



102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB0711

Introduced 2/8/2021, by Rep. Gregory Harris - Tom Demmer - William Davis - Anna Moeller - Ryan Spain, et al.

SYNOPSIS AS INTRODUCED:

New Act

215 ILCS 5/370g

from Ch. 73, par. 982g

215 ILCS 134/10

215 ILCS 134/65

305 ILCS 5/5-5.12d new

Creates the Prior Authorization Reform Act. Provides requirements concerning disclosure and review of prior authorization requirements, denial of claims or coverage by a utilization review organization, and the implementation of prior authorization requirements or restrictions. Provides requirements concerning a utilization review organization's obligations with respect to prior authorizations in nonurgent circumstances, urgent health care services, and emergency health care services. Provides that a utilization review organization shall not require prior authorization under specified circumstances. Provides requirements concerning the length of prior authorizations. Provides that health care services are automatically deemed authorized if a utilization review organization fails to comply with the requirements of the Act. Provides that the Director of Insurance may impose an administrative fine not to exceed \$250,000 for violations of the Act. Defines terms. Amends the Illinois Insurance Code to change the definition of "emergency medical condition". Amends the Managed Care Reform and Patient Rights Act to provide that companies that transact accident and health insurance shall comply with specified requirements of the Managed Care Reform and Patient Rights Act. Amends the Illinois Public Aid Code to provide that all managed care organizations shall comply with the requirements of the Prior Authorization Reform Act. Makes other changes. Effective January 1, 2022.

LRB102 10190 BMS 20259 b

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 1. Short title. This Act may be cited as the Prior
5 Authorization Reform Act.

6 Section 5. Purpose. The General Assembly hereby finds and
7 declares that:

8 (1) the health care professional-patient relationship
9 is paramount and should not be subject to third-party
10 intrusion;

11 (2) prior authorization programs shall be subject to
12 member coverage agreements and medical policies but shall
13 not hinder the independent medical judgment of a physician
14 or health care provider; and

15 (3) prior authorization programs must be transparent
16 to ensure a fair and consistent process for health care
17 providers and patients.

18 Section 10. Applicability; scope. This Act applies to
19 health insurance coverage as defined in the Illinois Health
20 Insurance Portability and Accountability Act, and policies
21 issued or delivered in this State to the Department of
22 Healthcare and Family Services and providing coverage to

1 persons who are enrolled under Article V of the Illinois
2 Public Aid Code or under the Children's Health Insurance
3 Program Act, amended, delivered, issued, or renewed on or
4 after the effective date of this Act, with the exception of
5 employee or employer self-insured health benefit plans under
6 the federal Employee Retirement Income Security Act of 1974,
7 health care provided pursuant to the Workers' Compensation Act
8 or the Workers' Occupational Diseases Act, and State employee
9 health plans. This Act does not diminish a health care plan's
10 duties and responsibilities under other federal or State law
11 or rules promulgated thereunder.

12 Section 15. Definitions. As used in this Act:

13 "Adverse determination" has the meaning given to that term
14 in Section 10 of the Health Carrier External Review Act.

15 "Appeal" means a formal request, either orally or in
16 writing, to reconsider an adverse determination.

17 "Approval" means a determination by a utilization review
18 organization that a health care service has been reviewed and,
19 based on the information provided, satisfies the utilization
20 review organization's requirements for medical necessity and
21 appropriateness.

22 "Clinical review criteria" has the meaning given to that
23 term in Section 10 of the Health Carrier External Review Act.

24 "Department" means the Department of Insurance.

25 "Emergency medical condition" has the meaning given to

1 that term in Section 10 of the Managed Care Reform and Patient
2 Rights Act.

3 "Emergency services" has the meaning given to that term in
4 federal health insurance reform requirements for the group and
5 individual health insurance markets, 45 CFR 147.138.

6 "Enrollee" has the meaning given to that term in Section
7 10 of the Managed Care Reform and Patient Rights Act.

8 "Health care professional" has the meaning given to that
9 term in Section 10 of the Managed Care Reform and Patient
10 Rights Act.

11 "Health care provider" has the meaning given to that term
12 in Section 10 of the Managed Care Reform and Patient Rights
13 Act.

14 "Health care service" means any services or level of
15 services included in the furnishing to an individual of
16 medical care or the hospitalization incident to the furnishing
17 of such care, as well as the furnishing to any person of any
18 other services for the purpose of preventing, alleviating,
19 curing, or healing human illness or injury, including
20 behavioral health, mental health, home health, and
21 pharmaceutical services and products.

22 "Health insurance issuer" has the meaning given to that
23 term in Section 5 of the Illinois Health Insurance Portability
24 and Accountability Act.

25 "Medically necessary" means a health care professional
26 exercising prudent clinical judgment would provide care to a

1 patient for the purpose of preventing, diagnosing, or treating
2 an illness, injury, disease, or its symptoms and that are: (i)
3 in accordance with generally accepted standards of medical
4 practice; (ii) clinically appropriate in terms of type,
5 frequency, extent, site, and duration and are considered
6 effective for the patient's illness, injury, or disease; and
7 (iii) not primarily for the convenience of the patient,
8 treating physician, other health care professional, caregiver,
9 family member, or other interested party.

10 "Physician" means a person licensed under the Medical
11 Practice Act of 1987 to practice medicine in all its branches.

12 "Prior authorization" means the process by which
13 utilization review organizations determine the medical
14 necessity and medical appropriateness of otherwise covered
15 health care services before the rendering of such health care
16 services. "Prior authorization" includes any utilization
17 review organization's requirement that an enrollee, health
18 care professional, or health care provider notify the
19 utilization review organization before, at the time of, or
20 concurrent to providing a health care service.

21 "Urgent health care service" means a health care service
22 with respect to which the application of the time periods for
23 making a non-expedited prior authorization that in the opinion
24 of a health care professional with knowledge of the enrollee's
25 medical condition:

26 (1) could seriously jeopardize the life or health of

1 the enrollee or the ability of the enrollee to regain
2 maximum function; or

3 (2) could subject the enrollee to severe pain that
4 cannot be adequately managed without the care or treatment
5 that is the subject of the utilization review.

6 "Urgent health care service" does not include emergency
7 services.

8 "Utilization review organization" has the meaning given to
9 that term in 50 Ill. Adm. Code 4520.30.

10 Section 20. Disclosure and review of prior authorization
11 requirements.

12 (a) A utilization review organization shall maintain a
13 complete list of services for which prior authorization is
14 required, including for all services where prior authorization
15 is performed by an entity under contract with the utilization
16 review organization.

17 (b) A utilization review organization shall make any
18 current prior authorization requirements and restrictions,
19 including the written clinical review criteria, readily
20 accessible and conspicuously posted on its website to
21 enrollees, health care professionals, and health care
22 providers. Content published by a thirty party and licensed
23 for use by a utilization review organization may be made
24 available through the utilization review organization's
25 secure, password-protected website so long as the access

1 requirements of the website do not unreasonably restrict
2 access. Requirements shall be described in detail, written in
3 easily understandable language, and readily available to the
4 health care professional and health care provider at the point
5 of care. The website shall indicate for each service subject
6 to prior authorization:

7 (1) when prior authorization became required for
8 policies issued or delivered in Illinois, including the
9 effective date or dates and the termination date or dates,
10 if applicable, in Illinois;

11 (2) the date the Illinois-specific requirement was
12 listed on the utilization review organization's website;
13 and

14 (3) where applicable, the date that prior
15 authorization was removed for Illinois.

16 (c) The clinical review criteria must:

17 (1) be based on nationally recognized standards except
18 where State law provides its own standard;

19 (2) be developed in accordance with the current
20 standards of national medical accreditation entities;

21 (3) ensure quality of care and access to needed health
22 care services;

23 (4) be evidence-based;

24 (5) be sufficiently flexible to allow deviations from
25 norms when justified on a case-by-case basis;

26 (6) be evaluated and updated, if necessary, at least

1 annually; and

2 (7) before establishing or substantially or materially
3 altering written clinical review criteria, obtain input
4 from actively practicing physicians representing major
5 areas of the specialty. The utilization review
6 organization shall seek input from physicians who are not
7 employees of the utilization review organization or
8 consultants to the utilization review organization.

9 (d) A utilization review organization shall not deny a
10 claim for failure to obtain prior authorization if the prior
11 authorization requirement was not in effect on the date of
12 service on the claim.

13 (e) A utilization review organization shall not deny prior
14 authorization of a health care service solely based on the
15 grounds that the health care service does not meet an
16 evidence-based standard where:

17 (1) no independently developed, evidence-based
18 standards can be derived from reliable scientific evidence
19 or documents published by professional societies;

20 (2) evidence-based standards conflict;

21 (3) evidence-based standards from expert consensus
22 panels do not exist; or

23 (4) a health care professional or health care provider
24 judges a service, product, or procedure is medically
25 appropriate for his or her patient even if it has not been
26 formally approved for the specific condition being

1 treated.

2 (f) A utilization review organization shall not deem as
3 incidental or deny supplies or health care services that are
4 routinely used as part of a health care service when:

5 (1) an associated health care service has received
6 prior authorization; or

7 (2) prior authorization for the health care service is
8 not required.

9 (g) If a utilization review organization intends to
10 implement a new prior authorization requirement or restriction
11 or amend an existing requirement or restriction, the
12 utilization review organization shall provide enrollees,
13 contracted health care professionals, and contracted health
14 care providers of enrollees written notice of the new or
15 amended requirement or amendment no less than 60 days before
16 the requirement or restriction is implemented. The written
17 notice may be provided in an electronic format, including
18 email or facsimile, if the enrollee, health care professional,
19 or health care provider has agreed in advance to receive
20 notices electronically. The utilization review organization
21 shall ensure that the new or amended requirement is not
22 implemented unless the utilization review organization's
23 website has been updated to reflect the new or amended
24 requirement or restriction.

25 (h) Entities utilizing prior authorization shall make
26 statistics available regarding prior authorization approvals

1 and denials on their website in a readily accessible format.
2 The categories must be updated quarterly and include all of
3 the following information:

4 (1) a list of all health care services, including
5 medications, that are subject to prior authorization;

6 (2) the total number of prior authorization requests
7 received;

8 (3) the physician specialty;

9 (4) the number of prior authorization requests
10 approved during the previous plan year by the utilization
11 review organization with respect to each service described
12 in paragraph (1);

13 (5) the number of prior authorization requests
14 approved during the previous plan year by the utilization
15 review organization after the receipt of additional
16 information from the enrollee, the enrollee's health care
17 professional, or the enrollee's health care provider;

18 (6) the number of prior authorization requests denied
19 during the previous plan year by the health insurance
20 issuer with respect to each service described in paragraph
21 (1) and the top 5 reasons for denial, which must include
22 related evidence-based criteria, if applicable;

23 (7) the number of requests described in paragraph (6)
24 that were appealed, the number of the appealed requests
25 that upheld the adverse determination, and the number of
26 appealed requests that reversed the adverse determination;

- 1 (8) the time between submission and response;
- 2 (9) the average length of time for resolution; and
- 3 (10) any other information as the Director determines
- 4 appropriate after consultation with and comment from
- 5 stakeholders.

6 Section 25. Utilization review organization's obligations

7 with respect to prior authorizations in nonurgent

8 circumstances. If a utilization review organization requires

9 prior authorization of a health care service, the utilization

10 review organization must make a prior authorization or adverse

11 determination and notify the enrollee, the enrollee's health

12 care professional, and the enrollee's health care provider of

13 the prior authorization or adverse determination within 72

14 hours after obtaining all necessary information to make the

15 prior authorization or adverse determination. As used in this

16 Section, "necessary information" includes the results of any

17 face-to-face clinical evaluation or second opinion that may be

18 required.

19 Section 30. Utilization review organization's obligations

20 with respect to prior authorizations concerning urgent health

21 care services.

22 (a) A utilization review organization must render a prior

23 authorization or adverse determination concerning urgent care

24 services and notify the enrollee, the enrollee's health care

1 professional, and the enrollee's health care provider of that
2 prior authorization or adverse determination not later than 24
3 hours after receiving all information needed to complete the
4 review of the requested health care services.

5 (b) To facilitate the rendering of a prior authorization
6 in conformance with this Section, a utilization review
7 organization must establish and provide access to a hotline
8 that is staffed 24 hours per day, 7 days per week by
9 appropriately trained and licensed clinical personnel who have
10 access to physicians for consultation that are designated by
11 the plan to make such determinations for prior authorization
12 concerning urgent care services.

13 Section 35. Utilization review organization's obligations
14 with respect to prior authorization concerning emergency
15 health care services.

16 (a) A utilization review organization shall cover
17 emergency health care services necessary to screen and
18 stabilize an enrollee. If a health care professional or health
19 care provider certifies in writing to a utilization review
20 organization within 72 hours after an enrollee's admission
21 that the enrollee's condition required emergency health care
22 services, that certification creates a presumption that the
23 emergency health care services were medically necessary and
24 such presumption may be rebutted only if the utilization
25 review organization can establish, with clear and convincing

1 evidence, that the emergency health care services were not
2 medically necessary.

3 (b) If an enrollee receives an emergency health care
4 service that requires immediate post-evaluation or
5 post-stabilization services, a utilization review organization
6 shall make a prior authorization determination within 60
7 minutes after receiving a request; if the prior authorization
8 determination is not made within 60 minutes, the services
9 shall be deemed approved.

10 Section 40. Personnel qualified to make adverse
11 determinations of a prior authorization request. A utilization
12 review organization must ensure that all adverse
13 determinations are made by a physician. The physician must:

14 (1) possess a current and valid nonrestricted license
15 to practice medicine in all its branches in Illinois or in
16 another United States jurisdiction;

17 (2) practice in the same or similar specialty as the
18 physician who typically manages the medical condition or
19 disease or provides the health care service involved in
20 the request; and

21 (3) have experience treating patients with the medical
22 condition or disease for which the health care service is
23 being requested.

24 Section 45. Consultation before issuing an adverse

1 determination of a prior authorization. If a utilization
2 review organization is questioning the medical necessity of a
3 health care service, the utilization review organization must
4 notify the enrollee's health care professional and health care
5 provider that medical necessity is being questioned. Before
6 issuing an adverse determination, the enrollee's health care
7 professional and health care provider must have the
8 opportunity to discuss the medical necessity of the health
9 care service on the telephone or by other agreeable method
10 with the physician who will be responsible for issuing the
11 prior authorization of the health care service under review.

12 Section 50. Requirements applicable to the physician who
13 can review consultations and appeals. A utilization program
14 must ensure that all appeals are reviewed by a physician. The
15 physician must:

16 (1) possess a current and valid nonrestricted license
17 to practice medicine in Illinois or in another United
18 States jurisdiction;

19 (2) be currently in active practice in the same or
20 similar specialty as physician who typically manages the
21 medical condition or disease for at least 5 consecutive
22 years;

23 (3) be knowledgeable of, and have experience
24 providing, the health care services under appeal;

25 (4) not be employed by a utilization review

1 organization, be under contract with the utilization
2 review organization other than to participate in one or
3 more of the utilization review organization's health care
4 professional networks or to perform reviews of appeals, or
5 otherwise have any financial interest in the outcome of
6 the appeal;

7 (5) not have been directly involved in making the
8 adverse determination; and

9 (6) consider all known clinical aspects of the health
10 care service under review, including, but not limited to,
11 a review of all pertinent medical records provided to the
12 utilization review organization by the enrollee's health
13 care professional or health care provider and any medical
14 literature provided to the utilization review organization
15 by the health care professional or health care provider.

16 Section 55. Limitation on prior authorization. A
17 utilization review organization shall not require prior
18 authorization:

19 (1) where a medication or procedure prescribed for a
20 patient is customary and properly indicated or is a
21 treatment for the clinical indication as supported by
22 peer-reviewed medical publications;

23 (2) for a patient currently managed with an
24 established treatment regimen; or

25 (3) for the provision of medication-assisted treatment

1 for the treatment of a substance use disorder as those
2 terms are defined in the Substance Use Disorder Act.

3 Section 60. Denial.

4 (a) A utilization review organization may not revoke,
5 limit, condition, or restrict a prior authorization.

6 (b) Notwithstanding any other provision of law, a
7 utilization review organization shall approve and payment
8 shall be made by the patient's health insurance issuer on
9 claims for health care services for which prior authorization
10 was required and approval received before the rendering of
11 health care services, unless one of the following occurs:

12 (1) it is timely determined that the enrollee's health
13 care professional or health care provider knowingly
14 provided health care services that required prior
15 authorization from the utilization review organization
16 without first obtaining prior authorization for those
17 health care services;

18 (2) it is timely determined that the health care
19 services claimed were not performed;

20 (3) it is timely determined that the health care
21 services rendered were contrary to the instructions of the
22 utilization review organization or its delegated physician
23 reviewer if contact was made between those parties before
24 the service being rendered;

25 (4) it is timely determined that the enrollee

1 receiving such health care services was not an enrollee of
2 the health care plan; or

3 (5) the approval was based upon a material
4 misrepresentation by the enrollee or health care provider;
5 as used in this paragraph (5), "material" means a fact or
6 situation that is not merely technical in nature and
7 results or could result in a substantial change in the
8 situation.

9 Section 65. Length of prior authorization approval. A
10 prior authorization approval shall be valid for 12 months
11 after the date the health care professional or health care
12 provider receives the prior authorization approval and the
13 approval period shall be effective regardless of any changes,
14 including any changes in dosage for a prescription drug
15 prescribed by the health care professional. Except to the
16 extent required by medical exceptions processes for
17 prescription drugs, nothing in this Section shall require a
18 policy to cover any care, treatment, or services for any
19 health condition that the terms of coverage otherwise
20 completely exclude from the policy's covered benefits without
21 regard for whether the care, treatment, or services are
22 medically necessary.

23 Section 70. Length of prior authorization for treatment
24 for chronic or long-term care conditions. If a utilization

1 review organization requires a prior authorization for a
2 health care service or medication for the treatment of a
3 chronic or long-term care condition, the prior authorization
4 shall remain valid for the length of the treatment as
5 determined by the patient's health care professional.

6 Section 75. Continuity of care for enrollees.

7 (a) On receipt of information documenting a prior
8 authorization from the enrollee or from the enrollee's health
9 care professional or health care provider, a utilization
10 review organization shall honor a prior authorization granted
11 to an enrollee from a previous utilization review organization
12 for at least the initial 90 days of an enrollee's coverage
13 under a new health plan.

14 (b) During the time period described in subsection (a), a
15 utilization review organization may perform its own review to
16 grant a prior authorization subject to the terms of the
17 member's coverage agreement.

18 (c) If there is a change in coverage of or approval
19 criteria for a previously authorized health care service, the
20 change in coverage or approval criteria does not affect an
21 enrollee who received prior authorization before the effective
22 date of the change for the remainder of the enrollee's plan
23 year.

24 (d) Except to the extent required by medical exceptions
25 processes for prescription drugs, nothing in this Section

1 shall require a policy to cover any care, treatment, or
2 services for any health condition that the terms of coverage
3 otherwise completely exclude from the policy's covered
4 benefits without regard for whether the care, treatment, or
5 services are medically necessary.

6 Section 80. Health care services deemed authorized if a
7 utilization review organization fails to comply with the
8 requirements of this Act. A failure by a utilization review
9 organization to comply with the deadlines and other
10 requirements specified in this Act shall result in any health
11 care services subject to review to be automatically deemed
12 authorized by the utilization review organization.

13 Section 85. Severability. If any provision of this Act or
14 its application to any person or circumstance is held invalid,
15 the invalidity does not affect other provisions or
16 applications of this Act that can be given effect without the
17 invalid provision or application, and to this end the
18 provisions of this Act are declared to be severable.

19 Section 90. Administration and enforcement.

20 (a) The Department shall enforce the provisions of this
21 Act pursuant to the enforcement powers granted to it by law. To
22 enforce the provisions of this Act, the Director is hereby
23 granted specific authority to issue a cease and desist order

1 or require a utilization review organization or health
2 insurance issuer to submit a plan of correction for violations
3 of this Act, or both, in accordance with the requirements and
4 authority set forth in Section 85 of the Managed Care Reform
5 and Patient Rights Act. Subject to the provisions of the
6 Illinois Administrative Procedure Act, the Director may,
7 pursuant to Section 403A of the Illinois Insurance Code,
8 impose upon a utilization review organization or health
9 insurance issuer an administrative fine not to exceed \$250,000
10 for failure to submit a requested plan of correction, failure
11 to comply with its plan of correction, or repeated violations
12 of this Act.

13 (b) Any person who believes that his or her utilization
14 review organization or health insurance issuer is in violation
15 of the provisions of this Act may file a complaint with the
16 Department. The Department shall review all complaints
17 received and investigate all complaints that it deems to state
18 a potential violation. The Department shall fairly,
19 efficiently, and timely review and investigate complaints.
20 Utilization review organizations found to be in violation of
21 this Act shall be penalized in accordance with this Section.

22 (c) The Department of Healthcare and Family Services shall
23 enforce the provisions of this Act as it applies to persons
24 enrolled under Article V of the Illinois Public Aid Code or
25 under the Children's Health Insurance Program Act.

1 Section 900. The Illinois Insurance Code is amended by
2 changing Section 370g as follows:

3 (215 ILCS 5/370g) (from Ch. 73, par. 982g)

4 Sec. 370g. Definitions. As used in this Article, the
5 following definitions apply:

6 (a) "Health care services" means health care services or
7 products rendered or sold by a provider within the scope of the
8 provider's license or legal authorization. The term includes,
9 but is not limited to, hospital, medical, surgical, dental,
10 vision and pharmaceutical services or products.

11 (b) "Insurer" means an insurance company or a health
12 service corporation authorized in this State to issue policies
13 or subscriber contracts which reimburse for expenses of health
14 care services.

15 (c) "Insured" means an individual entitled to
16 reimbursement for expenses of health care services under a
17 policy or subscriber contract issued or administered by an
18 insurer.

19 (d) "Provider" means an individual or entity duly licensed
20 or legally authorized to provide health care services.

21 (e) "Noninstitutional provider" means any person licensed
22 under the Medical Practice Act of 1987, as now or hereafter
23 amended.

24 (f) "Beneficiary" means an individual entitled to
25 reimbursement for expenses of or the discount of provider fees

1 for health care services under a program where the beneficiary
2 has an incentive to utilize the services of a provider which
3 has entered into an agreement or arrangement with an
4 administrator.

5 (g) "Administrator" means any person, partnership or
6 corporation, other than an insurer or health maintenance
7 organization holding a certificate of authority under the
8 "Health Maintenance Organization Act", as now or hereafter
9 amended, that arranges, contracts with, or administers
10 contracts with a provider whereby beneficiaries are provided
11 an incentive to use the services of such provider.

12 (h) "Emergency medical condition" has the meaning given to
13 that term in Section 10 of the Managed Care Reform and Patient
14 Rights Act. ~~means a medical condition manifesting itself by~~
15 ~~acute symptoms of sufficient severity (including severe pain)~~
16 ~~such that a prudent layperson, who possesses an average~~
17 ~~knowledge of health and medicine, could reasonably expect the~~
18 ~~absence of immediate medical attention to result in:~~

19 ~~(1) placing the health of the individual (or, with~~
20 ~~respect to a pregnant woman, the health of the woman or her~~
21 ~~unborn child) in serious jeopardy;~~

22 ~~(2) serious impairment to bodily functions; or~~

23 ~~(3) serious dysfunction of any bodily organ or part.~~

24 (Source: P.A. 91-617, eff. 1-1-00.)

25 Section 905. The Managed Care Reform and Patient Rights

1 Act is amended by changing Sections 10 and 65 as follows:

2 (215 ILCS 134/10)

3 Sec. 10. Definitions.

4 "Adverse determination" means a determination by a health
5 care plan under Section 45 or by a utilization review program
6 under Section 85 that a health care service is not medically
7 necessary.

8 "Clinical peer" means a health care professional who is in
9 the same profession and the same or similar specialty as the
10 health care provider who typically manages the medical
11 condition, procedures, or treatment under review.

12 "Department" means the Department of Insurance.

13 "Emergency medical condition" means a medical condition
14 manifesting itself by acute symptoms of sufficient severity,
15 regardless of the final diagnosis given, such that a prudent
16 layperson, who possesses an average knowledge of health and
17 medicine, could reasonably expect the absence of immediate
18 medical attention to result in:

19 (1) placing the health of the individual (or, with
20 respect to a pregnant woman, the health of the woman or her
21 unborn child) in serious jeopardy;

22 (2) serious impairment to bodily functions;

23 (3) serious dysfunction of any bodily organ or part;

24 (4) inadequately controlled pain; or

25 (5) with respect to a pregnant woman who is having

1 contractions:

2 (A) inadequate time to complete a safe transfer to
3 another hospital before delivery; or

4 (B) a transfer to another hospital may pose a
5 threat to the health or safety of the woman or unborn
6 child.

7 "Emergency medical screening examination" means a medical
8 screening examination and evaluation by a physician licensed
9 to practice medicine in all its branches, or to the extent
10 permitted by applicable laws, by other appropriately licensed
11 personnel under the supervision of or in collaboration with a
12 physician licensed to practice medicine in all its branches to
13 determine whether the need for emergency services exists.

14 "Emergency services" means, with respect to an enrollee of
15 a health care plan, transportation services, including but not
16 limited to ambulance services, and covered inpatient and
17 outpatient hospital services furnished by a provider qualified
18 to furnish those services that are needed to evaluate or
19 stabilize an emergency medical condition. "Emergency services"
20 does not refer to post-stabilization medical services.

21 "Enrollee" means any person and his or her dependents
22 enrolled in or covered by a health care plan.

23 "Health care plan" means a plan, including, but not
24 limited to, a health maintenance organization, a managed care
25 community network as defined in the Illinois Public Aid Code,
26 or an accountable care entity as defined in the Illinois

1 Public Aid Code that receives capitated payments to cover
2 medical services from the Department of Healthcare and Family
3 Services, that establishes, operates, or maintains a network
4 of health care providers that has entered into an agreement
5 with the plan to provide health care services to enrollees to
6 whom the plan has the ultimate obligation to arrange for the
7 provision of or payment for services through organizational
8 arrangements for ongoing quality assurance, utilization review
9 programs, or dispute resolution. Nothing in this definition
10 shall be construed to mean that an independent practice
11 association or a physician hospital organization that
12 subcontracts with a health care plan is, for purposes of that
13 subcontract, a health care plan.

14 For purposes of this definition, "health care plan" shall
15 not include the following:

16 (1) indemnity health insurance policies including
17 those using a contracted provider network;

18 (2) health care plans that offer only dental or only
19 vision coverage;

20 (3) preferred provider administrators, as defined in
21 Section 370g(g) of the Illinois Insurance Code;

22 (4) employee or employer self-insured health benefit
23 plans under the federal Employee Retirement Income
24 Security Act of 1974;

25 (5) health care provided pursuant to the Workers'
26 Compensation Act or the Workers' Occupational Diseases

1 Act; and

2 (6) not-for-profit voluntary health services plans
3 with health maintenance organization authority in
4 existence as of January 1, 1999 that are affiliated with a
5 union and that only extend coverage to union members and
6 their dependents.

7 "Health care professional" means a physician, a registered
8 professional nurse, or other individual appropriately licensed
9 or registered to provide health care services.

10 "Health care provider" means any physician, hospital
11 facility, facility licensed under the Nursing Home Care Act,
12 long-term care facility as defined in Section 1-113 of the
13 Nursing Home Care Act, or other person that is licensed or
14 otherwise authorized to deliver health care services. Nothing
15 in this Act shall be construed to define Independent Practice
16 Associations or Physician-Hospital Organizations as health
17 care providers.

18 "Health care services" means any services included in the
19 furnishing to any individual of medical care, or the
20 hospitalization incident to the furnishing of such care, as
21 well as the furnishing to any person of any and all other
22 services for the purpose of preventing, alleviating, curing,
23 or healing human illness or injury including behavioral
24 health, mental health, home health, and pharmaceutical
25 services and products.

26 "Medical director" means a physician licensed in any state

1 to practice medicine in all its branches appointed by a health
2 care plan.

3 "Person" means a corporation, association, partnership,
4 limited liability company, sole proprietorship, or any other
5 legal entity.

6 "Physician" means a person licensed under the Medical
7 Practice Act of 1987.

8 "Post-stabilization medical services" means health care
9 services provided to an enrollee that are furnished in a
10 licensed hospital by a provider that is qualified to furnish
11 such services, and determined to be medically necessary and
12 directly related to the emergency medical condition following
13 stabilization.

14 "Stabilization" means, with respect to an emergency
15 medical condition, to provide such medical treatment of the
16 condition as may be necessary to assure, within reasonable
17 medical probability, that no material deterioration of the
18 condition is likely to result.

19 "Utilization review" means the evaluation of the medical
20 necessity, appropriateness, and efficiency of the use of
21 health care services, procedures, and facilities.

22 "Utilization review program" means a program established
23 by a person to perform utilization review.

24 (Source: P.A. 101-452, eff. 1-1-20.)

25 (215 ILCS 134/65)

1 Sec. 65. Emergency services prior to stabilization.

2 (a) A health care plan that provides or that is required by
3 law to provide coverage for emergency services shall provide
4 coverage such that payment under this coverage is not
5 dependent upon whether the services are performed by a plan or
6 non-plan health care provider and without regard to prior
7 authorization. This coverage shall be at the same benefit
8 level as if the services or treatment had been rendered by the
9 health care plan physician licensed to practice medicine in
10 all its branches or health care provider.

11 (b) Prior authorization or approval by the plan shall not
12 be required for emergency services.

13 (c) Coverage and payment shall only be retrospectively
14 denied under the following circumstances:

15 (1) upon reasonable determination that the emergency
16 services claimed were never performed;

17 (2) upon timely determination that the emergency
18 evaluation and treatment were rendered to an enrollee who
19 sought emergency services and whose circumstance did not
20 meet the definition of emergency medical condition;

21 (3) upon determination that the patient receiving such
22 services was not an enrollee of the health care plan; or

23 (4) upon material misrepresentation by the enrollee or
24 health care provider; "material" means a fact or situation
25 that is not merely technical in nature and results or
26 could result in a substantial change in the situation.

1 (d) When an enrollee presents to a hospital seeking
2 emergency services, the determination as to whether the need
3 for those services exists shall be made for purposes of
4 treatment by a physician licensed to practice medicine in all
5 its branches or, to the extent permitted by applicable law, by
6 other appropriately licensed personnel under the supervision
7 of or in collaboration with a physician licensed to practice
8 medicine in all its branches. The physician or other
9 appropriate personnel shall indicate in the patient's chart
10 the results of the emergency medical screening examination.

11 (e) The appropriate use of the 911 emergency telephone
12 system or its local equivalent shall not be discouraged or
13 penalized by the health care plan when an emergency medical
14 condition exists. This provision shall not imply that the use
15 of 911 or its local equivalent is a factor in determining the
16 existence of an emergency medical condition.

17 (f) The medical director's or his or her designee's
18 determination of whether the enrollee meets the standard of an
19 emergency medical condition shall be based solely upon the
20 presenting symptoms documented in the medical record at the
21 time care was sought. Only a clinical peer may make an adverse
22 determination.

23 (g) Nothing in this Section shall prohibit the imposition
24 of deductibles, copayments, and co-insurance. Nothing in this
25 Section alters the prohibition on billing enrollees contained
26 in the Health Maintenance Organization Act.

1 (h) This Section shall apply to the types of companies
2 subject to Section 155.36 of the Illinois Insurance Code.

3 (Source: P.A. 91-617, eff. 1-1-00.)

4 Section 910. The Illinois Public Aid Code is amended by
5 adding Section 5-5.12d as follows:

6 (305 ILCS 5/5-5.12d new)

7 Sec. 5-5.12d. Managed care organization prior
8 authorization of health care services.

9 (a) As used in this Section, "health care service" has the
10 meaning given to that term in the Prior Authorization Reform
11 Act.

12 (b) Notwithstanding any other provision of law to the
13 contrary, all managed care organizations shall comply with the
14 requirements of the Prior Authorization Reform Act.

15 Section 999. Effective date. This Act takes effect January
16 1, 2022.