AN ACT concerning regulation.

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

Section 5. The Health Maintenance Organization Act is amended by changing Sections 1-2 and 2-3 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 limitations described in Section 4-20 of this Act and as 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 in which an ~~whereby any~~ organization provides, arranges ~~undertakes to provide or arrange~~ for, pays ~~and pay~~ for, or reimburses ~~reimburse~~ the cost of basic health care services, excluding any reasonable deductibles and copayments~~,~~ from providers selected by the Health Maintenance Organization; and the ~~such~~ arrangement consists of providing for the ~~arranging for or the~~ provision of basic ~~such~~ health care services that is ~~, as~~ distinguished from mere indemnification against the cost of such services~~,~~ on a per capita prepaid basis, through insurance or otherwise, 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 in which ~~whereby~~ an organization provides,

arranges ~~undertakes to provide or arrange~~ for, pays ~~or pay~~ for, or reimburses ~~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 a provision for the delivery of health care services that is ~~, 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. Nothing in this definition shall be construed as requiring a health care plan or health maintenance organization to utilize a referral system that enrollees must use to access basic health care services and other health care services from providers that are under contract with or employed by the health maintenance organization. The Director may prescribe by rule the language that must be included in the plan name, marketing, advertising, or other consumer disclosure requirements to differentiate a health care plan that does not use a referral system for such providers from a health care plan that does use a referral system for such providers.

(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 or a unit of local government health system operating within a county with a population of 3,000,000 or more.

(12) "Provider" means any physician, hospital facility, facility licensed under the Nursing Home Care Act, or facility or long-term care facility as those terms are defined in the Nursing Home Care Act 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) "Referral system" means any arrangement in a health care plan in which a primary care provider coordinates or manages the care of a health maintenance organization's enrollee by referring the enrollee to other providers or specialists.

(16) ~~(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. 98-651, eff. 6-16-14; 98-841, eff. 8-1-14; 99-78, eff. 7-20-15.)

(215 ILCS 125/2-3) (from Ch. 111 1/2, par. 1405)

Sec. 2-3. Powers of health maintenance organizations. The powers of a health maintenance organization include, but are not limited to the following:

(a) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization.

(b) The making of loans to a medical group under contract with it and in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities at hospitals or in furtherance of a program providing health care services for enrollees.

(c) The furnishing of health care services through providers which are under contract with or employed by the health maintenance organization.

(d) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration.

(d-5) The voluntary use of a referral system for enrollees to access providers under contract with or employed by the health maintenance organization. Nothing in this subsection (d-5) shall be construed as requiring the use of a referral

system with the health maintenance organization's contracted or employed providers to obtain a certificate of authority as set forth in Section 2-1.

(e) The contracting with an insurance company licensed in this State, or with a hospital, medical, dental, vision or pharmaceutical service corporation authorized to do business in this State, for the provision of insurance, indemnity, or reimbursement against the cost of health care service provided by the health maintenance organization.

(f) The offering, in addition to basic health care services, of (1) health care services, (2) indemnity benefits covering out of area or emergency services, (3) indemnity benefits provided through insurers or hospital, medical, dental, vision, or pharmaceutical service corporations, and (4) health maintenance organization point-of-service benefits as authorized under Article 4.5.

(g) Rendering services related to the functions involved in the operating of its health maintenance organization business including but not limited to providing health services, data processing, accounting, or claims.

(g-5) Indemnification for services provided to a child as required under subdivision (e)(3) of Section 4-2.

(h) Any other business activity reasonably complementary or supplementary to its health maintenance organization business to the extent approved by the Director.

(Source: P.A. 92-135, eff. 1-1-02.)

Section 99. Effective date. This Act takes effect January 1, 2024.