Rep. Greg Harris

Filed: 4/7/2021

AMENDMENT TO HOUSE BILL 711

AMENDMENT NO. _____. Amend House Bill 711 by replacing everything after the enacting clause with the following:

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

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

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

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

(3) prior authorization programs must be transparent to ensure a fair and consistent process for health care

providers and patients.

Section 10. Applicability; scope. This Act applies to health insurance coverage as defined in the Illinois Health Insurance Portability and Accountability Act, and policies issued or delivered in this State to the Department of Healthcare and Family Services and providing coverage to persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act, amended, delivered, issued, or renewed on or after the effective date of this Act, with the exception of employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974, health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act, and State employee health plans. This Act does not diminish a health care plan's duties and responsibilities under other federal or State law or rules promulgated thereunder.

Section 15. Definitions. As used in this Act:

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

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

"Approval" means a determination by a utilization review organization that a health care service has been reviewed and,

based on the information provided, satisfies the utilization review organization's requirements for medical necessity and appropriateness.

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

"Department" means the Department of Insurance.

"Emergency medical condition" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

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

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

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

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

"Health care service" means any services or level of services included in the furnishing to an individual of medical care or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human illness or injury, including

behavioral health, mental health, home health, and pharmaceutical services and products.

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

"Medically necessary" means a health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and (iii) not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member, or other interested party, but focused on what is best for the patient's health outcome.

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

"Prior authorization" means the process by which utilization review organizations determine the medical necessity and medical appropriateness of otherwise covered health care services before the rendering of such health care services. "Prior authorization" includes any utilization review organization's requirement that an enrollee, health care professional, or health care provider notify the

utilization review organization before, at the time of, or concurrent to providing a health care service.

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

(1) could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

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

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

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

Section 20. Disclosure and review of prior authorization requirements.

(a) A health insurance issuer shall maintain a complete list of services for which prior authorization is required, including for all services where prior authorization is performed by an entity under contract with the health insurance issuer.

(b) A health insurance issuer shall make any current prior

authorization requirements and restrictions, including the written clinical review criteria, readily accessible and conspicuously posted on its website to enrollees, health care professionals, and health care providers. Content published by a third party and licensed for use by a health insurance issuer or its contracted utilization review organization may be made available through the health insurance issuer's or its contracted utilization review organization's secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access. Requirements shall be described in detail, written in easily understandable language, and readily available to the health care professional and health care provider at the point of care. The website shall indicate for each service subject to prior authorization:

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

(2) the date the Illinois-specific requirement was listed on the health insurance issuer's or its contracted utilization review organization's website; and

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

(c) The clinical review criteria must:

(1) be based on nationally recognized, generally

accepted standards except where State law provides its own standard;

(2) be developed in accordance with the current standards of a national medical accreditation entity;

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

(4) be evidence-based;

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

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

(d) A health insurance issuer shall not deny a claim for failure to obtain prior authorization if the prior authorization requirement was not in effect on the date of service on the claim.

(e) Neither a health insurance issuer nor a contracted utilization review organization shall deny prior authorization of a health care service solely based on the grounds that:

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

(2) evidence-based standards conflict; or

(3) evidence-based standards from expert consensus panels do not exist.

(f) A health insurance issuer or its contracted utilization review organization shall not deem as incidental

or deny supplies or health care services that are routinely used as part of a health care service when:

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

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

(g) If a health insurance issuer intends either to implement a new prior authorization requirement or restriction or amend an existing requirement or restriction, the health insurance issuer shall provide enrollees, contracted health care professionals, and contracted health care providers of enrollees written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented. The written notice may be provided in an electronic format, including email or facsimile, if the enrollee, health care professional, or health care provider has agreed in advance to receive notices electronically. The health insurance issuer shall ensure that the new or amended requirement is not implemented unless the health insurance issuer's or its contracted utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

(h) Entities utilizing prior authorization shall make statistics available regarding prior authorization approvals and denials on their website in a readily accessible format. The categories must be updated quarterly and include all of

the following information:

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

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

(3) the number of prior authorization requests denied during the previous plan year by the health insurance issuer or its contracted utilization review organization with respect to each service described in paragraph (1) and the top 5 reasons for denial;

(4) the number of requests described in paragraph (3) that were appealed, the number of the appealed requests that upheld the adverse determination, and the number of appealed requests that reversed the adverse determination;

(5) the average time between submission and response; and

(6) any other information as the Director determines appropriate.

Section 25. Health insurance issuer's and its contracted utilization review organization's obligations with respect to prior authorizations in nonurgent circumstances. If a health insurance issuer requires prior authorization of a health care service, the health insurance issuer or its contracted utilization review organization must make an approval or adverse determination and notify the enrollee, the enrollee's

health care professional, and the enrollee's health care provider of the approval or adverse determination as required by applicable law, but no later than 72 hours after obtaining all necessary information to make the approval or adverse determination. As used in this Section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

Section 30. Health insurance issuer's and its contracted utilization review organization's obligations with respect to prior authorizations concerning urgent health care services.

(a) A health insurance issuer or its contracted utilization review organization must render an approval or adverse determination concerning urgent care services and any services for any current or prospective resident of a skilled nursing facility and notify the enrollee, the enrollee's health care professional, and the enrollee's health care provider of that approval or adverse determination not later than 24 hours after receiving all information needed to complete the review of the requested health care services.

(b) To facilitate the rendering of a prior authorization determination in conformance with this Section, a health insurance issuer or its contracted utilization review organization must establish and provide access to a hotline that is staffed 24 hours per day, 7 days per week by appropriately trained and licensed clinical personnel who have

access to physicians for consultation, designated by the plan to make such determinations for prior authorization concerning urgent care services.

Section 35. Health insurance issuer's and its contracted utilization review organization's obligations with respect to prior authorization concerning emergency health care services.

(a) A health insurance issuer shall cover emergency health care services necessary to screen and stabilize an enrollee. If a health care professional or health care provider certifies in writing to a health insurance issuer within 72 hours after an enrollee's admission that the enrollee's condition required emergency health care services, that certification shall create a presumption that the emergency health care services were medically necessary and such presumption may be rebutted only if the health insurance issuer or its contracted utilization review organization can establish, with clear and convincing evidence, that the emergency health care services were not medically necessary.

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

Section 40. Personnel qualified to make adverse determinations of a prior authorization request. A health insurance issuer or its contracted utilization review organization must ensure that all adverse determinations are made by a physician when the request is by a physician or a representative of a physician. The physician must:

(1) possess a current and valid nonrestricted license to practice medicine in all its branches in any United States jurisdiction;

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

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

Notwithstanding the foregoing, a licensed health care professional who satisfies the requirements of this Section may make an adverse determination of a prior authorization request submitted by a health care professional licensed in the same profession.

Section 45. Consultation before issuing an adverse determination of a prior authorization. If a health insurance issuer or its contracted utilization review organization is

questioning the medical necessity of a health care service, the health insurance issuer or its contracted utilization review organization must notify the enrollee's health care professional and health care provider that medical necessity is being questioned. Before issuing an adverse determination, the enrollee's health care professional and health care provider must have the opportunity to discuss the medical necessity of the health care service on the telephone or by other agreeable method with the health care professional who will be responsible for issuing the prior authorization determination of the health care service under review.

Section 50. Requirements applicable to the physician who can review consultations and appeals. A health insurance issuer or its contracted utilization review organization must ensure that all appeals are reviewed by a physician. The physician must:

(1) possess a current and valid nonrestricted license to practice medicine in any United States jurisdiction;

(2) be currently in active practice in the same or similar specialty as a physician who typically manages the medical condition or disease;

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

(4) not have been directly involved in making the adverse determination; and

(5) consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the health insurance issuer or its contracted utilization review organization by the enrollee's health care professional or health care provider and any medical literature provided to the health insurance issuer or its contracted utilization review organization by the health care professional or health care provider.

Section 55. Review of prior authorization requirements. A health insurance issuer shall periodically review its prior authorization requirements and consider removal of prior authorization requirements:

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

(2) for patients currently managed with an established treatment regimen.

Section 60. Denial.

(a) The health insurance issuer or its contracted utilization review organization may not revoke, limit, condition, or restrict a previously issued prior authorization approval.

(b) Notwithstanding any other provision of law, if a claim is properly coded and submitted timely to a health insurance issuer, the health insurance issuer shall make payment on claims for health care services for which prior authorization was required and approval received before the rendering of health care services, unless one of the following occurs:

(1) it is timely determined that the enrollee's health care professional or health care provider knowingly provided health care services that required prior authorization from the health insurance issuer or its contracted utilization review organization without first obtaining prior authorization for those health care services;

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

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

(4) it is timely determined that the enrollee receiving such health care services was not an enrollee of the health care plan; or

(5) the approval was based upon a material misrepresentation by the enrollee or health care provider;

as used in this paragraph (5), "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

Section 65. Length of prior authorization approval. A prior authorization approval shall be valid for the lesser of 12 months after the date the health care professional or health care provider receives the prior authorization approval or the length of treatment as determined by the patient's health care professional, and the approval period shall be effective regardless of any changes, including any changes in dosage for a prescription drug prescribed by the health care professional. This Section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids. Except to the extent required by medical exceptions processes for prescription drugs, nothing in this Section shall require a policy to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Section 70. Length of prior authorization approval for treatment for chronic or long-term conditions. If a health insurance issuer requires a prior authorization for a

recurring health care service or maintenance medication for the treatment of a chronic or long-term condition, the approval shall remain valid for the lesser of 12 months from the date the health care professional or health care provider receives the prior authorization approval or the length of the treatment as determined by the patient's health care professional. Except to the extent required by medical exceptions processes for prescription drugs, nothing in this Section shall require a policy to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Section 75. Continuity of care for enrollees.

(a) On receipt of information documenting a prior authorization approval from the enrollee or from the enrollee's health care professional or health care provider, a health insurance issuer shall honor a prior authorization granted to an enrollee from a previous health insurance issuer or its contracted utilization review organization for at least the initial 90 days of an enrollee's coverage under a new health plan.

(b) During the time period described in subsection (a), a health insurance issuer or its contracted utilization review organization may perform its own review to grant a prior

authorization approval subject to the terms of the member's coverage agreement.

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

(d) Except to the extent required by medical exceptions processes for prescription drugs, nothing in this Section shall require a policy to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Section 80. Health care services deemed authorized if a health insurance issuer or its contracted utilization review organization fails to comply with the requirements of this Act. A failure by a health insurance issuer or its contracted utilization review organization to comply with the deadlines and other requirements specified in this Act shall result in any health care services subject to review to be automatically deemed authorized by the health insurance issuer or its contracted utilization review organization.

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

Section 90. Administration and enforcement.

(a) The Department shall enforce the provisions of this Act pursuant to the enforcement powers granted to it by law. To enforce the provisions of this Act, the Director is hereby granted specific authority to issue a cease and desist order or require a utilization review organization or health insurance issuer to submit a plan of correction for violations of this Act, or both, in accordance with the requirements and authority set forth in Section 85 of the Managed Care Reform and Patient Rights Act. Subject to the provisions of the Illinois Administrative Procedure Act, the Director may, pursuant to Section 403A of the Illinois Insurance Code, impose upon a utilization review organization or health insurance issuer an administrative fine not to exceed $250,000 for failure to submit a requested plan of correction, failure to comply with its plan of correction, or repeated violations of this Act.

(b) Any person who believes that his or her utilization review organization or health insurance issuer is in violation

of the provisions of this Act may file a complaint with the Department. The Department shall review all complaints received and investigate all complaints that it deems to state a potential violation. The Department shall fairly, efficiently, and timely review and investigate complaints. Utilization review organizations found to be in violation of this Act shall be penalized in accordance with this Section.

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

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

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

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

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

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

care services.

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

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

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

(f) "Beneficiary" means an individual entitled to reimbursement for expenses of or the discount of provider fees for health care services under a program where the beneficiary has an incentive to utilize the services of a provider which has entered into an agreement or arrangement with an administrator.

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

(h) "Emergency medical condition" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act. ~~means a medical condition manifesting itself by~~

~~acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:~~

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

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

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

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

Section 905. The Managed Care Reform and Patient Rights Act is amended by changing Sections 10 and 65 as follows:

(215 ILCS 134/10)

Sec. 10. Definitions.

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

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

"Department" means the Department of Insurance.

"Emergency medical condition" means a medical condition

manifesting itself by acute symptoms of sufficient severity, regardless of the final diagnosis given, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

(2) serious impairment to bodily functions;

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

(4) inadequately controlled pain; or

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

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

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

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

"Emergency services" means, with respect to an enrollee of

a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.

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

"Health care plan" means a plan, including, but not limited to, a health maintenance organization, a managed care community network as defined in the Illinois Public Aid Code, or an accountable care entity as defined in the Illinois Public Aid Code that receives capitated payments to cover medical services from the Department of Healthcare and Family Services, that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that subcontracts with a health care plan is, for purposes of that subcontract, a health care plan.

For purposes of this definition, "health care plan" shall

not include the following:

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

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

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

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

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

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

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

"Health care provider" means any physician, hospital facility, facility licensed under the Nursing Home Care Act, long-term care facility as defined in Section 1-113 of the Nursing Home Care Act, or other person that is licensed or otherwise authorized to deliver health care services. Nothing

in this Act shall be construed to define Independent Practice Associations or Physician-Hospital Organizations as health care providers.

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

"Medical director" means a physician licensed in any state to practice medicine in all its branches appointed by a health care plan.

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

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

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

"Stabilization" means, with respect to an emergency

medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result.

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

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

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

(215 ILCS 134/65)

Sec. 65. Emergency services prior to stabilization.

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

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

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

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

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

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

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

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

(e) The appropriate use of the 911 emergency telephone system or its local equivalent shall not be discouraged or penalized by the health care plan when an emergency medical condition exists. This provision shall not imply that the use

of 911 or its local equivalent is a factor in determining the existence of an emergency medical condition.

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

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

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

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

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

(305 ILCS 5/5-5.12d new)

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

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

(b) Notwithstanding any other provision of law to the

contrary, all managed care organizations shall comply with the requirements of the Prior Authorization Reform Act.

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