Sen. M. Maggie Crotty

Filed: 5/21/2008

AMENDMENT TO HOUSE BILL 5595

AMENDMENT NO. ______. Amend House Bill 5595 by replacing everything after the enacting clause with the following:

"Section 5. 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, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, ~~and~~ 356z.9, 356z.10, and 356z.11 ~~and 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. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

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.5, 356u, 356w, 356x, 356z.6, ~~and~~ 356z.9, 356z.10, and 356z.11 ~~and 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. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(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.5, 356u, 356w, 356x, 356z.6, ~~and~~ 356z.9, 356z.10, and 356z.11 ~~and 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 20. 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

1 policy of accident and health insurance under Section 356t and
2 the coverage required under Sections 356g.5, 356u, 356w, 356x,
3 356z.6, ~~and~~ 356z.9, and 356z.11 of the Illinois Insurance Code.
4 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
5 revised 12-4-07.)

6 Section 25. The Illinois Insurance Code is amended by
7 adding Sections 356z.11 and 370c as follows:

8 (215 ILCS 5/356z.11 new)
9 Sec. 356z.11. Habilitative services for children.
10 (a) As used in this Section, "habilitative services" means
11 occupational therapy, physical therapy, speech therapy, and
12 other services prescribed by the insured's treating physician
13 pursuant to a treatment plan to enhance the ability of a child
14 to function with a congenital, genetic, or early acquired
15 disorder. A congenital or genetic disorder includes, but is not
16 limited to, hereditary disorders. An early acquired disorder
17 refers to a disorder resulting from illness, trauma, injury, or
18 some other event or condition suffered by a child prior to that
19 child developing functional life skills such as, but not
20 limited to, walking, talking, or self-help skills. Congenital,
21 genetic, and early acquired disorders may include, but are not
22 limited to, autism or an autism spectrum disorder, cerebral
23 palsy, and other disorders resulting from early childhood
24 illness, trauma, or injury.

(b) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly must provide coverage for habilitative services for children under 19 years of age with a congenital, genetic, or early acquired disorder so long as all of the following conditions are met:

(1) A physician licensed to practice medicine in all its branches has diagnosed the child's congenital, genetic, or early acquired disorder.

(2) The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, licensed physician, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist upon the referral of a physician licensed to practice medicine in all its branches.

(3) The initial or continued treatment must be medically necessary and therapeutic and not experimental or investigational.

(c) The coverage required by this Section shall be subject to other general exclusions and limitations of the policy, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services,

1 including review of medical necessity, case management,
2 experimental, and investigational treatments, and other
3 managed care provisions.
4 (d) Coverage under this Section does not apply to those
5 services that are solely educational in nature or otherwise
6 paid under State or federal law for purely educational
7 services. Nothing in this subsection (d) relieves an insurer or
8 similar third party from an otherwise valid obligation to
9 provide or to pay for services provided to a child with a
10 disability.
11 (e) Coverage under this Section for children under age 19
12 shall not apply to treatment of mental or emotional disorders
13 or illnesses as covered under Section 370 of this Code as well
14 as any other benefit based upon a specific diagnosis that may
15 be otherwise required by law.
16 (f) The provisions of this Section do not apply to
17 short-term travel, accident-only, limited, or specific disease
18 policies.
19 (g) Any denial of care for habilitative services shall be
20 subject to appeal and external independent review procedures as
21 provided by Section 45 of the Managed Care Reform and Patient
22 Rights Act.
23 (h) Upon request of the reimbursing insurer, the provider
24 under whose supervision the habilitative services are being
25 provided shall furnish medical records, clinical notes, or
26 other necessary data to allow the insurer to substantiate that

1 initial or continued medical treatment is medically necessary
2 and that the patient's condition is clinically improving. When
3 the treating provider anticipates that continued treatment is
4 or will be required to permit the patient to achieve
5 demonstrable progress, the insurer may request that the
6 provider furnish a treatment plan consisting of diagnosis,
7 proposed treatment by type, frequency, anticipated duration of
8 treatment, the anticipated goals of treatment, and how
9 frequently the treatment plan will be updated.
10 (i) Notwithstanding any other rulemaking authority that
11 may exist, neither the Governor nor any agency or agency head
12 under the jurisdiction of the Governor has any authority to
13 make or promulgate rules to implement or enforce the provisions
14 of this amendatory Act of the 95th General Assembly. If,
15 however, the Governor believes that rules are necessary to
16 implement or enforce the provisions of this amendatory Act of
17 the 95th General Assembly, the Governor may suggest rules to
18 the General Assembly by filing them with the Clerk of the House
19 and the Secretary of the Senate and by requesting that the
20 General Assembly authorize such rulemaking by law, enact those
21 suggested rules into law, or take any other appropriate action
22 in the General Assembly's discretion. Nothing contained in this
23 amendatory Act of the 95th General Assembly shall be
24 interpreted to grant rulemaking authority under any other
25 Illinois statute where such authority is not otherwise
26 explicitly given. For the purposes of this amendatory Act of

1 the 95th General Assembly, "rules" is given the meaning
2 contained in Section 1-70 of the Illinois Administrative
3 Procedure Act, and "agency" and "agency head" are given the
4 meanings contained in Sections 1-20 and 1-25 of the Illinois
5 Administrative Procedure Act to the extent that such
6 definitions apply to agencies or agency heads under the
7 jurisdiction of the Governor.

8 (215 ILCS 5/370c) (from Ch. 73, par. 982c)
9 Sec. 370c. Mental and emotional disorders.
10 (a) (1) On and after the effective date of this Section,
11 every insurer which delivers, issues for delivery or renews or
12 modifies group A&H policies providing coverage for hospital or
13 medical treatment or services for illness on an
14 expense-incurred basis shall offer to the applicant or group
15 policyholder subject to the insurers standards of
16 insurability, coverage for reasonable and necessary treatment
17 and services for mental, emotional or nervous disorders or
18 conditions, other than serious mental illnesses as defined in
19 item (2) of subsection (b), up to the limits provided in the
20 policy for other disorders or conditions, except (i) the
21 insured may be required to pay up to 50% of expenses incurred
22 as a result of the treatment or services, and (ii) the annual
23 benefit limit may be limited to the lesser of $10,000 or 25% of
24 the lifetime policy limit.
25 (2) Each insured that is covered for mental, emotional or

nervous disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor of his choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, or licensed clinical professional counselor is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his profession.

(3) Insofar as this Section applies solely to licensed clinical social workers and licensed clinical professional counselors, those persons who may provide services to individuals shall do so after the licensed clinical social worker or licensed clinical professional counselor has informed the patient of the desirability of the patient conferring with the patient's primary care physician and the licensed clinical social worker or licensed clinical professional counselor has provided written notification to the patient's primary care physician, if any, that services are being provided to the patient. That notification may, however,

be waived by the patient on a written form. Those forms shall be retained by the licensed clinical social worker or licensed clinical professional counselor for a period of not less than 5 years.

(b) (1) An insurer that provides coverage for hospital or medical expenses under a group policy of accident and health insurance or health care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 92nd General Assembly shall provide coverage under the policy for treatment of serious mental illness under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. The coverage required under this Section must provide for same durational limits, amount limits, deductibles, and co-insurance requirements for serious mental illness as are provided for other illnesses and diseases. This subsection does not apply to coverage provided to employees by employers who have 50 or fewer employees.

(2) "Serious mental illness" means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

(A) schizophrenia;

(B) paranoid and other psychotic disorders;

(C) bipolar disorders (hypomanic, manic, depressive, and mixed);

(D) major depressive disorders (single episode or

1 recurrent);
2 (E) schizoaffective disorders (bipolar or depressive);
3 (F) pervasive developmental disorders;
4 (G) obsessive-compulsive disorders;
5 (H) depression in childhood and adolescence;
6 (I) panic disorder; and
7 (J) post-traumatic stress disorders (acute, chronic,
8 or with delayed onset).
9 (3) Upon request of the reimbursing insurer, a provider of
10 treatment of serious mental illness shall furnish medical
11 records or other necessary data that substantiate that initial
12 or continued treatment is at all times medically necessary. An
13 insurer shall provide a mechanism for the timely review by a
14 provider holding the same license and practicing in the same
15 specialty as the patient's provider, who is unaffiliated with
16 the insurer, jointly selected by the patient (or the patient's
17 next of kin or legal representative if the patient is unable to
18 act for himself or herself), the patient's provider, and the
19 insurer in the event of a dispute between the insurer and
20 patient's provider regarding the medical necessity of a
21 treatment proposed by a patient's provider. If the reviewing
22 provider determines the treatment to be medically necessary,
23 the insurer shall provide reimbursement for the treatment.
24 Future contractual or employment actions by the insurer
25 regarding the patient's provider may not be based on the
26 provider's participation in this procedure. Nothing prevents

1 the insured from agreeing in writing to continue treatment at
2 his or her expense. When making a determination of the medical
3 necessity for a treatment modality for serous mental illness,
4 an insurer must make the determination in a manner that is
5 consistent with the manner used to make that determination with
6 respect to other diseases or illnesses covered under the
7 policy, including an appeals process.

8 (4) A group health benefit plan:

9 (A) shall provide coverage based upon medical
10 necessity for the following treatment of mental illness in
11 each calendar year:

12 (i) 45 days of inpatient treatment; and

13 (ii) beginning on June 26, 2006 (the effective date
14 of Public Act 94-921), 60 visits for outpatient
15 treatment including group and individual outpatient
16 treatment; and

17 (iii) for plans or policies delivered, issued for
18 delivery, renewed, or modified after January 1, 2007
19 (the effective date of Public Act 94-906), 20
20 additional outpatient visits for speech therapy for
21 treatment of pervasive developmental disorders that
22 will be in addition to speech therapy provided pursuant
23 to item (ii) of this subparagraph (A);

24 (B) may not include a lifetime limit on the number of
25 days of inpatient treatment or the number of outpatient
26 visits covered under the plan; and

1 (C) shall include the same amount limits, deductibles,
2 copayments, and coinsurance factors for serious mental
3 illness as for physical illness.
4 (5) An issuer of a group health benefit plan may not count
5 toward the number of outpatient visits required to be covered
6 under this Section an outpatient visit for the purpose of
7 medication management and shall cover the outpatient visits
8 under the same terms and conditions as it covers outpatient
9 visits for the treatment of physical illness.
10 (6) An issuer of a group health benefit plan may provide or
11 offer coverage required under this Section through a managed
12 care plan.
13 (7) This Section shall not be interpreted to require a
14 group health benefit plan to provide coverage for treatment of:
15 (A) an addiction to a controlled substance or cannabis
16 that is used in violation of law; or
17 (B) mental illness resulting from the use of a
18 controlled substance or cannabis in violation of law.
19 (8) (Blank).
20 (c) This Section shall not be interpreted to require
21 coverage for speech therapy or other habilitative services for
22 those individuals covered under Section 356z.11 of this Code.
23 (Source: P.A. 94-402, eff. 8-2-05; 94-584, eff. 8-15-05;
24 94-906, eff. 1-1-07; 94-921, eff. 6-26-06; 95-331, eff.
25 8-21-07.)

Section 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, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11 ~~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 of this State, except a corporation subject to

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

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

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

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

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

account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to 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.

(Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

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

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

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.5, 356r, 356t, 356u, 356v, 356w,
5 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8,
6 356z.9, 356z.10, 356z.11 ~~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 90. The State Mandates Act is amended by adding
13 Section 8.32 as follows:

14 (30 ILCS 805/8.32 new)
15 Sec. 8.32. Exempt mandate. Notwithstanding Sections 6 and 8
16 of this Act, no reimbursement by the State is required for the
17 implementation of any mandate created by this amendatory Act of
18 the 95th General Assembly.".