



Sen. Julie A. Morrison

**Filed: 5/4/2016**

09900HB3549sam002

LRB099 09324 EGJ 48067 a

1 AMENDMENT TO HOUSE BILL 3549

2 AMENDMENT NO. \_\_\_\_\_. Amend House Bill 3549, AS AMENDED, by  
3 replacing everything after the enacting clause with the  
4 following:

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

7 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

8 Sec. 5-3. Insurance Code provisions.

9 (a) Health Maintenance Organizations shall be subject to  
10 the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,  
11 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154,  
12 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2, 355.3,  
13 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4,  
14 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12,  
15 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.21,  
16 356z.22, 364, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c,

1 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408,  
2 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection  
3 (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2,  
4 XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

5 (b) For purposes of the Illinois Insurance Code, except for  
6 Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health  
7 Maintenance Organizations in the following categories are  
8 deemed to be "domestic companies":

9 (1) a corporation authorized under the Dental Service  
10 Plan Act or the Voluntary Health Services Plans Act;

11 (2) a corporation organized under the laws of this  
12 State; or

13 (3) a corporation organized under the laws of another  
14 state, 30% or more of the enrollees of which are residents  
15 of this State, except a corporation subject to  
16 substantially the same requirements in its state of  
17 organization as is a "domestic company" under Article VIII  
18 1/2 of the Illinois Insurance Code.

19 (c) In considering the merger, consolidation, or other  
20 acquisition of control of a Health Maintenance Organization  
21 pursuant to Article VIII 1/2 of the Illinois Insurance Code,

22 (1) the Director shall give primary consideration to  
23 the continuation of benefits to enrollees and the financial  
24 conditions of the acquired Health Maintenance Organization  
25 after the merger, consolidation, or other acquisition of  
26 control takes effect;

1           (2) (i) the criteria specified in subsection (1) (b) of  
2           Section 131.8 of the Illinois Insurance Code shall not  
3           apply and (ii) the Director, in making his determination  
4           with respect to the merger, consolidation, or other  
5           acquisition of control, need not take into account the  
6           effect on competition of the merger, consolidation, or  
7           other acquisition of control;

8           (3) the Director shall have the power to require the  
9           following information:

10           (A) certification by an independent actuary of the  
11           adequacy of the reserves of the Health Maintenance  
12           Organization sought to be acquired;

13           (B) pro forma financial statements reflecting the  
14           combined balance sheets of the acquiring company and  
15           the Health Maintenance Organization sought to be  
16           acquired as of the end of the preceding year and as of  
17           a date 90 days prior to the acquisition, as well as pro  
18           forma financial statements reflecting projected  
19           combined operation for a period of 2 years;

20           (C) a pro forma business plan detailing an  
21           acquiring party's plans with respect to the operation  
22           of the Health Maintenance Organization sought to be  
23           acquired for a period of not less than 3 years; and

24           (D) such other information as the Director shall  
25           require.

26           (d) The provisions of Article VIII 1/2 of the Illinois

1 Insurance Code and this Section 5-3 shall apply to the sale by  
2 any health maintenance organization of greater than 10% of its  
3 enrollee population (including without limitation the health  
4 maintenance organization's right, title, and interest in and to  
5 its health care certificates).

6 (e) In considering any management contract or service  
7 agreement subject to Section 141.1 of the Illinois Insurance  
8 Code, the Director (i) shall, in addition to the criteria  
9 specified in Section 141.2 of the Illinois Insurance Code, take  
10 into account the effect of the management contract or service  
11 agreement on the continuation of benefits to enrollees and the  
12 financial condition of the health maintenance organization to  
13 be managed or serviced, and (ii) need not take into account the  
14 effect of the management contract or service agreement on  
15 competition.

16 (f) Except for small employer groups as defined in the  
17 Small Employer Rating, Renewability and Portability Health  
18 Insurance Act and except for medicare supplement policies as  
19 defined in Section 363 of the Illinois Insurance Code, a Health  
20 Maintenance Organization may by contract agree with a group or  
21 other enrollment unit to effect refunds or charge additional  
22 premiums under the following terms and conditions:

23 (i) the amount of, and other terms and conditions with  
24 respect to, the refund or additional premium are set forth  
25 in the group or enrollment unit contract agreed in advance  
26 of the period for which a refund is to be paid or

1 additional premium is to be charged (which period shall not  
2 be less than one year); and

3 (ii) the amount of the refund or additional premium  
4 shall not exceed 20% of the Health Maintenance  
5 Organization's profitable or unprofitable experience with  
6 respect to the group or other enrollment unit for the  
7 period (and, for purposes of a refund or additional  
8 premium, the profitable or unprofitable experience shall  
9 be calculated taking into account a pro rata share of the  
10 Health Maintenance Organization's administrative and  
11 marketing expenses, but shall not include any refund to be  
12 made or additional premium to be paid pursuant to this  
13 subsection (f)). The Health Maintenance Organization and  
14 the group or enrollment unit may agree that the profitable  
15 or unprofitable experience may be calculated taking into  
16 account the refund period and the immediately preceding 2  
17 plan years.

18 The Health Maintenance Organization shall include a  
19 statement in the evidence of coverage issued to each enrollee  
20 describing the possibility of a refund or additional premium,  
21 and upon request of any group or enrollment unit, provide to  
22 the group or enrollment unit a description of the method used  
23 to calculate (1) the Health Maintenance Organization's  
24 profitable experience with respect to the group or enrollment  
25 unit and the resulting refund to the group or enrollment unit  
26 or (2) the Health Maintenance Organization's unprofitable

1 experience with respect to the group or enrollment unit and the  
2 resulting additional premium to be paid by the group or  
3 enrollment unit.

4 In no event shall the Illinois Health Maintenance  
5 Organization Guaranty Association be liable to pay any  
6 contractual obligation of an insolvent organization to pay any  
7 refund authorized under this Section.

8 (g) Rulemaking authority to implement Public Act 95-1045,  
9 if any, is conditioned on the rules being adopted in accordance  
10 with all provisions of the Illinois Administrative Procedure  
11 Act and all rules and procedures of the Joint Committee on  
12 Administrative Rules; any purported rule not so adopted, for  
13 whatever reason, is unauthorized.

14 (Source: P.A. 97-282, eff. 8-9-11; 97-343, eff. 1-1-12; 97-437,  
15 eff. 8-18-11; 97-486, eff. 1-1-12; 97-592, eff. 1-1-12; 97-805,  
16 eff. 1-1-13; 97-813, eff. 7-13-12; 98-189, eff. 1-1-14;  
17 98-1091, eff. 1-1-15.)

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

20 (215 ILCS 134/45.1)

21 Sec. 45.1. Medical exceptions procedures required.

22 (a) Notwithstanding any other provision of law, on or after  
23 the effective date of this amendatory Act of the 99th General  
24 Assembly, every insurer licensed in this State to sell a policy

1 of group or individual accident and health insurance or a  
2 health benefits plan shall ~~Every health carrier that offers a~~  
3 ~~qualified health plan, as defined in the federal Patient~~  
4 ~~Protection and Affordable Care Act of 2010 (Public Law~~  
5 ~~111 148), as amended by the federal Health Care and Education~~  
6 ~~Reconciliation Act of 2010 (Public Law 111 152), and any~~  
7 ~~amendments thereto, or regulations or guidance issued under~~  
8 ~~those Acts (collectively, "the Federal Act"), directly to~~  
9 ~~consumers in this State shall~~ establish and maintain a medical  
10 exceptions process that allows covered persons or their  
11 authorized representatives to request any clinically  
12 appropriate prescription drug when (1) the drug is not covered  
13 based on the health benefit plan's formulary; (2) the health  
14 benefit plan is discontinuing coverage of the drug on the  
15 plan's formulary for reasons other than safety or other than  
16 because the prescription drug has been withdrawn from the  
17 market by the drug's manufacturer; (3) the prescription drug  
18 alternatives required to be used in accordance with a step  
19 therapy requirement (A) has been ineffective in the treatment  
20 of the enrollee's disease or medical condition or, based on  
21 both sound clinical evidence and medical and scientific  
22 evidence, the known relevant physical or mental  
23 characteristics of the enrollee, and the known characteristics  
24 of the drug regimen, is likely to be ineffective or adversely  
25 affect the drug's effectiveness or patient compliance or (B)  
26 has caused or, based on sound medical evidence, is likely to

1 cause an adverse reaction or harm to the enrollee; or (4) the  
2 number of doses available under a dose restriction for the  
3 prescription drug (A) has been ineffective in the treatment of  
4 the enrollee's disease or medical condition or (B) based on  
5 both sound clinical evidence and medical and scientific  
6 evidence, the known relevant physical and mental  
7 characteristics of the enrollee, and known characteristics of  
8 the drug regimen, is likely to be ineffective or adversely  
9 affect the drug's effective or patient compliance.

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

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

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

25 (3) In the case of an expedited coverage determination,  
26 the health carrier must either approve or deny the request



1 within 24 hours after receipt of the request. In the case  
2 of a denial, the health carrier shall provide the covered  
3 person or the covered person's authorized representative  
4 and the covered person's prescribing provider with the  
5 reason for the denial, an alternative covered medication,  
6 if applicable, and information regarding the procedure for  
7 submitting an appeal to the denial.

8 (c) A step therapy requirement exception request shall be  
9 approved if:

10 (1) the required prescription drug is contraindicated;

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

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

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

25 (e) Any approval of a medical exception request made  
26 pursuant to this Section shall be honored for 12 months

1 following the date of the approval or until renewal of the  
2 plan.

3 (f) ~~(e)~~ Notwithstanding any other provision of this  
4 Section, nothing in this Section shall be interpreted or  
5 implemented in a manner not consistent with the federal Patient  
6 Protection and Affordable Care Act of 2010 (Public Law  
7 111-148), as amended by the federal Health Care and Education  
8 Reconciliation Act of 2010 (Public Law 111-152), and any  
9 amendments thereto, or regulations or guidance issued under  
10 those Acts ~~Federal Act.~~

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

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

17 Section 99. Effective date. This Act takes effect January  
18 1, 2018."