HB2951

LRB09708423RPM48550b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB2951

Introduced 2/23/2011, by Rep. Jehan A. Gordon

SYNOPSIS AS INTRODUCED:

5 ILCS 375/6.11	
55 ILCS 5/5-1069.3	
65 ILCS 5/10-4-2.3	
105 ILCS 5/10-22.3f	
215 ILCS 5/356z.19 new	
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2
215 ILCS 165/10	from Ch. 32, par. 604

Amends the State Employees Group Insurance Act of 1971, Counties Code, Illinois Municipal Code, School Code, Illinois Insurance Code, Health Maintenance Organization Act, and Voluntary Health Services Plans Act. Provides that accident and health insurance policies and managed care plans must provide coverage for routine patient care costs incurred for cancer treatment in an approved cancer clinical trial to the same extent that such policy or contract provides coverage for treating any other sickness, injury, disease, or condition covered under the policy or contract if the insured has been referred for such cancer treatment. Sets forth criteria under which routine patient care costs for cancer treatment given pursuant to an approved cancer clinical trial shall be covered. Sets forth definitions for "approved cancer clinical trial", "institutional review board", "routine patient care costs", and "therapeutic intent". Effective on January 1, 2012.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning insurance.

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 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 356z.19 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 356z.19 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 356z.19 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 356z.19 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 adding Section 356z.19 as follows:

(215 ILCS 5/356z.19 new)

Sec. 356z.19. Approved cancer clinical trials.

(a) A group or individual policy of accident and health insurance or managed care plan that is amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 97th General Assembly must provide coverage for routine patient care costs incurred for cancer treatment in an approved cancer clinical trial to the same extent that such

policy or contract provides coverage for treating any other sickness, injury, disease, or condition covered under the policy or contract if the insured has been referred for such cancer treatment by 2 physicians who specialize in oncology and the cancer treatment is given pursuant to an approved cancer clinical trial that meets the criteria set forth in subsection (b) of this Section. Services that are furnished without charge to a participant in the approved cancer clinical trial are not required to be covered as routine patient care costs pursuant to this Section.

(b) Routine patient care costs for cancer treatment given pursuant to an approved cancer clinical trial shall be covered pursuant to this Section if all of the following requirements are met:

(1) The treatment is provided with therapeutic intent and is provided pursuant to an approved cancer clinical trial that has been authorized or approved by the National Institutes of Health, the United States Food and Drug Administration, the United States Department of Defense, the United States Department of Veterans Affairs, the United States Department of Energy, the Centers for Disease Control and Prevention, or the Agency for Healthcare Research and Quality.

(2) The proposed treatment has been reviewed and approved by the applicable qualified institutional review board.

(3) The available clinical or preclinical data indicate that the treatment that shall be provided pursuant to the approved cancer clinical trial shall be at least as effective as the standard therapy and is anticipated to constitute an improvement in therapeutic effectiveness for the treatment of the disease in question.

(c) For purposes of this Section:

"Approved cancer clinical trial" means a scientific study of a new therapy for the treatment of cancer in human beings that meets the requirements set forth in subsection (b) of this Section and consists of a scientific plan of treatment that includes specified goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of quantitative measures for determining treatment response, and methods for documenting and treating adverse reactions.

"Institutional review board" means a board, committee, or other group formally designated by an institution and approved by the National Institutes of Health, Office of Human Subjects Research to review, approve the initiation of, and conduct periodic review of biomedical research involving human subjects. "Institutional review board" has the same meaning as "institutional review committee" as used in section 520(g) of the federal Food, Drug, and Cosmetic Act, as codified in 21 U.S.C. § 301 et seq.

"Routine patient care costs" means medically necessary

services or treatments that are a benefit under a contract or policy providing for third-party payment or prepayment of health or medical expenses that would be covered if the patient were receiving standard cancer treatment. "Routine patient care costs" does not include any of the following:

(1) Costs of any treatments, procedures, drugs, devices, services, or items that are the subject of the approved cancer clinical trial or any other investigational treatments, procedures, drugs, devices, services, or items.

(2) Costs of non-health care services that the patient is required to receive as a result of participation in the approved cancer clinical trial.

(3) Costs associated with managing the research that is associated with the approved cancer clinical trial.

(4) Costs that would not be covered by the third-party payment provider if non-investigational treatments were provided.

(5) Costs of any services, procedures, or tests provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient participating in an approved cancer clinical trial.

(6) Costs paid for, or not charged for, by the approved cancer clinical trial providers.

(7) Costs for transportation, lodging, food, or other

expenses for the patient, a family member, or a companion of the patient that are associated with travel to or from a facility where an approved cancer clinical trial is conducted.

(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.

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

(10) Costs of extra treatments, services, procedures, tests, or drugs that would not be performed or administered except for participation in the cancer clinical trial.

"Therapeutic intent" means that a treatment is aimed at improving a patient's health outcome relative to either survival or quality of life.

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, 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, 356z.19, 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; 96-1000, eff. 7-2-10.)

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, 356g, 356g.5, 356g.5-1, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 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.18, 356z.19, 364.01, 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.

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; 95-331, eff. 8-21-07; 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; 96-328, eff. 8-11-09; 96-833, eff. 6-1-10; 96-1000, eff. 7-2-10.)

Section 99. Effective date. This Act takes effect January

1 1, 2012.