Insurance Legislation

Although **Senate Bill 1901** was passed by the Illinois General Assembly in 1998, it was not signed into law until January 6, 1999. As a result, a synopsis of this legislation was not included in the Department's 1998 Annual Report.

SB 1901 (P.A. 90—810) authorizes a mutual insurance company to reorganize its corporate structure to form a **mutual holding company system**. Upon conversion, the former mutual insurance company becomes a stock insurance company subsidiary of the mutual holding company (MHC). Policyholders' interests in the mutual company is split: their policy related interests remain as contractual obligations of the converted stock insurance company, while their membership interests become membership interests in the MHC. The legislation establishes a statutory framework for MHC conversion and for the Director's and policyholders' approval.

The spring 1999 session of the Illinois General Assembly produced a near record number of legislative measures (729 bills), including a number of important changes to the Illinois Insurance Code and related laws. Foremost among them were the Managed Care Reform and Patient Rights Act, the Protected Cell Company Act, and a bill to establish an Insurance Fraud Task Force. Following is a synopsis of each insurance—related bill. Complete texts can be found at *www.legis.state.il.us.*

House Bills

HB 812 (PA 91—292, effective 7/29/99)—Amends the Illinois Insurance Code (215 ILCS 5/123B—4) to provide that an **out—of—state risk retention group** that selects Illinois law to govern its policies may provide coverage for punitive damages and the multiplied portion of multiple damages if those coverages are permitted by law in the state where the risk retention group is organized.

HB 1177 (PA 91—0230, effective 1/1/00)—Creates the **Home Repair and Remodeling Act** to provide that, before initiating home repair or remodeling work for over $1,000, a person engaged in the business of home repair or remodeling shall furnish to the customer a written contract or work order with specified information. Requires any person engaged in the business of home repair and remodeling to obtain and maintain in full force and effect during the operation of the business public liability and property damage insurance in the amount of $100,000 per person and $300,000 per occurrence of bodily injury, $50,000 per occurrence for property damage, and $10,000 per occurrence for improper home repair or remodeling not in conformance with applicable state, county, or municipal building codes, unless the person has a net worth of not less than $1,000,000 as determined on the basis of the person's most recent financial statement, prepared within 13 months.

Makes it unlawful for any person engaged in the business of home repairs and remodeling to remodel or make repairs or charge for remodeling or repair work before obtaining a signed contract or work order over $1,000. Provides that the Attorney General or the State's Attorney of any county in this state may enforce the Act. Amends the Consumer Fraud and Deceptive Business Practices Act to include the Home Repair and Remodeling Act in the list of Acts for which a violation is also a violation of the Consumer Fraud and Deceptive Business Practices Act.

HB 1252 (PA 91—430, effective 1/1/00)—Amends the Service Contract Act (215 ILCS 152/10) to exclude a person who sells or leases motorcycles.

HB 1305 (PA 91—232, effective 1/1/00)—Amends the Illinois Criminal Code (720 ILCS 5/46—1, 5/46—1.1, 5/46—2 and 5/46—5) and adds Section 5/46—6 to **expand insurance fraud offenses** to include making a false claim and causing a false claim to be made. It also defines aggravated fraud as causing three or more false claims to be made.

HB 1348 (PA 91—549, effective 8/14/99)—Makes a number of changes to the Illinois Insurance Code. First, the bill amends the **Risk Based Capital Article** (Section 5/35A) to apply risk based capital standards to dental service plans, health maintenance organizations, limited health service organizations, and voluntary health services organizations. The law requires companies to calculate their risk based capital needs and authorizes the Department to take regulatory action based on the level of capital deficiency a company may demonstrate under the risk based capital calculations.

Second, the bill brings numerous sections of the Illinois Insurance Code and HMO Act into compliance with the **Illinois Health Insurance Portability and Accounting Act** (HIPAA), while also increasing the allowable compensation payable to insurance company officers without board approval from $100,000 to $200,000.

Lastly, the bill virtually eliminates all of Section 5/3.1 and Section 125/1—3 of the Insurance Code and replaces them with the National Association of Insurance Commissioners **(NAIC) Accounting Practices and Procedures** (based upon Health and Property and Casualty Codification).

HB 1355 (PA 91—77, effective 7/9/99)—Amends Sections 5/107.15a and 5/107.29 of the Illinois Insurance Code to shorten references to the phrase **"Illinois Insurance Exchange"** to the word "Exchange," which is predominately used in the rest of the statute.

HB 1388 (PA 91—0661, effective 12/22/99)—Amends the Illinois Vehicle Code (625 ILCS 5/7) to provide that all state employees who are assigned a **state—owned vehicle** shall annually certify that they are licensed to drive and have liability insurance covering them while driving a state vehicle for purposes other than official state business. Provides that if, for any reason, a state employee no longer has a driver's license or liability insurance, he or she shall not have authority to operate a state owned vehicle. Exempts peace officers from the provisions of the legislation.

HB 1587 (PA 91—375, effective 1/1/00)—Amends the **Workers Compensation Act** (820 ILCS 305/4) and the Occupational Diseases Act (820 ILCS 310/4) to include general contractors and their subcontractors among employers who must insure their payment of compensation.

HB 1622 (PA 91—406, effective 1/1/00)—Amends the Civil Administration Code (20 ILCS 1405/56.3), Illinois Insurance Code (5/356y), Health Maintenance Organization Act (215 ILCS 125/5—3), and Voluntary Health Services Plans Act (215 ILCS 165/10) to require that insurance companies, HMOs and VHSOs offer to the policyholder or applicant the option of coverage for **investigational cancer treatments,** including routine care in connection with those trials. Such coverages may have an annual benefit limit of $10,000. The bill also requires the Department of Insurance to conduct a study of the costs and benefits of the establishment of coverage for investigational cancer treatments.

The coverage requirement will sunset on January 1, 2003, and the Department will be required to submit the results of its study to the Governor and General Assembly on or before March 1, 2003.

HB 1697 (PA 91—552, effective 8/14/99)—Amends Sections 5/143.3(a) and 5/143.3(e) of the Insurance Code to void **automobile insurance** policies, binders, or applications paid for by a check or credit card that is dishonored for payment. Applies to both commercial and personal lines insurance.

HB 1771 (PA 91—380, effective 7/30/99)—Amends the Wrongful Death Act (740 ILCS 180/2) to reduce damages in the case of **contributory fault** on the part of the decedent or a beneficiary. Requires the trier of fact to determine the decedent's contributory fault in accordance with the Code of Civil Procedure, and provides for barred or diminished damages accordingly. Provides for diminished damages for a beneficiary whose contributory fault is not more than 50% of the proximate cause of the wrongful death, and bars damages for a beneficiary whose contributory fault is more than 50% of the proximate cause of the wrongful death. Applies to actions pending on or filed after the effective date of this amendatory Act.

HB 2166 (PA 91–639, effective 8/20/99)—Changes the **Comprehensive Health Insurance Plan** (CHIP) Act as follows: Amends Section 105/7 to make any person whose prior health coverage was terminated due to fraud within the previous five years ineligible for CHIP coverage.

Amends Section 105/8 to expand the list of covered services to include: physician services for physicals and immunizations for covered children under the age of 16 and "mental health parity" for inpatient hospitalizations for traditional CHIP participants only (those in Plans 1–3); and to limit CHIP benefits for services provided by a hospital that is located more than 75 miles outside the State of Illinois to a maximum of 45 days in a calendar year.

Amends Section 105/8 to allow the CHIP Board to set separate deductibles and co–payments and place other restrictions and limitations on the coverage of prescription drugs, including the use of a prescription drug card program or other program or both. This provision also restricts and reduces the list of oral surgical procedures which CHIP can cover to those in relation to injuries of natural teeth or a fractured jaw due to an accident, removes and repeals existing language which allowed CHIP to cover other types of oral surgery and procedures, and clarifies language concerning certain maternal and child health services.

The bill also repeals Section 105/8.5 which mandated that CHIP follow the requirements outlined in 215 ILCS 5/356r in regards to a woman's principal health care provider.

HB 2271 (PA 91–510, effective 1/1/00)—Amends Section 97/5 and adds Sections 97/26, 97/27 and 97/28 to the Illinois Health Insurance Portability and Accountability Act (IHIPAA) to create the **Small Employer Health Insurance Rating Act**. The bill establishes rating classes (bands) for small group plans (defined in IHIPAA as those with between 2 and 50 employees) based on expected claims experience. Limits the number of bands for any one insurance carrier to four. The bill further establishes parameters for premium increases within those classes and requires carriers to maintain records, available for review by the Director, justifying the actuarial basis for their rating practices.

HB 2713 (PA 91–605, effective 12/14/99)—Amends the State Employees Group Insurance Act (5 ILCS 375/6–12), Sections 5/357.9 and 5/370a of the Insurance Code, Section 125/5–3 of the Health Maintenance Organization Act, Section 130/4003 of the Limited Health Service Organization Act, and Section 165/10 of the Voluntary Health Service Organization Act and adds Section 5/356y to the Insurance Code to provide for **timely payment of periodic payments from payors to providers**. Payors are defined as insurers, HMOs, managed care plans, health care plans, preferred provider organizations (PPOs), third party administrators (TPAs), independent practice associations (IPAs), and physician–hospital organizations (PHOs).

The bill requires that for insurers, HMOs, managed care plans, health care plans, PPOs and TPAs, payments are to be made within 60 working days of an individual's enrollment in a plan or policy that requires the designation of a health care professional or facility. After December 31, 2000, those payments are to be made on a monthly basis. Failure to make periodic payments within the stated time results in the application of 9% annual interest on late payments.

Payments other than periodic payments are to be made within 30 days of written due proof of loss. Failure to make payments within the stated time results in the application of 9% annual interest on late payments. For IPAs and PHOs, payments are to be paid within 60 days of written due proof of loss prior to January 1, 2001 and 30 days thereafter.

Furthermore, the bill requires that notice be given to insureds or their assignees for failure to provide sufficient documentation for due proof of loss within 30 business days of receipt of claim or indemnity and grants the Department authority to take corrective action against IPAs and PHOs and to adopt rules to enforce compliance.

HB 2720 (PA 91—390, effective 7/30/99)—Makes technical changes to the **State Employees Group Insurance Act** in a number of areas, including benefit choice options, enrollment and effective dates of coverage, benefits in regards to Medicare eligibility and definitions. The amendments will bring the Act into compliance with the Insurance Code and with provisions of the federal Health Insurance Portability and Accountability Act (HIPAA). Changes are also being made in accordance with recent union negotiations and the start of the new College Insurance Program on July 1, 1999.

Senate Bills

SB 251 (PA 91—617, Sections 200 and 299 effective 8/19/99; Sections 25 and 85 effective 7/1/00; remaining sections effective 1/1/00)—Creates the **Managed Care Reform and Patient Rights Act** (MCRPR Act) to redefine the way managed care organizations treat consumers. The bill amends the State Employees Group Insurance Act (5 ILCS 375/3, 375/6.12, 375/10), the Counties Code (55 ILCS 5/5—1069.8), the Illinois Municipal Code (65 ILCS 5/10—4—2.8), the Illinois Insurance Code (215 ILCS 5/155.36, 215 ILCS 5/370g, 5/370s), the Health Care Reimbursement Reform Act (Article XX ½, 215 ILCS 5.370f, also known as the Preferred Provider Administration or PPA Act), Article XXXI¼ dealing with third party administrators (215 ILCS 5/511.118), the Comprehensive Health Insurance Plan Act (215 ILCS 105/8.6), the Health Maintenance Organization Act (215 ILCS 125/2—2, 125/5—3.6, 125/6—7), the Limited Health Service Organization Act (215 ILCS 130/4002.6), the Voluntary Health Services Plan Act (215 ILCS 165/15.30), and the Public Aid Code (305 ILCS 5/5—16.12) to bring those acts into full or partial compliance with the MCRPR Act.

The bill also adds a provision to the State Mandates Act (30 ILCS 805.23) that the MCRPR Act is an exempt mandate under that Act, and amends the Health Care Purchasing Group Act (215 ILCS 123/15 and 123/20) to raise the limits on the number of employees allowed in a group and to raise the limit of covered individuals allowed to be sponsored by one sponsor.

Note: the following analysis addresses only the managed care reform provisions and does not include changes to the State Employees Group Insurance Act of 1971.

The MCRPR Act, more specifically, is divided into 20 substantive sections as follows:

Sec. 5. List of patients' rights: taken in large part directly from the Medical Patient Rights Act (410 ILCS 50/0.01 et seq.).

Sec. 10. Definitions: includes definitions of "clinical peer," "emergency medical condition" (based upon the prudent lay person standard), and "health care plan" (excluding indemnity insurers, dental and vision only plans, PPOs, self—insured plans, workers comp coverage, and not—for—profit voluntary health service union plans).

Sec. 15. Provision of information: outlines what a plan must disclose to enrollees and prospective enrollees including terms of coverage, financial relationships and provider information.

Sec. 20. Notice of nonrenewal or termination: provides for 60 days notice (except in the case of discipline by a state licensing board) to the provider and enrollees of a provider's termination.

Sec. 25. Transition of services: ensures continuity of care for enrollees through a 90 day continuation in cases involving ongoing care, post partum care for women in the third trimester, and similar allowances for new enrollees. Such continuation is predicated on physicians agreeing to the plan's contractual parameters.

Sec. 30. Prohibitions: prohibits gag clauses and the dispensing of non—prescribed drugs.

Sec. 35. Medically appropriate health care protection: prohibits the termination of providers for advocating for medically appropriate health care, while reserving the current rights of provider licensing entities to take disciplinary action.

Sec. 40. Access to Specialists: allows enrollees who have conditions requiring ongoing specialty care to receive a standing referral for such care when referred by their primary care physician.

Sec. 45. Health care services appeals, complaints and external independent reviews: establishes a basis of three business days (24 hours in the case of significant increase to the health risk of the patient) for the internal resolution of appeals relating to treatment decisions when possible. For unresolvable cases, the bill establishes the right of an enrollee to pursue an independent external appeal through a reviewer mutually agreeable to the enrollee and the plan and requires plans to develop a mechanism for the selection of this reviewer.

Sec. 50. Administrative complaints and Departmental review: establishes that complaints falling outside the purview of Sec. 45 may be filed with the Department of Insurance and sets time frames and informational requirements on the Department's responses.

Sec. 55. Record of complaints: requires companies to file complaint information with the Department on an annual basis in a manner to be determined by the Department. Further directs the Department on how complaints will be recorded, categorized, and reported including a summarization to be included on the World Wide Web.

Sec. 60. Choosing a physician: allows plans to offer open access to contracted physicians and allows for rulemaking to ensure network adequacy.

Sec. 65. Emergency services prior to stabilization: establishes parameters for the coverage of emergency services performed by non network providers without prior authorization based on the prudent lay person standard.

Sec. 70. Post—stabilization medical services: establishes parameters to be followed by providers in attempting to secure plan authorization and direction after an enrollee admitted to an emergency room has been stabilized. Such parameters deal with good faith efforts of contacting the plan, recording of contact verification information, and the reasonable attempt to continue to make contact when immediate contact has not been accomplished.

Sec. 72. Pharmacy providers: prohibits plans from discriminating between pharmacy providers through contract variations and establishes the groundwork for the application of coinsurance, co—payments and deductibles applicable to prescriptions.

Sec. 75. Consumer advisory committee: requires plans to establish committees made up of enrollees to review consumer concerns and make advisory recommendations.

Sec. 80. Quality assessment program: requires plans to establish internal strategies for assuring accessibility, continuity, and quality of care within plans. Such strategies shall provide for improvement strategies and oversight by an internal committee with required reporting deadlines. Such programs are to be based on URAC, NCQA or JCAHO guidelines and overseen by the Department of Public Health acting in conjunction with the Department of Insurance.

Sec. 85. Utilization review (U.R.) program registration: establishes registration requirements within the Department for entities conducting U.R. Such registration may be by URAC accreditation or alternative accreditation to be established by the Department of Insurance in conjunction with the Department of Public Health. Exempts entities that provide U.R. only to the federal government, self—insured plans, and hospital and medical groups performing U.R. for internal purposes. Allows the Department of Insurance to establish by rule a registration fee for U.R. firms.

Sec. 90. Office of Consumer Health Insurance: establishes such an office within the Department of Insurance to assist consumers by educating them about their rights, assisting with complaint and appeal processes, establishing an "800" number consumer complaint line, providing information in languages other than English, assessing all health care laws, making recommendations for legislation to the Governor, and filing annual reports.

Sec. 95. Prohibited Activity: prohibits the transfer through indemnification and other means of certain liabilities.

These requirements are generally, but not solely, applicable to managed care entities. It is necessary to note that Section 85 (U.R.) and the definition of "emergency medical condition" based upon the prudent lay person standard in Section 10 are generally applicable to all insurers. Furthermore, Section 55 (record of complaints) is applicable to Third Party Administrators (TPAs) and Preferred Provider Organizations (PPOs) as well as managed care entities.

SB 338 (PA 91—643, effective 8/20/99)—Amends the State Finance Act (30 ILCS 105/5.490) to create the **Insurance Premium Tax Refund Fund**. The bill also amends Section 5/412 of the Insurance Code to establish the procedure for mandatory cash refunds of overpayment of premium taxes paid by insurance companies unless certain conditions are present and provides language for an appropriation mechanism. Interest will not be assessed.

The bill further amends the Illinois Income Tax Act to provide that in the case of a foreign insurer, the sum of the rates of the corporate income tax and the personal property tax replacement income tax shall be reduced to the rate of tax imposed on and measured by net income by the state or country in which the insurer is domiciled. Provides that the reduction may not reduce the corporate income tax and personal property tax replacement income tax to an amount that causes the total amount of taxes due from a foreign insurer for any taxable year to be less than 1.25% of the net taxable premiums written in Illinois.

Those taxes are the sum of taxes collected for: the income and property replacement taxes (Section 201 of the Income Tax Act); privilege taxes (Section 409 of the Insurance Code); fire insurance company tax (Section 12 of the Fire Investigation Act); and the fire department tax (Section 11—10—1 of the Municipal Code), to be less than 1.25% of the net taxable premiums written. In the case of an insurer taking a reduction, the corporate income tax will be reduced first, with only the excess reduction, if any, reducing the personal property replacement tax. This provision sunsets on January 1, 2001.

SB 359 (PA 91—522, effective 8/13/99)—Amends the Civil Administrative Code (20 ILCS 1405/56.3) to establish an **Insurance Fraud Task Force** composed of: the Director of Insurance (or designee), the Director of State Police (or designee), the Attorney General (or designee), nine representatives appointed by the Governor, and seven members representing insurers and an HMO appointed by the Director of Insurance.

The bill requires that the Task Force investigate the issue of insurance fraud and methods to combat organized insurance fraud, while also examining ways to unite the resources of the insurance industry and the criminal justice system to recognize and prosecute organized insurance fraud, and requires them to consider the creation of an agency to investigate those matters, as well as devise possible funding methods. The Task Force is to report its findings to the Governor and the General Assembly.

SB 363 (PA 91—234, effective 1/1/00)—Amends a number of sections of Article XXXI of the Illinois Insurance Code and adds Section 5/495.2. Provides for the payment of **insurance producer licensing fees** on a two year rather than annual cycle; requires producers to obtain their required bond, but eliminates the requirement to file it with the Department; requires that producers disclose

their bonding company and bond number to any consumer who requests that information; and creates a limited license for insurance sold by car rental firms.

SB 667 (PA 91—591, effective 8/14/99)—Amends the **Workers Compensation Act** (820 ILCS 305/3) to provide that the corporate officers of a domestic or foreign corporation (rather than a small business) who are employed by the corporation may elect to withdraw as individuals from the operation of the Act. Provides that the Act does not apply to a member of a limited liability company (LLC) who elects not to provide and pay for his or her accidental injuries.

SB 721 (PA 91—355, effective 1/1/00)—Creates the **Dental Care Patient Protection Act** and grants regulatory authority to the Department of Insurance for the regulation of managed care dental plans. Currently, the Dental Service Plan Act, Limited Health Service Organization Act, and Voluntary Health Service Plans Act establish standards for the licensure and regulation of Dental Service Plans. Authority is also granted under the Health Maintenance Organization Act and Insurance Code.

The bill contains stipulations regarding: the establishment of an advisory committee to provide the Department advice and counsel regarding managed care issues; the provision of information upon request about a plan's operations; credentialing of dentists, utilization review procedures and provider input into plan operations; continuity of care; a prohibition on gag clauses; the establishment of grievance procedures; coverage for emergency dental care without prior authorization; the requirement on the plan to offer a point—of—service option when an employer has more than 25 employees and provides at least 25% of the cost for the dental benefit; a limitation on the extension of liability based on the act; and a complaint review, investigation and record keeping process to be coordinated between the Departments of Insurance and Public Health.

SB 778 (PA 91—593, effective 8/14/99)—Amends Section 5/86 of the Illinois Insurance Code, the Business Corporation Act (805 ILCS 5/13.05 and 5/14.05), the Limited Liability Company Act (805 ILCS 180/45—5) and the Revised Uniform Limited Partnership Act (805 ILCS 210/105 and 210/902) to **abolish** specific **registration requirements** that certain **Lloyds** must obtain from the Secretary of State to transact business in Illinois. The bill also contains language to eliminate a double taxation, and language initiated by the Department to make the Limited Liability Company Act consistent with the Insurance Code in regards to syndicates and limited syndicates operating under an insurance exchange.

SB 856 (PA 91—466, effective 8/6/99)— Amends the Illinois Pension Code (40 ILCS 5/4—108, 4—109, 4—109.1, 4—109.2, 4—110, 4—110.1, 4—114, and 4—118.1) to make a number of changes to the **Downstate Firefighter Article** and adds Section 5/3—113.1 to make a change in relation to the **Downstate Police Article**. The bill also amends the State Mandates Act (30 ILCS 805/8.23) to specify that no reimbursement by the state is required for the implementation of any mandate created by this bill.

SB 1024 (PA 91—597, effective 1/1/00)—Amends Sections 5/143.13 and 5/143.17 of the Illinois Insurance Code to specify that a company may **renew a policy of insurance** containing minor policy changes. Any changes in deductibles or coverage must be mailed to the insured at least 60 days prior the renewal or anniversary date.

SB 1115 (PA 91—278, effective 7/23/99)—Creates the **Protected Cell Company Act** within the Illinois Insurance Code to securitize insurance risks against catastrophic losses (such as natural disasters) by creating protected cells and issuing securities to sophisticated investors. Securitization of insurance liabilities increases the sources and availability of capital and the stability of underwriting results of domestic companies.

1999 Rulemaking

Rule 201 (Subordinated Indebtedness) was amended March 10, 1999, to provide consistency with NAIC codification of statutory accounting principles and other state practices. The amendment deletes language in Section 201.20 that allowed an artificial floor for repayment of subordinated indebtedness. With the advent of risk–based capital, that language is no longer needed. New language in the section provides an additional safeguard for prepayment without the Director's approval. Section 201.50 was amended to clarify the accounting for accrued interest; Section 201.60(b) has been deleted.

Rule 301 (Accumulation of Guaranty Fund or Guaranty Capital—Reporting and Accounting of Such Indebtedness) was amended March 10, 1999, to delete language allowing artificial payment floors, add new language providing an additional safeguard for prepayment without the Director's approval, and clarify the accounting for accrued interest.

Rule 2008 (Minimum Standards for Individual and Group Medicare Supplement Insurance) was amended March 10, 1999, to make our regulatory standards consistent with federal law and the latest NAIC model regulation on Medicare Supplement insurance.

Rule 926 (Insurance Department Consumer Complaints) was amended May 3, 1999, to prohibit the release of consumer complaint files under subpoena pursuant to Section 404(1)(a) of the Illinois Insurance Code. Language is being added to Section 926.40 to also prohibit the release to third parties of consumer complaints files and all documents submitted with the consumer complaint or in response to the consumer complaint.

Rule 5421 (Health Maintenance Organization) was amended May 3, 1999, to provide consistency both with NAIC codification of statutory accounting principles and other state practices. With the advent of risk–based capital, language in Section 5421.70 allowing an artificial floor for repayment of subordinated indebtedness is no longer needed and has been deleted.

Rule 5420 (Managed Care Reform and Patient Rights) was adopted on an emergency basis for 150 days beginning September 27, 1999, to implement Public Act 91–617 (the Managed Care Reform and Patient Rights Act), to assure the proper provision of information to enrollees by health care plans; the proper treatment of enrollees by health care plans; the proper treatment of health care providers by health care plans; and the proper oversight of health care plans by the Department of Insurance.

Rule 1407 (Accelerated Benefit/Terminal Illness/Qualified Conditions) was amended effective December 14, 1999, to revise the definition of "Qualified Covered Condition" and to increase the accelerated benefit for those conditions from 25% to 75% of the face amount of the policy. The amendment also makes the definition of "Terminal Illness" consistent with that in the US Internal Revenue Code [26 USCS 101(g)(4)] and adds a section on actuarial standards consistent with the current NAIC model rule on accelerated benefits.

Rule 2501 (Fees for Examination) was repealed December 27, 1999, because it has been replaced by 50 Ill. Adm. Code 2505.90, Financial Examination Expenses and Fees.

DOI Archives

State agencies were first required to file all rules and regulations with the Secretary of State in 1951. In 1983, insurance regulations were codified under Title 50 of the Illinois Administrative Code.