Rep. Frank J. Mautino

Filed: 11/26/2012

AMENDMENT TO SENATE BILL 3233

AMENDMENT NO. _____. Amend Senate Bill 3233 by replacing everything after the enacting clause with the following:

"Section 5. The Health Maintenance Organization Act is amended by changing Sections 1-2 and 4-14 and by adding Section 4-20 as follows:

(215 ILCS 125/1-2) (from Ch. 111 1/2, par. 1402)

Sec. 1-2. Definitions. As used in this Act, unless the context otherwise requires, the following terms shall have the meanings ascribed to them:

(1) "Advertisement" means any printed or published material, audiovisual material and descriptive literature of the health care plan used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards and similar displays; and any descriptive literature or sales aids of all kinds disseminated by a representative of the health

care plan for presentation to the public including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, form letters and prepared sales presentations.

(2) "Director" means the Director of Insurance.

(3) "Basic health care services" means emergency care, and inpatient hospital and physician care, outpatient medical services, mental health services and care for alcohol and drug abuse, including any reasonable deductibles and co-payments, all of which are subject to the ~~such~~ limitations described in Section 4-20 of this Act and as ~~are~~ determined by the Director pursuant to rule.

(4) "Enrollee" means an individual who has been enrolled in a health care plan.

(5) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled in exchange for a per capita prepaid sum.

(6) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group.

(7) "Health care plan" means any arrangement whereby any organization undertakes to provide or arrange for and pay for or reimburse the cost of basic health care services, excluding any reasonable deductibles and copayments, from providers selected by the Health Maintenance Organization and such arrangement consists of arranging for or the provision of such

health care services, as distinguished from mere indemnification against the cost of such services, except as otherwise authorized by Section 2-3 of this Act, on a per capita prepaid basis, through insurance or otherwise. A "health care plan" also includes any arrangement whereby an organization undertakes to provide or arrange for or pay for or reimburse the cost of any health care service for persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act through providers selected by the organization and the arrangement consists of making provision for the delivery of health care services, as distinguished from mere indemnification. A "health care plan" also includes any arrangement pursuant to Section 4-17. Nothing in this definition, however, affects the total medical services available to persons eligible for medical assistance under the Illinois Public Aid Code.

(8) "Health care services" means any services included in the furnishing to any individual of medical or dental care, or the hospitalization or incident to the furnishing of such care or hospitalization as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness or injury.

(9) "Health Maintenance Organization" means any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care

delivery to be borne by the organization or its providers.

(10) "Net worth" means admitted assets, as defined in Section 1-3 of this Act, minus liabilities.

(11) "Organization" means any insurance company, a nonprofit corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act, or a corporation organized under the laws of this or another state for the purpose of operating one or more health care plans and doing no business other than that of a Health Maintenance Organization or an insurance company. "Organization" shall also mean the University of Illinois Hospital as defined in the University of Illinois Hospital Act.

(12) "Provider" means any physician, hospital facility, or other person which is licensed or otherwise authorized to furnish health care services and also includes any other entity that arranges for the delivery or furnishing of health care service.

(13) "Producer" means a person directly or indirectly associated with a health care plan who engages in solicitation or enrollment.

(14) "Per capita prepaid" means a basis of prepayment by which a fixed amount of money is prepaid per individual or any other enrollment unit to the Health Maintenance Organization or for health care services which are provided during a definite time period regardless of the frequency or extent of the services rendered by the Health Maintenance Organization,

except for copayments and deductibles and except as provided in subsection (f) of Section 5-3 of this Act.

(15) "Subscriber" means a person who has entered into a contractual relationship with the Health Maintenance Organization for the provision of or arrangement of at least basic health care services to the beneficiaries of such contract.

(Source: P.A. 92-370, eff. 8-15-01.)

(215 ILCS 125/4-14) (from Ch. 111 1/2, par. 1409.7)

Sec. 4-14. Evidence of Coverage.

(a) Every subscriber shall be issued an evidence of coverage, which shall contain a clear and complete statement of:

(1) The health services to which each enrollee is entitled;

(2) Eligibility requirements indicating the conditions which must be met to enroll in a Health Care Plan;

(3) Any limitation of the services, kinds of services or benefits to be provided, and exclusions, including any reasonable deductibles, copayments, ~~co-payment,~~ or other charges;

(4) The terms or conditions upon which coverage may be cancelled or otherwise terminated;

(5) Where and in what manner information is available as to where and how services may be obtained; and

(6) The method for resolving complaints.

(b) Any amendment to the evidence of coverage may be provided to the subscriber in a separate document.

(Source: P.A. 86-620.)

(215 ILCS 125/4-20 new)

Sec. 4-20. Deductibles and copayments.

(a) A Health Maintenance Organization may require deductibles and copayments of enrollees as a condition for the receipt of specific health care services, including basic health care services. Deductibles and copayments shall be the only allowable charges, other than premiums, assessed enrollees. Nothing within this subsection (a) shall preclude the provider from charging reasonable administrative fees, such as service fees for checks returned for non-sufficient funds and missed appointments.

(b) Deductibles and copayments shall be for specific dollar amounts or for specific percentages of the cost of the health care services.

(c) No deductible and copayment paid for the receipt of basic health care services may exceed the annual out-of-pocket expenses as defined in Section 223 of the federal Internal Revenue Code.

(d) No combination of deductibles and copayments for basic health care services may exceed the annual maximums as specified by the federal Affordable Care Act.

(e) Deductibles and copayments applicable to supplemental health care services, catastrophic-only plans as defined under the federal Affordable Care Act, or pre-existing conditions are not subject to the annual limitations described in this Section.

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