 149, 155.37, 354, 355.2, 356g.5, 356g.5-1, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10 ~~356z.9~~, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.
(Source: P.A. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07; 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-5-07.)

Article 15. Reducing Financial Barriers To Mammography

Section 15-5. The Illinois Insurance Code is amended by changing Section 356g as follows:

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

Sec. 356g. Mammograms; mastectomies.

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

1 coverage shall be as follows:
2 (1) A baseline mammogram for women 35 to 39 years of
3 age.
4 (2) An annual mammogram for women 40 years of age or
5 older.
6 (3) A mammogram at the age and intervals considered
7 medically necessary by the woman's health care provider for
8 women under 40 years of age and having a family history of
9 breast cancer, prior personal history of breast cancer,
10 positive genetic testing, or other risk factors.
11 (4) A comprehensive ultrasound screening of an entire
12 breast or breasts if a mammogram demonstrates
13 heterogeneous or dense breast tissue, when medically
14 necessary as determined by a physician licensed to practice
15 medicine in all of its branches.
16 ~~These benefits shall be at least as favorable as for other~~
17 ~~radiological examinations and subject to the same dollar~~
18 ~~limits, deductibles, and co-insurance factors.~~ For purposes of
19 this Section, "low-dose mammography" means the x-ray
20 examination of the breast using equipment dedicated
21 specifically for mammography, including the x-ray tube,
22 filter, compression device, and image receptor, with radiation
23 exposure delivery of less than 1 rad per breast for 2 views of
24 an average size breast. <u>The term also includes digital</u>
25 <u>mammography.</u>
26 <u>(a-5) Coverage as described by subsection (a) shall be</u>

provided at no cost to the insured and shall not be applied to an annual or lifetime maximum benefit.

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

(b) No policy of accident or health insurance that provides for the surgical procedure known as a mastectomy shall be issued, amended, delivered, or renewed in this State unless that coverage also provides for prosthetic devices or reconstructive surgery incident to the mastectomy. Coverage for breast reconstruction in connection with a mastectomy shall include:

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

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

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

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

13 Written notice of the availability of coverage under this
14 Section shall be delivered to the insured upon enrollment and
15 annually thereafter. An insurer may not deny to an insured
16 eligibility, or continued eligibility, to enroll or to renew
17 coverage under the terms of the plan solely for the purpose of
18 avoiding the requirements of this Section. An insurer may not
19 penalize or reduce or limit the reimbursement of an attending
20 provider or provide incentives (monetary or otherwise) to an
21 attending provider to induce the provider to provide care to an
22 insured in a manner inconsistent with this Section.
23 (Source: P.A. 94-121, eff. 7-6-05; 95-431, eff. 8-24-07.)

24 Section 15-10. The State Employees Group Insurance Act of
25 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, ~~and~~ 356z.9, and 356z.10 ~~356z.9~~ of the Illinois Insurance Code. The program of health benefits must comply with Section 155.37 of the Illinois Insurance Code.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 15-15. The Counties Code is amended by changing Sections 5-1069 and 5-1069.3 as follows:

(55 ILCS 5/5-1069) (from Ch. 34, par. 5-1069)

Sec. 5-1069. Group life, health, accident, hospital, and medical insurance.

(a) The county board of any county may arrange to provide, for the benefit of employees of the county, group life, health, accident, hospital, and medical insurance, or any one or any combination of those types of insurance, or the county board may self-insure, for the benefit of its employees, all or a

1 portion of the employees' group life, health, accident,
2 hospital, and medical insurance, or any one or any combination
3 of those types of insurance, including a combination of
4 self-insurance and other types of insurance authorized by this
5 Section, provided that the county board complies with all other
6 requirements of this Section. The insurance may include
7 provision for employees who rely on treatment by prayer or
8 spiritual means alone for healing in accordance with the tenets
9 and practice of a well recognized religious denomination. The
10 county board may provide for payment by the county of a portion
11 or all of the premium or charge for the insurance with the
12 employee paying the balance of the premium or charge, if any.
13 If the county board undertakes a plan under which the county
14 pays only a portion of the premium or charge, the county board
15 shall provide for withholding and deducting from the
16 compensation of those employees who consent to join the plan
17 the balance of the premium or charge for the insurance.
18 (b) If the county board does not provide for self-insurance
19 or for a plan under which the county pays a portion or all of
20 the premium or charge for a group insurance plan, the county
21 board may provide for withholding and deducting from the
22 compensation of those employees who consent thereto the total
23 premium or charge for any group life, health, accident,
24 hospital, and medical insurance.
25 (c) The county board may exercise the powers granted in
26 this Section only if it provides for self-insurance or, where

it makes arrangements to provide group insurance through an insurance carrier, if the kinds of group insurance are obtained from an insurance company authorized to do business in the State of Illinois. The county board may enact an ordinance prescribing the method of operation of the insurance program.

(d) If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the insurance coverage shall include screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer unless the county elects to provide mammograms itself under Section 5-1069.1. The coverage shall be as follows:

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

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

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

(4) A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a physician licensed to practice medicine in all of its branches.

1 ~~Those benefits shall be at least as favorable as for other~~
2 ~~radiological examinations and subject to the same dollar~~
3 ~~limits, deductibles, and co-insurance factors.~~ For purposes of
4 this subsection, "low-dose mammography" means the x-ray
5 examination of the breast using equipment dedicated
6 specifically for mammography, including the x-ray tube,
7 filter, compression device, ~~screens,~~ and image receptor
8 ~~receptors~~, with an average radiation exposure delivery of less
9 than one rad per breast for ~~mid-breast, with~~ 2 views of an
10 average size ~~for each~~ breast. The term also includes digital
11 mammography.
12 (d-5) Coverage as described by subsection (d) shall be
13 provided at no cost to the insured and shall not be applied to
14 an annual or lifetime maximum benefit.
15 (d-10) When health care services are available through
16 contracted providers and a person does not comply with plan
17 provisions specific to the use of contracted providers, the
18 requirements of subsection (d-5) are not applicable. When a
19 person does not comply with plan provisions specific to the use
20 of contracted providers, plan provisions specific to the use of
21 non-contracted providers must be applied without distinction
22 for coverage required by this Section and shall be at least as
23 favorable as for other radiological examinations covered by the
24 policy or contract.
25 (d-15) If a county, including a home rule county, is a
26 self-insurer for purposes of providing health insurance

1 coverage for its employees, the insurance coverage shall
2 include mastectomy coverage, which includes coverage for
3 prosthetic devices or reconstructive surgery incident to the
4 mastectomy. Coverage for breast reconstruction in connection
5 with a mastectomy shall include:
6 (1) reconstruction of the breast upon which the
7 mastectomy has been performed;
8 (2) surgery and reconstruction of the other breast to
9 produce a symmetrical appearance; and
10 (3) prostheses and treatment for physical
11 complications at all stages of mastectomy, including
12 lymphedemas.
13 Care shall be determined in consultation with the attending
14 physician and the patient. The offered coverage for prosthetic
15 devices and reconstructive surgery shall be subject to the
16 deductible and coinsurance conditions applied to the
17 mastectomy, and all other terms and conditions applicable to
18 other benefits. When a mastectomy is performed and there is no
19 evidence of malignancy then the offered coverage may be limited
20 to the provision of prosthetic devices and reconstructive
21 surgery to within 2 years after the date of the mastectomy. As
22 used in this Section, "mastectomy" means the removal of all or
23 part of the breast for medically necessary reasons, as
24 determined by a licensed physician.
25 A county, including a home rule county, that is a
26 self-insurer for purposes of providing health insurance

1 coverage for its employees, may not penalize or reduce or limit
2 the reimbursement of an attending provider or provide
3 incentives (monetary or otherwise) to an attending provider to
4 induce the provider to provide care to an insured in a manner
5 inconsistent with this Section.
6 (d-20) The requirement that mammograms be included in
7 health insurance coverage as provided in subsections this
8 subsection (d) through (d-15) is an exclusive power and
9 function of the State and is a denial and limitation under
10 Article VII, Section 6, subsection (h) of the Illinois
11 Constitution of home rule county powers. A home rule county to
12 which subsections (d) through (d-15) apply this subsection
13 applies must comply with every provision of those subsections
14 this subsection.
15 (e) The term "employees" as used in this Section includes
16 elected or appointed officials but does not include temporary
17 employees.
18 (f) The county board may, by ordinance, arrange to provide
19 group life, health, accident, hospital, and medical insurance,
20 or any one or a combination of those types of insurance, under
21 this Section to retired former employees and retired former
22 elected or appointed officials of the county.
23 (Source: P.A. 90-7, eff. 6-10-97; 91-217, eff. 1-1-00.)

24 (55 ILCS 5/5-1069.3)
25 Sec. 5-1069.3. Required health benefits. If a county,

including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356u, 356w, 356x, 356z.6, ~~and~~ 356z.9, and 356z.10 ~~356z.9~~ of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 15-20. The Illinois Municipal Code is amended by changing Sections 10-4-2 and 10-4-2.3 as follows:

(65 ILCS 5/10-4-2) (from Ch. 24, par. 10-4-2)

Sec. 10-4-2. Group insurance.

(a) The corporate authorities of any municipality may arrange to provide, for the benefit of employees of the municipality, group life, health, accident, hospital, and medical insurance, or any one or any combination of those types of insurance, and may arrange to provide that insurance for the

benefit of the spouses or dependents of those employees. The insurance may include provision for employees or other insured persons who rely on treatment by prayer or spiritual means alone for healing in accordance with the tenets and practice of a well recognized religious denomination. The corporate authorities may provide for payment by the municipality of a portion of the premium or charge for the insurance with the employee paying the balance of the premium or charge. If the corporate authorities undertake a plan under which the municipality pays a portion of the premium or charge, the corporate authorities shall provide for withholding and deducting from the compensation of those municipal employees who consent to join the plan the balance of the premium or charge for the insurance.

(b) If the corporate authorities do not provide for a plan under which the municipality pays a portion of the premium or charge for a group insurance plan, the corporate authorities may provide for withholding and deducting from the compensation of those employees who consent thereto the premium or charge for any group life, health, accident, hospital, and medical insurance.

(c) The corporate authorities may exercise the powers granted in this Section only if the kinds of group insurance are obtained from an insurance company authorized to do business in the State of Illinois, or are obtained through an intergovernmental joint self-insurance pool as authorized

under the Intergovernmental Cooperation Act. The corporate authorities may enact an ordinance prescribing the method of operation of the insurance program.

(d) If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the insurance coverage shall include screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer unless the municipality elects to provide mammograms itself under Section 10-4-2.1. The coverage shall be as follows:

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

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

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

(4) A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a physician licensed to practice medicine in all of its branches.

~~Those benefits shall be at least as favorable as for other radiological examinations and subject to the same dollar~~

~~limits, deductibles, and co-insurance factors.~~ For purposes of this subsection, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, ~~screens,~~ and image receptor ~~receptors~~, with an average radiation exposure delivery of less than one rad per breast for ~~mid-breast, with~~ 2 views of an average size ~~for each~~ breast. The term also includes digital mammography.

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

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

(d-15) If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the insurance coverage shall include mastectomy coverage, which includes

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

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

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

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

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

A municipality, including a home rule municipality, that is a self-insurer for purposes of providing health insurance coverage for its employees, may not penalize or reduce or limit the reimbursement of an attending provider or provide

incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with this Section.

(d-20) The requirement that mammograms be included in health insurance coverage as provided in subsections ~~this subsection~~ (d) through (d-15) is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution of home rule municipality powers. A home rule municipality to which subsections (d) through (d-15) apply ~~this subsection applies~~ must comply with every provision of through subsections ~~this subsection~~.

(Source: P.A. 90-7, eff. 6-10-97; 91-160, eff. 1-1-00.)

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356u, 356w, 356x, 356z.6, ~~and~~ 356z.9, and 356z.10 ~~356z.9~~ of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under

1 Article VII, Section 6, subsection (h) of the Illinois
2 Constitution. A home rule municipality to which this Section
3 applies must comply with every provision of this Section.
4 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
5 95-520, eff. 8-28-07; revised 12-4-07.)

6 Section 15-25. The School Code is amended by changing
7 Section 10-22.3f as follows:

8 (105 ILCS 5/10-22.3f)
9 Sec. 10-22.3f. Required health benefits. Insurance
10 protection and benefits for employees shall provide the
11 post-mastectomy care benefits required to be covered by a
12 policy of accident and health insurance under Section 356t and
13 the coverage required under Sections 356g, 356g.5, 356u, 356w,
14 356x, 356z.6, and 356z.9 of the Illinois Insurance Code.
15 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
16 revised 12-4-07.)

17 Section 15-30. The Health Maintenance Organization Act is
18 amended by changing Section 4-6.1 as follows:

19 (215 ILCS 125/4-6.1) (from Ch. 111 1/2, par. 1408.7)
20 Sec. 4-6.1. Mammograms; mastectomies.
21 (a) Every contract or evidence of coverage issued by a
22 Health Maintenance Organization for persons who are residents

of this State shall contain coverage for screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer. The coverage shall be as follows:

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

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

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

(4) A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a physician licensed to practice medicine in all of its branches.

~~These benefits shall be at least as favorable as for other radiological examinations and subject to the same dollar limits, deductibles, and co-insurance factors.~~ For purposes of this Section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of

1 an average size breast. The term also includes digital
2 mammography.
3 (a-5) Coverage as described in subsection (a) shall be
4 provided at no cost to the enrollee and shall not be applied to
5 an annual or lifetime maximum benefit.
6 (b) No contract or evidence of coverage issued by a health
7 maintenance organization that provides for the surgical
8 procedure known as a mastectomy shall be issued, amended,
9 delivered, or renewed in this State on or after the effective
10 date of this amendatory Act of the 92nd General Assembly unless
11 that coverage also provides for prosthetic devices or
12 reconstructive surgery incident to the mastectomy, providing
13 that the mastectomy is performed after the effective date of
14 this amendatory Act. Coverage for breast reconstruction in
15 connection with a mastectomy shall include:
16 (1) reconstruction of the breast upon which the
17 mastectomy has been performed;
18 (2) surgery and reconstruction of the other breast to
19 produce a symmetrical appearance; and
20 (3) prostheses and treatment for physical
21 complications at all stages of mastectomy, including
22 lymphedemas.
23 Care shall be determined in consultation with the attending
24 physician and the patient. The offered coverage for prosthetic
25 devices and reconstructive surgery shall be subject to the
26 deductible and coinsurance conditions applied to the

1 mastectomy and all other terms and conditions applicable to
2 other benefits. When a mastectomy is performed and there is no
3 evidence of malignancy, then the offered coverage may be
4 limited to the provision of prosthetic devices and
5 reconstructive surgery to within 2 years after the date of the
6 mastectomy. As used in this Section, "mastectomy" means the
7 removal of all or part of the breast for medically necessary
8 reasons, as determined by a licensed physician.
9 Written notice of the availability of coverage under this
10 Section shall be delivered to the enrollee upon enrollment and
11 annually thereafter. A health maintenance organization may not
12 deny to an enrollee eligibility, or continued eligibility, to
13 enroll or to renew coverage under the terms of the plan solely
14 for the purpose of avoiding the requirements of this Section. A
15 health maintenance organization may not penalize or reduce or
16 limit the reimbursement of an attending provider or provide
17 incentives (monetary or otherwise) to an attending provider to
18 induce the provider to provide care to an insured in a manner
19 inconsistent with this Section.
20 (Source: P.A. 94-121, eff. 7-6-05; 95-431, eff. 8-24-07.)

21 Section 15-35. The Voluntary Health Services Plans Act is
22 amended by changing Section 10 as follows:

23 (215 ILCS 165/10) (from Ch. 32, par. 604)
24 Sec. 10. Application of Insurance Code provisions. Health

1 services plan corporations and all persons interested therein
2 or dealing therewith shall be subject to the provisions of
3 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,
4 149, 155.37, 354, 355.2, 356g, 356g.5, 356r, 356t, 356u, 356v,
5 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6,
6 356z.8, 356z.9, 356z.10 ~~356z.9~~, 364.01, 367.2, 368a, 401,
7 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7)
8 and (15) of Section 367 of the Illinois Insurance Code.
9 (Source: P.A. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07;
10 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff.
11 8-28-07; revised 12-5-07.)

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