AN ACT relating to insurance.

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 2-3, 2-4, and 2-6 and adding Article 4.5 as follows:

(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.

(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, ~~and~~ (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. 89-183, eff. 1-1-96.)

(215 ILCS 125/2-4) (from Ch. 111 1/2, par. 1406)

Sec. 2-4. Required minimum net worth; special contingent reserve; deficiency; impairment.

(a) A health maintenance organization issued a certificate of authority on or after the effective date of this amendatory Act of 1987 shall have and at all times maintain net worth of not less than $1,500,000. As an allocation of net worth, organizations certified prior to the effective date of this amendatory Act of 1987 shall maintain a special contingent reserve. The special contingent reserve for an organization certified between January 1, 1986 and the effective date of this amendatory Act of 1987 shall be equal to 5% of its net earned subscription revenue for health care

services through December 31st of the year in which certified. In subsequent years such organization shall accumulate additions to the contingent reserve in an amount which is equal to 2% of its net earned subscription revenue for each calendar year. For purposes of this Section, net earned subscription revenue means premium minus reinsurance expenses. Maintenance of the contingent reserve requires that net worth equals or exceeds the contingent reserve at any balance sheet date.

(b) Additional accumulations under subsection (a) will no longer be required at such time that the total special contingent reserve required by subsection (a) is equal to $1,500,000.

(c) A deficiency in meeting amounts required in subsections (a), (b), and (d) will require (1) filing with the Director a plan for correction of the deficiency, acceptable to the Director and (2) correction of the deficiency within a reasonable time, not to exceed 60 days unless an extension of time, not to exceed 60 additional days, is granted by the Director. Such a deficiency will be deemed an impairment, and failure to correct the deficiency in the prescribed time shall be grounds for suspension or revocation pursuant to subsection (h) of Section 5-5.

(d) All health maintenance organizations issued a certificate of authority on or prior to December 31, 1985 and regulated under this Act must have and at all times maintain, prior to December 31, 1988, the net worth and special contingent reserve that was required for that particular organization at the time it was certified. All such organizations must have by December 31, 1988 and thereafter maintain at all times, net worth of not less than $300,000 and a special contingent reserve calculated and accumulated in the same manner as required of a health maintenance organization issued a certificate of authority on or between

January 1, 1986 and the effective date of this amendatory Act of 1987. Such calculation shall commence with the financial reporting period first following certification.

All organizations issued a certificate of authority between January 1, 1986 and the effective date of this amendatory Act of 1987 must have and at all times maintain the net worth and special contingent reserve that was required for that particular organization at the time it was certified.

(d-5) A health maintenance organization that offers a point-of-service product must maintain minimum net worth of not less than:

(1) the greater of 300% of the "authorized control level" as defined by Article IIA of the Illinois Insurance Code; or

(2) $3,500,000 if the health maintenance organization's annual projected out-of-plan claims are less than $500,000; or

(3) $4,500,000 if the health maintenance organization's annual projected out-of-plan claims are equal to or greater than $500,000 but less than $1,000,000; or

(4) $6,000,000 if the health maintenance organization's annual projected out-of-plan claims are $1,000,000 or greater.

(e) Unless allowed by the Director, no health maintenance organization, officer, director, trustee, producer, or employee of such organization may renew, issue, or deliver, or cause to be renewed, issued or delivered, any certificate, agreement, or contract of coverage in this State, for which a premium is charged or collected, when the organization writing such coverage is insolvent or impaired, and the fact of such insolvency or impairment is known to the organization, officer, director, trustee, producer, or

employee of such organization. An organization is impaired when a deficiency exists in meeting the amounts required in subsections(a), (b), and (d) of Section 2-4.

However, the existence of an impairment does not prevent the issuance or renewal of a certificate, agreement or contract when the enrollee exercises an option granted under the plan to obtain new, renewed or converted coverage.

Any organization, officer, director, trustee, producer, or employee of such organization violating this subsection shall be guilty of a Class A misdemeanor.

(Source: P.A. 85-20.)

(215 ILCS 125/2-6) (from Ch. 111 1/2, par. 1406.2)

Sec. 2-6. Statutory deposits.

(a) Every organization subject to the provisions of this Act shall make and maintain with the Director through December 30, 1993, for the protection of enrollees of the organization, a deposit of securities which are authorized investments under paragraphs (1) and (2) of subsection (h) of Section 3-1 having a fair market value equal to at least $100,000. Effective December 31, 1993 and through December 30, 1994, the deposit shall have a fair market value at least equal to $200,000. Effective December 31, 1994 and thereafter, the deposit shall have a fair market value at least equal to $300,000. An organization issued a certificate of authority on or after the effective date of this Amendatory Act of 1993, shall make and maintain with the Director; for the protection of enrollees of the organization, a deposit of securities which are authorized investments under paragraphs (1) and (2) of subsection (h) of Section 3-1 having a fair market value equal to at least $300,000. The amount on deposit shall remain as an admitted asset of the organization in the determination of its net worth.

(b) An organization that offers a point-of-service product, as permitted by Article 4.5, must maintain an additional deposit in an amount that is not less than the greater of 125% of the organization's annual projected point-of-service claims or $300,000.

(Source: P.A. 88-364.)

(215 ILCS 125/Art. 4.5, heading new)

ARTICLE 4.5. POINT-OF-SERVICE PRODUCTS

(215 ILCS 125/4.5-1 new)

Sec. 4.5-1. Point-of-service health service contracts.

(a) A health maintenance organization that offers a point-of-service contract:

(1) must include as in-plan covered services all services required by law to be provided by a health maintenance organization;

(2) must provide incentives, which shall include financial incentives, for enrollees to use in-plan covered services;

(3) may not offer services out-of-plan without providing those services on an in-plan basis;

(4) may include annual out-of-pocket limits and lifetime maximum benefits allowances for out-of-plan services that are separate from any limits or allowances applied to in-plan services;

(5) may not consider emergency services, authorized referral services, or non-routine services obtained out of the service area to be point-of-service services; and

(6) may treat as out-of-plan services those services that an enrollee obtains from a participating provider, but for which the proper authorization was not given by the health maintenance organization.

(b) A health maintenance organization offering a point-of-service contract is subject to all of the following limitations:

(1) The health maintenance organization may not expend in any calendar quarter more than 20% of its total expenditures for all its members for out-of-plan covered services.

(2) If the amount specified in item (1) of this subsection is exceeded by 2% in a quarter, the health maintenance organization must effect compliance with item (1) of this subsection by the end of the following quarter.

(3) If compliance with the amount specified in item (1) of this subsection is not demonstrated in the health maintenance organization's next quarterly report, the health maintenance organization may not offer the point-of-service contract to new groups or include the point-of-service option in the renewal of an existing group until compliance with the amount specified in item (1) of this subsection is demonstrated or until otherwise allowed by the Director.

(4) A health maintenance organization failing, without just cause, to comply with the provisions of this subsection shall be required, after notice and hearing, to pay a penalty of $250 for each day out of compliance, to be recovered by the Director. Any penalty recovered shall be paid into the General Revenue Fund. The Director may reduce the penalty if the health maintenance organization demonstrates to the Director that the imposition of the penalty would constitute a financial hardship to the health maintenance organization.

(c) A health maintenance organization that offers a point-of-service product must do all of the following:

(1) File a quarterly financial statement detailing

compliance with the requirements of subsection (b).

(2) Track out-of-plan, point-of-service utilization separately from in-plan or non-point-of-service, out-of-plan emergency care, referral care, and urgent care out of the service area utilization.

(3) Record out-of-plan utilization in a manner that will permit such utilization and cost reporting as the Director may, by rule, require.

(4) Demonstrate to the Director's satisfaction that the health maintenance organization has the fiscal, administrative, and marketing capacity to control its point-of-service enrollment, utilization, and costs so as not to jeopardize the financial security of the health maintenance organization.

(5) Maintain, in addition to any other deposit required under this Act, the deposit required by Section 2-6.

(6) Maintain cash and cash equivalents of sufficient amount to fully liquidate 10 days' average claim payments, subject to review by the Director.

(7) Maintain and file with the Director, reinsurance coverage protecting against catastrophic losses on out of network point-of-service services. Deductibles may not exceed $100,000 per covered life per year, and the portion of risk retained by the health maintenance organization once deductibles have been satisfied may not exceed 20%. Reinsurance must be placed with licensed authorized reinsurers qualified to do business in this State.

(d) A health maintenance organization may not issue a point-of-service contract until it has filed and had approved by the Director a plan to comply with the provisions of this Section. The compliance plan must, at a minimum, include provisions demonstrating that the health maintenance

organization will do all of the following:

(1) Design the benefit levels and conditions of coverage for in-plan covered services and out-of-plan covered services as required by this Article.

(2) Provide or arrange for the provision of adequate systems to:

(A) process and pay claims for all out-of-plan covered services;

(B) meet the requirements for point-of-service contracts set forth in this Section and any additional requirements that may be set forth by the Director; and

(C) generate accurate data and financial and regulatory reports on a timely basis so that the Department of Insurance can evaluate the health maintenance organization's experience with the point-of-service contract and monitor compliance with point-of-service contract provisions.

(3) Comply with the requirements of subsections (b) and (c).