AN ACT concerning insurance coverage for pregnancy prevention, amending named Acts.

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

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 356u, 356w, ~~and~~ 356x, 356z.2 of the Illinois Insurance Code. The program of health benefits must comply with Section 155.37 of the Illinois Insurance Code.

(Source: P.A. 92-440, eff. 8-17-01.)

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 356u, 356w, ~~and~~ 356x, and 356z.2 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. 90-7, eff. 6-10-97; 90-741, eff. 1-1-99.)

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 356u, 356w, ~~and~~ 356x, and 356z.2 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. 90-7, eff. 6-10-97; 90-741, eff. 1-1-99.)

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 356u, 356w, and 356x, and 356z.2 of the Illinois Insurance Code.

(Source: P.A. 90-7, eff. 6-10-97; 90-741, eff. 1-1-99.)

Section 25. The Illinois Insurance Code is amended by adding Section 356z.2 as follows:

(215 ILCS 5/356z.2 new)

Sec. 356z.2. Clinical cancer trials; routine patient care costs.

(a) For the purposes of this Section, the following terms have the following meanings:

(1) "Clinical or principal investigator" means the person managing the clinical trial.

(2) "Life threatening disease or condition" means a disease or condition, which includes, but is not limited to, breast cancer, prostate cancer, and leukemia, in which either or both of the following is applicable:

(A) The likelihood of death is high unless the course of the disease or condition is interrupted.

(B) The outcome is potentially fatal and the purpose of clinical intervention is survival.

(3) "Routine patient care costs" means the costs associated with the provision of items and services that would otherwise be covered under the policy if those items and services were not provided in connection with an approved clinical trial program. For purposes of this Section, "routine patient care costs" does not include the costs associated with the provision of any of the following:

(A) The cost of an investigational drug or device.

(B) The cost of services other than health

care services that an insured may require as a result of the treatment being provided for purposes of the clinical trial.

(C) The costs associated with managing the research associated with the clinical trial.

(D) The costs that would not be covered under the insured's coverage with respect to a medical procedure not involving a clinical trial.

(b) A group or individual policy of accident and health insurance that is amended, delivered, issued, or renewed in this State on and after the effective date of this amendatory Act of the 92nd General Assembly must provide coverage for routine patient care costs for an insured for treatment in a Phase II through Phase III clinical trial that meets the requirements of this Section, if all of the following conditions are met:

(1) the treatment is being provided for a life-threatening disease or condition;

(2) the insured's physician recommends participation in the clinical trial; and

(3) the insured's physician certifies that the clinical trial is likely to be more beneficial for the insured than any available standard therapy.

(c) The treatment shall be provided in a clinical trial approved by one of the following:

(1) One of the National Institutes of Health.

(2) The federal Food and Drug Administration, in the form of an investigational new drug application.

(3) The Department of Defense.

(d) In the case of routine patient care costs provided by a participating provider, the payment rate shall be at the agreed upon rate. In the case of a nonparticipating provider, the payment rate shall be at the rate the insurer would pay to a participating provider for comparable services. Nothing

in this Section shall be construed to prohibit an insurer from restricting coverage for clinical trials to participating hospitals and physicians in Illinois unless the protocol for the clinical trial is not provided for at an Illinois hospital or by an Illinois physician.

(e) The clinical or principal investigator seeking coverage on behalf of an insured for treatment in a clinical trial approved pursuant to subsection (c) shall post electronically on the National Cancer Institute's national physician data query data base a current list of the clinical trials for which he or she is seeking coverage and that meet the requirements of subsection (b).

This information shall also be provided to the insured's insurer.

The list shall include, for each clinical trial, all of the following:

(1) The name of the trial.

(2) The phase of the trial.

(3) The disease being treated by the trial.

(4) The method by which further information about the trial may be obtained.

(f) On or before June 1 of each year, an insurer shall submit a report to the Director, in a form required by the Director, that describes the clinical trials that the insurer covered with respect to an insured. The Director shall compile an annual summary report. A copy of the annual summary report shall be provided to the Governor and to the General Assembly.

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, 367i, 368a, 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.

(Source: P.A. 90-25, eff. 1-1-98; 90-177, eff. 7-23-97; 90-372, eff. 7-1-98; 90-583, eff. 5-29-98; 90-655, eff. 7-30-98; 90-741, eff. 1-1-99; 91-357, eff. 7-29-99; 91-406, eff. 1-1-00; 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff. 6-9-00.)

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 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, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, <u>356z.2,</u> 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 91-406, eff. 1-1-00; 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff. 6-9-00; 92-130, eff. 7-20-01; 92-440, eff. 8-17-01; revised 9-12-01.)

Section 95. The State Mandates Act is amended by adding Section 8.26 as follows:

(30 ILCS 805/8.26 new)

Sec. 8.26. Exempt mandate. Notwithstanding Sections 6 and 8 of this Act, no reimbursement by the State is required for the implementation of any mandate created by this amendatory Act of the 92nd General Assembly.