HB6156

LRB09620829RPM36596b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB6156

Introduced 2/11/2010, by Rep. Elaine Nekritz

SYNOPSIS AS INTRODUCED:

215 ILCS 5/154	from Ch. 73, par. 766
215 ILCS 5/359d new	
215 ILCS 97/30	
215 ILCS 97/50	
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2

Amends the Illinois Insurance Code. Provides that with the exception of a policy of accident and health insurance, no misrepresentation or false warranty shall defeat or avoid a policy unless it shall have been made with actual intent to deceive or materially affects either the acceptance of the risk or the hazard assumed. Provides that no insurer shall rescind or cancel any policy of insurance, contract, evidence of coverage, or certificate that provides accident and health coverage on the basis of written information by the insured if the insurer failed to complete medical underwriting and resolve all reasonable medical questions. Provides that an insurer shall apply for approval of a policy rescission or cancellation by submitting written information to the Director of Insurance. Sets forth provisions concerning the approval of a rescission or cancellation. Amends the Illinois Health Insurance Portability and Accountability Act. Provides that a health insurance issuer may rescind health insurance coverage offered in connection with a group health plan or coverage of an individual in the individual market only upon evidence of fraud. Amends the Health Maintenance Organization Act to provide that Health Maintenance Organizations shall be subject to the provisions of the Illinois Insurance Code concerning the prior approval of health insurance rescissions. Contains a nonacceleration clause. Makes other changes. Effective July 1, 2010.

LRB096 20829 RPM 36596 b

A BILL FOR

AN ACT concerning insurance, which may be referred to as the Health Insurance Contract Fairness Act.

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

Section 5. The Illinois Insurance Code is amended by changing Section 154 and by adding Section 359d as follows:

(215 ILCS 5/154) (from Ch. 73, par. 766)

Sec. 154. Misrepresentations and false warranties.

(a) No misrepresentation or false warranty made by the insured or in his behalf in the negotiation for a policy of insurance, or breach of a condition of such policy shall defeat or avoid the policy or prevent its attaching unless such misrepresentation, false warranty or condition shall have been stated in the policy or endorsement or rider attached thereto, or in the written application therefor.

(b) With respect to a policy of insurance as defined in subsection (a), (b), or (c) of Section 143.13 of this Code, except a policy of accident and health insurance, no ~~No~~ such misrepresentation or false warranty shall defeat or avoid the policy unless it shall have been made with actual intent to deceive or materially affects either the acceptance of the risk or the hazard assumed by the company.

(c) With respect to a policy of insurance as defined in

subsection (a), (b), or (c) of Section 143.13, except life, accident and health, fidelity and surety, and ocean marine policies, a policy or policy renewal shall not be rescinded after the policy has been in effect for one year or one policy term, whichever is less. This Section shall not apply to policies of marine or transportation insurance.

(Source: P.A. 89-413, eff. 6-1-96.)

(215 ILCS 5/359d new)

Sec. 359d. Health insurance rescissions; prior approval required.

(a) Notwithstanding any other provision of law, unless approval is granted pursuant to subsection (b) of this Section, no insurer shall rescind or cancel any policy of insurance, contract, evidence of coverage, or certificate that provides coverage of the type specified in clause (b) of Class 1 or clause (a) of Class 2 of Section 4 of this Code on the basis of written information submitted on or with or omitted from an insurance application by the insured if the insurer failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on or with or omitted from the insurance application before issuing the policy, contract, evidence of coverage, or certificate.

(b) An insurer shall apply for approval of such rescission or cancellation by submitting written information to the

Director on an application in such form as the Director prescribes. The insurer shall provide a copy of the application for approval to the insured or the insured's representative. Not later than 7 business days after receipt of the application for approval, the insured or the insured's representative shall have an opportunity to review the application and respond and submit relevant information to the Director with respect to the application. Not later than 15 business days after the submission of information by the insured or the insured's representative, the Director shall issue a written decision on the application. The Director may approve the rescission or cancellation if the Director finds that the insured performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage. The decision shall be mailed to the insured, the insured's representative, if any, and the insurer.

(c) The Director shall not approve a rescission or cancellation under subsection (b) of this Section if the rescission or cancellation is initiated after a claim is submitted by the insured unless the submitted claim bears a direct relationship to the information found by the Director under subsection (b) of this Section to have been fraudulently submitted on or with or omitted from the insurance application by the insured.

(d) An insurer or insured may appeal a decision by the Director under this Section by making a written request for a

hearing before the Director within 30 days after the date that the Director's decision is mailed.

(e) This Section shall not apply to short term, disability income, long-term care, accident only, or limited or specified disease policies.

Section 10. The Illinois Health Insurance Portability and Accountability Act is amended by changing Sections 30 and 50 as follows:

(215 ILCS 97/30)

Sec. 30. Guaranteed renewability of coverage for employers in the group market.

(A) In general. Except as provided in this Section, if a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, the issuer must renew or continue in force, including without rescission, such coverage at the option of the plan sponsor of the plan.

(B) General exceptions. A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of the following:

(1) Nonpayment of premiums. The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has

not received timely premium payments.

(2) Fraud. The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Violation of participation or contribution rules. The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under Section 40(D) in the case of the small group market or pursuant to applicable State law in the case of the large group market.

(4) Termination of coverage. The issuer is ceasing to offer coverage in such market in accordance with subsection (C) and applicable State law.

(5) Movement outside service area. In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under Section 40(C)(1)(a).

(6) Association membership ceases. In the case of health insurance coverage that is made available in the small or large group market (as the case may be) only

through one or more bona fide association, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

(C) Requirements for uniform termination of coverage.

(1) Particular type of coverage not offered. In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if:

(a) the issuer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(b) the issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan in such market; and

(c) in exercising the option to discontinue

coverage of this type and in offering the option of coverage under subparagraph (b), the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries who may become eligible for such coverage.

(2) Discontinuance of all coverage.

(a) In general. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in Illinois, health insurance coverage may be discontinued by the issuer only in accordance with Illinois law and if:

(i) the issuer provides notice to the Department and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

(ii) all health insurance issued or delivered for issuance in Illinois in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(b) Prohibition on market reentry. In the case of a discontinuation under subparagraph (a) in a market,

the issuer may not provide for the issuance of any health insurance coverage in the Illinois market involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(D) Exception for uniform modification of coverage. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan:

(1) in the large group market; or

(2) in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with State law and effective on a uniform basis among group health plans with that product.

(E) Application to coverage offered only through associations. In applying this Section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

(F) Rescission. A health insurance issuer may rescind health insurance coverage offered in connection with a group health plan in the small or large group market only upon

evidence of fraud described in subsection (2) of Section (B).

(Source: P.A. 90-30, eff. 7-1-97.)

(215 ILCS 97/50)

Sec. 50. Guaranteed renewability of individual health insurance coverage.

(A) In general. Except as provided in this Section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force, including without rescission, such coverage at the option of the individual.

(B) General exceptions. A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) Nonpayment of premiums. The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) Fraud. The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Termination of plan. The issuer is ceasing to offer coverage in the individual market in accordance with subsection (C) of this Section and applicable Illinois law.

(4) Movement outside the service area. In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the issuer is authorized to do business), but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(5) Association membership ceases. In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(C) Requirements for uniform termination of coverage.

(1) Particular type of coverage not offered. In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if:

(a) the issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least 90 days prior

to the date of the discontinuation of such coverage;

(b) the issuer offers, to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

(c) in exercising the option to discontinue coverage of that type and in offering the option of coverage under subparagraph (b), the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(2) Discontinuance of all coverage.

(a) In general. Subject to subparagraph (c), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in Illinois, health insurance coverage may be discontinued by the issuer only if:

(i) the issuer provides notice to the Director and to each individual of the discontinuation at least 180 days prior to the date of the expiration of such coverage;

(ii) all health insurance issued or delivered for issuance in Illinois in such market is discontinued and coverage under such health insurance coverage in such market is not renewed;

and

(iii) in the case where the issuer has affiliates in the individual market, the issuer gives notice to each affected individual at least 180 days prior to the date of the expiration of the coverage of the individual's option to purchase all other individual health benefit plans currently offered by any affiliate of the carrier.

(b) Prohibition on market reentry. In the case of a discontinuation under subparagraph (a) in the individual market, the issuer may not provide for the issuance of any health insurance coverage in Illinois involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(c) If an issuer elects to discontinue offering all health insurance coverage in the individual market under subparagraph (a), its affiliates that offer health insurance coverage in the individual market in Illinois shall offer individual health insurance coverage to all individuals who were covered by the discontinued health insurance coverage on the date of the notice provided to affected individuals under subdivision (iii) of subparagraph (a) of this item (2) if the individual applies for coverage no later than 63 days after the discontinuation of coverage.

(d) Subject to subparagraph (e) of this item (2), an affiliate that issues coverage under subparagraph (c) shall waive the preexisting condition exclusion period to the extent that the individual has satisfied the preexisting condition exclusion period under the individual's prior contract or policy.

(e) An affiliate that issues coverage under subparagraph (c) may require the individual to satisfy the remaining part of the preexisting condition exclusion period, if any, under the individual's prior contract or policy that has not been satisfied, unless the coverage has a shorter preexisting condition exclusion period, and may include in any coverage issued under subparagraph (c) any waivers or limitations of coverage that were included in the individual's prior contract or policy.

(D) Exception for uniform modification of coverage. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as the modification is consistent with Illinois law and effective on a uniform basis among all individuals with that policy form.

(E) Application to coverage offered only through associations. In applying this Section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one

or more associations, a reference to an "individual" is deemed to include a reference to such an association (of which the individual is a member).

The changes to this Section made by this amendatory Act of the 94th General Assembly apply only to discontinuances of coverage occurring on or after the effective date of this amendatory Act of the 94th General Assembly.

(F) Rescission. A health insurance issuer may rescind health insurance coverage of an individual in the individual market only upon evidence of fraud described in subsection (2) of Section (B).

(Source: P.A. 94-502, eff. 8-8-05.)

Section 15. 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~~, 359d, 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, 359d, 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 95. 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 July 1, 2010.