Rep. Greg Harris

Filed: 3/9/2011

AMENDMENT TO HOUSE BILL 1191

AMENDMENT NO. _____. Amend House Bill 1191 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, 356z.13, 356z.14, 356z.15, ~~and~~ 356z.17, 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, 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; 96-1000, eff. 7-2-10.)

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, 356z.13,

356z.14, ~~and~~ 356z.15, 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, 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; 96-1000, eff. 7-2-10.)

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, 356z.13, 356z.14, ~~and~~ 356z.15, 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, 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; 96-1000, eff. 7-2-10.)

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, 356z.14, ~~and~~ 356z.15, and 364.01 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; 95-422, 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; 96-1000, eff. 7-2-10.)

Section 25. The Illinois Insurance Code is amended by changing Section 364.01 as follows:

(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.

(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 group policy of accident and health insurance with a preferred provider program shall reimburse:

(1) a preferred provider for routine patient care in connection with a qualified clinical cancer trial at the preferred provider's negotiated rate, less any applicable insured cost sharing; and

(2) a nonpreferred provider at rates comparable to

negotiated rates for preferred providers; the nonpreferred provider shall accept those amounts plus any applicable copayments, coinsurance, and deductible as payment in full for items billed.

The preferred provider and the nonpreferred provider may bill the insured any applicable deductible, copayment, and coinsurance.

(g) 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.

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

(i) 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.

(j) 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;

(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) the cost of an oncologic drug, if the qualified clinical cancer trial's purpose is to study the use of the oncologic drug in the particular cancer in question or study the administration of the drug in a new manner;

(8) 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

(9) costs associated with approved cancer clinical trials designed exclusively to test toxicity or disease pathophysiology; or

(10) 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.

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