1 AN ACT concerning regulation.

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

4 Section 5. The Health Maintenance Organization Act is
5 amended by changing Section 5-3 as follows:

6 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)
7 Sec. 5-3. Insurance Code provisions.
8 (a) Health Maintenance Organizations shall be subject to
9 the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,
10 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154,
11 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2, 355.3,
12 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4,
13 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12,
14 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.21,
15 356z.22, 364, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c,
16 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408,
17 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection
18 (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2,
19 XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.
20 (b) For purposes of the Illinois Insurance Code, except for
21 Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health
22 Maintenance Organizations in the following categories are
23 deemed to be "domestic companies":

1 (1) a corporation authorized under the Dental Service
2 Plan Act or the Voluntary Health Services Plans Act;
3 (2) a corporation organized under the laws of this
4 State; or
5 (3) a corporation organized under the laws of another
6 state, 30% or more of the enrollees of which are residents
7 of this State, except a corporation subject to
8 substantially the same requirements in its state of
9 organization as is a "domestic company" under Article VIII
10 1/2 of the Illinois Insurance Code.
11 (c) In considering the merger, consolidation, or other
12 acquisition of control of a Health Maintenance Organization
13 pursuant to Article VIII 1/2 of the Illinois Insurance Code,
14 (1) the Director shall give primary consideration to
15 the continuation of benefits to enrollees and the financial
16 conditions of the acquired Health Maintenance Organization
17 after the merger, consolidation, or other acquisition of
18 control takes effect;
19 (2)(i) the criteria specified in subsection (1)(b) of
20 Section 131.8 of the Illinois Insurance Code shall not
21 apply and (ii) the Director, in making his determination
22 with respect to the merger, consolidation, or other
23 acquisition of control, need not take into account the
24 effect on competition of the merger, consolidation, or
25 other acquisition of control;
26 (3) the Director shall have the power to require the

1 following information:
2 (A) certification by an independent actuary of the
3 adequacy of the reserves of the Health Maintenance
4 Organization sought to be acquired;
5 (B) pro forma financial statements reflecting the
6 combined balance sheets of the acquiring company and
7 the Health Maintenance Organization sought to be
8 acquired as of the end of the preceding year and as of
9 a date 90 days prior to the acquisition, as well as pro
10 forma financial statements reflecting projected
11 combined operation for a period of 2 years;
12 (C) a pro forma business plan detailing an
13 acquiring party's plans with respect to the operation
14 of the Health Maintenance Organization sought to be
15 acquired for a period of not less than 3 years; and
16 (D) such other information as the Director shall
17 require.
18 (d) The provisions of Article VIII 1/2 of the Illinois
19 Insurance Code and this Section 5-3 shall apply to the sale by
20 any health maintenance organization of greater than 10% of its
21 enrollee population (including without limitation the health
22 maintenance organization's right, title, and interest in and to
23 its health care certificates).
24 (e) In considering any management contract or service
25 agreement subject to Section 141.1 of the Illinois Insurance
26 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. 97-282, eff. 8-9-11; 97-343, eff. 1-1-12; 97-437, eff. 8-18-11; 97-486, eff. 1-1-12; 97-592, eff. 1-1-12; 97-805, eff. 1-1-13; 97-813, eff. 7-13-12; 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15.)

Section 10. The Managed Care Reform and Patient Rights Act is amended by changing Section 45.1 as follows:

(215 ILCS 134/45.1)

Sec. 45.1. Medical exceptions procedures required.

(a) Notwithstanding any other provision of law, on or after the effective date of this amendatory Act of the 99th General Assembly, every insurer licensed in this State to sell a policy of group or individual accident and health insurance or a health benefits plan shall ~~Every health carrier that offers a qualified health plan, as defined in the federal Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those Acts (collectively, "the Federal Act"), directly to~~

1 ~~consumers in this State shall~~ establish and maintain a medical
2 exceptions process that allows covered persons or their
3 authorized representatives to request any clinically
4 appropriate prescription drug when (1) the drug is not covered
5 based on the health benefit plan's formulary; (2) the health
6 benefit plan is discontinuing coverage of the drug on the
7 plan's formulary for reasons other than safety or other than
8 because the prescription drug has been withdrawn from the
9 market by the drug's manufacturer; (3) the prescription drug
10 alternatives required to be used in accordance with a step
11 therapy requirement (A) has been ineffective in the treatment
12 of the enrollee's disease or medical condition or, based on
13 both sound clinical evidence and medical and scientific
14 evidence, the known relevant physical or mental
15 characteristics of the enrollee, and the known characteristics
16 of the drug regimen, is likely to be ineffective or adversely
17 affect the drug's effectiveness or patient compliance or (B)
18 has caused or, based on sound medical evidence, is likely to
19 cause an adverse reaction or harm to the enrollee; or (4) the
20 number of doses available under a dose restriction for the
21 prescription drug (A) has been ineffective in the treatment of
22 the enrollee's disease or medical condition or (B) based on
23 both sound clinical evidence and medical and scientific
24 evidence, the known relevant physical and mental
25 characteristics of the enrollee, and known characteristics of
26 the drug regimen, is likely to be ineffective or adversely

affect the drug's effective or patient compliance.

(b) The health carrier's established medical exceptions procedures must require, at a minimum, the following:

(1) Any request for approval of coverage made verbally or in writing (regardless of whether made using a paper or electronic form or some other writing) at any time shall be reviewed by appropriate health care professionals.

(2) The health carrier must, within 72 hours after receipt of a request made under subsection (a) of this Section, either approve or deny the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(3) In the case of an expedited coverage determination, the health carrier must either approve or deny the request within 24 hours after receipt of the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(c) A step therapy requirement exception request shall be

approved if:

(1) the required prescription drug is contraindicated;

(2) the patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan and the prescribing provider submits evidence of failure or intolerance; or

(3) the patient is stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan.

(d) Upon the granting of an exception request, the insurer, health plan, utilization review organization, or other entity shall authorize the coverage for the drug prescribed by the enrollee's treating health care provider, to the extent the prescribed drug is a covered drug under the policy or contract up to the quantity covered.

(e) Any approval of a medical exception request made pursuant to this Section shall be honored for 12 months following the date of the approval or until renewal of the plan.

(f) ~~(c)~~ Notwithstanding any other provision of this Section, nothing in this Section shall be interpreted or implemented in a manner not consistent with the federal Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any

amendments thereto, or regulations or guidance issued under those Acts ~~Federal Act~~.

(g) Nothing in this Section shall require or authorize the State agency responsible for the administration of the medical assistance program established under the Illinois Public Aid Code to approve, supply, or cover prescription drugs pursuant to the procedure established in this Section.

(Source: P.A. 98-1035, eff. 8-25-14.)

Section 99. Effective date. This Act takes effect January 1, 2018.