**Sen. David Koehler**

# Filed: 5/4/2010



AMENDMENT TO HOUSE BILL 5085

AMENDMENT NO. _____. Amend House Bill 5085 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, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, ~~and~~ 356z.13, ~~and~~ 356z.14, 356z.15 ~~and 356z.14~~, ~~and~~ 356z.17 ~~356z.15~~, and 364.01 of the Illinois Insurance Code. The program of

health benefits must comply with Section 155.37 of the Illinois Insurance Code.

Rulemaking authority to implement Public Act 95-1045 ~~this amendatory Act of the 95th General Assembly~~, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1044, eff. 3-26-09; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; revised 10-22-09.)

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, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, ~~and~~ 356z.13, ~~and~~ 356z.14, ~~and~~ 356z.15 ~~356z.14~~, and 364.01 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.

Rulemaking authority to implement Public Act 95-1045 ~~this amendatory Act of the 95th General Assembly~~, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; revised 10-22-09.)

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, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, ~~and~~ 356z.13, ~~and~~ 356z.14, ~~and~~ 356z.15 ~~356z.14~~, and 364.01 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.

Rulemaking authority to implement Public Act 95-1045 ~~this amendatory Act of the 95th General Assembly~~, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045,

eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; revised 10-23-09.)

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 policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, ~~and~~ 356z.14, ~~and~~ 356z.15 ~~356z.14~~, and 364.01 of the Illinois Insurance Code.

Rulemaking authority to implement Public Act 95-1045 ~~this amendatory Act of the 95th General Assembly~~, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; revised

10-23-09.)

Section 25. The Illinois Insurance Code is amended by changing Sections 356z.3 and 364.01 and by adding Section 356z.3a as follows:

(215 ILCS 5/356z.3)

Sec. 356z.3. Disclosure of limited benefit. An insurer that issues, delivers, amends, or renews an individual or group policy of accident and health insurance in this State after the effective date of this amendatory Act of the 92nd General Assembly and arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE

AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill as provided in Section 356z.3a of this Code. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.".

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 5/356z.3a new)

Sec. 356z.3a. Nonparticipating facility-based physicians and providers.

(a) For purposes of this Section, "facility-based provider" means a physician or other provider who provide radiology, anesthesiology, pathology, neonatology, or emergency department services to insureds, beneficiaries, or enrollees in a participating hospital or participating ambulatory surgical treatment center.

(b) When a beneficiary, insured, or enrollee utilizes a participating network hospital or a participating network ambulatory surgery center and, due to any reason, in network services for radiology, anesthesiology, pathology, emergency

physician, or neonatology are unavailable and are provided by a nonparticipating facility-based physician or provider, the insurer or health plan shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating physician or provider for covered services.

(c) If a beneficiary, insured, or enrollee agrees in writing, notwithstanding any other provision of this Code, any benefits a beneficiary, insured, or enrollee receives for services under the situation in subsection (b) are assigned to the nonparticipating facility-based providers. The insurer or health plan shall provide the nonparticipating provider with a written explanation of benefits that specifies the proposed reimbursement and the applicable deductible, copayment or coinsurance amounts owed by the insured, beneficiary or enrollee. The insurer or health plan shall pay any reimbursement directly to the nonparticipating facility-based provider. The nonparticipating facility-based physician or provider shall not bill the beneficiary, insured, or enrollee, except for applicable deductible, copayment, or coinsurance amounts that would apply if the beneficiary, insured, or enrollee utilized a participating physician or provider for covered services. If a beneficiary, insured, or enrollee specifically rejects assignment under this Section in writing to the nonparticipating facility-based provider, then the

nonparticipating facility-based provider may bill the beneficiary, insured, or enrollee for the services rendered.

(d) For bills assigned under subsection (c), the nonparticipating facility-based provider may bill the insurer or health plan for the services rendered, and the insurer or health plan may pay the billed amount or attempt to negotiate reimbursement with the nonparticipating facility-based provider. If attempts to negotiate reimbursement for services provided by a nonparticipating facility-based provider do not result in a resolution of the payment dispute within 30 days after receipt of written explanation of benefits by the insurer or health plan, then an insurer or health plan or nonparticipating facility-based physician or provider may initiate binding arbitration to determine payment for services provided on a per bill basis. The party requesting arbitration shall notify the other party arbitration has been initiated and state its final offer before arbitration. In response to this notice, the nonrequesting party shall inform the requesting party of its final offer before the arbitration occurs. Arbitration shall be initiated by filing a request with the Department of Insurance.

(e) The Department of Insurance shall publish a list of approved arbitrators or entities that shall provide binding arbitration. These arbitrators shall be American Arbitration Association or American Health Lawyers Association trained arbitrators. Both parties must agree on an arbitrator from the

Department of Insurance's list of arbitrators. If no agreement can be reached, then a list of 5 arbitrators shall be provided by the Department of Insurance. From the list of 5 arbitrators, the insurer can veto 2 arbitrators and the provider can veto 2 arbitrators. The remaining arbitrator shall be the chosen arbitrator. This arbitration shall consist of a review of the written submissions by both parties. Binding arbitration shall provide for a written decision within 45 days after the request is filed with the Department of Insurance. Both parties shall be bound by the arbitrator's decision. The arbitrator's expenses and fees, together with other expenses, not including attorney's fees, incurred in the conduct of the arbitration, shall be paid as provided in the decision.

(f) This Section 356z.3a does not apply to a beneficiary, insured, or enrollee who willfully chooses to access a nonparticipating facility-based physician or provider for health care services available through the insurer's or plan's network of participating physicians and providers. In these circumstances, the contractual requirements for nonparticipating facility-based provider reimbursements will apply.

(g) Section 368a of this Act shall not apply during the pendency of a decision under subsection (d) any interest required to be paid a provider under Section 368a shall not accrue until after 30 days of an arbitrator's decision as provided in subsection (d), but in no circumstances longer than

150 days from date the nonparticipating facility-based provider billed for services rendered.".

(215 ILCS 5/364.01)

Sec. 364.01. Qualified clinical cancer trials.

(a) No individual or group policy of accident and health insurance issued or renewed in this State may be cancelled or non-renewed for any individual based on that individual's participation in a qualified clinical cancer trial.

(b) Qualified clinical cancer trials must meet the following criteria:

(1) the effectiveness of the treatment has not been determined relative to established therapies;

(2) the trial is under clinical investigation as part of an approved cancer research trial in Phase II, Phase III, or Phase IV of investigation;

(3) the trial is:

(A) approved by the Food and Drug Administration; or

(B) approved and funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the United States Department of Defense, the United States Department of Veterans Affairs, or the United States Department of Energy in the form of an investigational new drug application, or a cooperative

group or center of any entity described in this subdivision (B); and

(4) the patient's primary care physician, if any, is involved in the coordination of care.

(c) No group policy of accident and health insurance shall exclude coverage for any routine patient care administered to an insured who is a qualified individual participating in a qualified clinical cancer trial, if the policy covers that same routine patient care of insureds not enrolled in a qualified clinical cancer trial.

(d) The coverage that may not be excluded under subsection (c) of this Section is subject to all terms, conditions, restrictions, exclusions, and limitations that apply to the same routine patient care received by an insured not enrolled in a qualified clinical cancer trial, including the application of any authorization requirement, utilization review, or medical management practices. The insured or enrollee shall incur no greater out-of-pocket liability than had the insured or enrollee not enrolled in a qualified clinical cancer trial.

(e) If the group policy of accident and health insurance uses a preferred provider program and a preferred provider provides routine patient care in connection with a qualified clinical cancer trial, then the insurer may require the insured to use the preferred provider if the preferred provider agrees to provide to the insured that routine patient care.

(f) A qualified clinical cancer trial may not pay or refuse

to pay for routine patient care of a individual participating in the trial, based in whole or in part on the person's having or not having coverage for routine patient care under a group policy of accident and health insurance.

(g) Nothing in this Section shall be construed to limit an insurer's coverage with respect to clinical trials.

(h) Nothing in this Section shall require coverage for out-of-network services where the underlying health benefit plan does not provide coverage for out-of-network services.

(i) As used in this Section, "routine patient care" means all health care services provided in the qualified clinical cancer trial that are otherwise generally covered under the policy if those items or services were not provided in connection with a qualified clinical cancer trial consistent with the standard of care for the treatment of cancer, including the type and frequency of any diagnostic modality, that a provider typically provides to a cancer patient who is not enrolled in a qualified clinical cancer trial. "Routine patient care" does not include, and a group policy of accident and health insurance may exclude, coverage for:

(1) a health care service, item, or drug that is the subject of the cancer clinical trial;

(2) a health care service, item, or drug provided solely to satisfy data collection and analysis needs for the qualified clinical cancer trial that is not used in the direct clinical management of the patient;

(3) an investigational drug or device that has not been approved for market by the United States Food and Drug Administration;

(4) transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with the travel to or from a facility providing the qualified clinical cancer trial, unless the policy covers these expenses for a cancer patient who is not enrolled in a qualified clinical cancer trial;

(5) a health care service, item, or drug customarily provided by the qualified clinical cancer trial sponsors free of charge for any patient;

(6) a health care service or item, which except for the fact that it is being provided in a qualified clinical cancer trial, is otherwise specifically excluded from coverage under the insured's policy, including:

(A) costs of extra treatments, services, procedures, tests, or drugs that would not be performed or administered except for the fact that the insured is participating in the cancer clinical trial; and

(B) costs of nonhealth care services that the patient is required to receive as a result of participation in the approved cancer clinical trial;

(7) costs for services, items, or drugs that are eligible for reimbursement from a source other than a

patient's contract or policy providing for third-party payment or prepayment of health or medical expenses, including the sponsor of the approved cancer clinical trial; or

(8) costs associated with approved cancer clinical trials designed exclusively to test toxicity or disease pathophysiology, unless the policy covers these expenses for a cancer patient who is not enrolled in a qualified clinical cancer trial; or

(9) a health care service or item that is eligible for reimbursement by a source other than the insured's policy, including the sponsor of the qualified clinical cancer trial.

The definitions of the terms "health care services", "Non-Preferred Provider", "Preferred Provider", and "Preferred Provider Program", stated in 50 IL Adm. Code Part 2051 Preferred Provider Programs apply to these terms in this Section.

(j) The external review procedures established under the Health Carrier External Review Act shall apply to the provisions under this Section.

(Source: P.A. 93-1000, eff. 1-1-05.)

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)

(Text of Section before amendment by P.A. 96-833)

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.11, 356z.12, 356z.13, 356z.14, 356z.15 ~~356z.14~~, 356z.17 ~~356z.15~~, 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 substantially the same requirements in its state of

organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

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

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of

a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the 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 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.

(g) Rulemaking authority to implement Public Act 95-1045 ~~this amendatory Act of the 95th General Assembly~~, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;

95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; revised 10-23-09.)

(Text of Section after amendment by P.A. 96-833)

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.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 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 substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

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

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the

combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the

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 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.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; 96-833, eff. 6-1-10.)

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)

(Text of Section before amendment by P.A. 96-833)

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, 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.11, 356z.12, 356z.13, 356z.14, 356z.15 ~~356z.14~~, 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.

Rulemaking authority to implement Public Act 95-1045 ~~this amendatory Act of the 95th General Assembly~~, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative

Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-189, eff. 8-16-07; 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-328, eff. 8-11-09; revised 9-25-09.)

(Text of Section after amendment by P.A. 96-833)

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, 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.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18, 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.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-189, eff. 8-16-07; 95-331, eff. 8-21-07;

95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-328, eff. 8-11-09; 96-833, eff. 6-1-10.)

Section 97. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

Section 99. Effective date. This Act takes effect January 1, 2011.".