Rep. Bob Morgan

Filed: 4/16/2024

AMENDMENT TO HOUSE BILL 2472

AMENDMENT NO. _____. Amend House Bill 2472, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Sections 143.31, 155.36, 315.6, and 370s as follows:

(215 ILCS 5/143.31)

Sec. 143.31. Uniform medical claim and billing forms.

(a) The Director shall prescribe by rule, after consultation with providers of health care or treatment, insurers, hospital, medical, and dental service corporations, and other prepayment organizations, insurance claim and billing forms that the Director determines will provide for uniformity and simplicity in insurance claims handling. The claim forms shall include, but need not be limited to, information regarding the medical diagnosis, treatment, and

prognosis of the patient, together with the details of charges incident to the providing of care, treatment, or services, sufficient for the purpose of meeting the proof requirements of an insurance policy or a hospital, medical, or dental service contract.

(b) An insurer or a provider of health care treatment may not refuse to accept a claim or bill submitted on duly promulgated uniform claim and billing forms. An insurer, however, may accept claims and bills submitted on any other form.

(c) After receipt and adjudication or readjudication of any claim or bill with all required documentation from an insured or provider, or a notification under 42 U.S.C. 300gg-136, an accident ~~Accident~~ and health insurer shall send explanation of benefits paid statements or claims summary statements ~~sent~~ to an insured ~~by the accident and health insurer shall be~~ in a format and written in a manner that promotes understanding by the insured by setting forth all of the following:

(1) The total dollar amount submitted to the insurer for payment.

(2) Any reduction in the amount paid due to the application of any co-payment, coinsurance, or deductible, along with an explanation of the amount of the co-payment, coinsurance, or deductible applied under the insured's policy.

(3) Any reduction in the amount paid due to the application of any other policy limitation, penalty, or exclusion set forth in the insured's policy, along with an explanation thereof.

(4) The total dollar amount paid.

(5) The total dollar amount remaining unpaid.

(6) If applicable under 42 U.S.C. 300gg-111 or 42 U.S.C. 300gg-115, other information required for any explanation of benefits described in either of those Sections.

(d) The Director may issue an order directing an accident and health insurer to comply with subsection (c).

(e) An accident and health insurer does not violate subsection (c) by using a document that the accident and health insurer is required to use by the federal government or the State.

(f) The adoption of uniform claim forms and uniform billing forms by the Director under this Section does not preclude an insurer, hospital, medical, or dental service corporation, or other prepayment organization from obtaining any necessary additional information regarding a claim from the claimant, provider of health care or treatment, or certifier of coverage, as may be required.

(g) On and after January 1, 1996 when billing insurers or otherwise filing insurance claims with insurers subject to this Section, providers of health care or treatment, medical

services, dental services, pharmaceutical services, or medical equipment must use the uniform claim and billing forms adopted by the Director under this Section.

(Source: P.A. 91-357, eff. 7-29-99.)

(215 ILCS 5/155.36)

Sec. 155.36. Managed Care Reform and Patient Rights Act. Insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of this Code shall comply with Sections 25, 45, 45.1, 45.2, 45.3, 65, 70, and 85, subsection (d) of Section 30, and the definition of the term "emergency medical condition" in Section 10 of the Managed Care Reform and Patient Rights Act. Except as provided by Section 85 of the Managed Care Reform and Patient Rights Act, no law or rule shall be construed to exempt any utilization review program from the requirements of Section 85 of the Managed Care Reform and Patient Rights Act with respect to any insurance described in this Section.

(Source: P.A. 102-409, eff. 1-1-22; 103-426, eff. 8-4-23.)

(215 ILCS 5/315.6) (from Ch. 73, par. 927.6)

(Section scheduled to be repealed on January 1, 2027)

Sec. 315.6. Application of other Code provisions. Unless otherwise provided in this amendatory Act, every fraternal benefit society shall be governed by this amendatory Act and shall be exempt from all other provisions of the insurance

laws of this State not only in governmental relations with the State but for every other purpose, except for those provisions specified in this amendatory Act and except as follows:

(a) Sections 1, 2, 2.1, 3.1, 117, 118, 132, 132.1, 132.2, 132.3, 132.4, 132.5, 132.6, 132.7, 133, 134, 136, 138, 139, 140, 141, 141.01, 141.1, 141.2, 141.3, 143, 143.31, 143c, 144.1, 147, 148, 149, 150, 151, 152, 153, 154.5, 154.6, 154.7, 154.8, 155, 155.04, 155.05, 155.06, 155.07, 155.08 and 408 of this Code; and

(b) Articles VIII 1/2, XII, XII 1/2, XIII, XXIV, and XXVIII of this Code.

(Source: P.A. 98-814, eff. 1-1-15.)

(215 ILCS 5/370s)

Sec. 370s. Managed Care Reform and Patient Rights Act. All administrators shall comply with Sections 55 and 85 of the Managed Care Reform and Patient Rights Act. Except as provided by Section 85 of the Managed Care Reform and Patient Rights Act, no law or rule shall be construed to exempt any utilization review program from the requirements of Section 85 of the Managed Care Reform and Patient Rights Act with respect to any insured or beneficiary described in this Article.

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

Section 10. The Dental Service Plan Act is amended by changing Section 25 as follows:

(215 ILCS 110/25) (from Ch. 32, par. 690.25)

Sec. 25. Application of Insurance Code provisions. Dental service plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA, XI, and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143.31, 143c, 149, 155.49, 355.2, 355.3, 367.2, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and subsection (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 103-426, eff. 8-4-23.)

Section 15. The Network Adequacy and Transparency Act is amended by changing Section 10 as follows:

(215 ILCS 124/10)

Sec. 10. Network adequacy.

(a) An insurer providing a network plan shall file a description of all of the following with the Director:

(1) The written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

(2) The written policies and procedures for making referrals within and outside the network.

(3) The written policies and procedures on how the

network plan will provide 24-hour, 7-day per week access to network-affiliated primary care, emergency services, and women's principal health care providers.

An insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) Insurers must file for review a description of the services to be offered through a network plan. The description shall include all of the following:

(1) A geographic map of the area proposed to be served by the plan by county service area and zip code, including marked locations for preferred providers.

(2) As deemed necessary by the Department, the names, addresses, phone numbers, and specialties of the providers who have entered into preferred provider agreements under the network plan.

(3) The number of beneficiaries anticipated to be covered by the network plan.

(4) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access current and accurate lists of preferred providers,

additional information about the plan, as well as any other information required by Department rule.

(5) A description of how health care services to be rendered under the network plan are reasonably accessible and available to beneficiaries. The description shall address all of the following:

(A) the type of health care services to be provided by the network plan;

(B) the ratio of physicians and other providers to beneficiaries, by specialty and including primary care physicians and facility-based physicians when applicable under the contract, necessary to meet the health care needs and service demands of the currently enrolled population;

(C) the travel and distance standards for plan beneficiaries in county service areas; and

(D) a description of how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable.

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to

insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, the insurer shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

(7) A provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the emergency

services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider. For purposes of this paragraph (7), "the same benefit level" means that the beneficiary is provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This provision shall be consistent with Section 356z.3a of the Illinois Insurance Code.

(8) A limitation that complies with subsections (d) and (e) of Section 55 of the Prior Authorization Reform Act~~, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed $1,000 per occurrence in addition to the plan cost sharing provisions~~.

(c) The network plan shall demonstrate to the Director a minimum ratio of providers to plan beneficiaries as required by the Department.

(1) The ratio of physicians or other providers to plan beneficiaries shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific

benefits. The Department shall consider establishing ratios for the following physicians or other providers:

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

(F) Neurology;

(G) OB/GYN;

(H) Oncology/Radiation;

(I) Ophthalmology;

(J) Urology;

(K) Behavioral Health;

(L) Allergy/Immunology;

(M) Chiropractic;

(N) Dermatology;

(O) Endocrinology;

(P) Ears, Nose, and Throat (ENT)/Otolaryngology;

(Q) Infectious Disease;

(R) Nephrology;

(S) Neurosurgery;

(T) Orthopedic Surgery;

(U) Physiatry/Rehabilitative;

(V) Plastic Surgery;

(W) Pulmonary;

(X) Rheumatology;

(Y) Anesthesiology;

(Z) Pain Medicine;

(AA) Pediatric Specialty Services;

(BB) Outpatient Dialysis; and

(CC) HIV.

(2) The Director shall establish a process for the review of the adequacy of these standards, along with an assessment of additional specialties to be included in the list under this subsection (c).

(d) The network plan shall demonstrate to the Director maximum travel and distance standards for plan beneficiaries, which shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. These standards shall consist of the maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as large counties, metro counties, or rural counties as defined by Department rule.

The maximum travel time and distance standards must include standards for each physician and other provider category listed for which ratios have been established.

The Director shall establish a process for the review of the adequacy of these standards along with an assessment of additional specialties to be included in the list under this subsection (d).

(d-5)(1) Every insurer shall ensure that beneficiaries

have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. Insurers shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance

use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions.

Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential treatment for mental, emotional, nervous, or substance use disorders or conditions.

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the

insurer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(e) Except for network plans solely offered as a group health plan, these ratio and time and distance standards apply to the lowest cost-sharing tier of any tiered network.

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section.

(g) Except for the requirements set forth in subsection (d-5), insurers who are not able to comply with the provider ratios and time and distance standards established by the Department may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific time and distance standard in a specific service area and the insurer (i) discloses information on the distance and travel time points that beneficiaries would have to travel beyond the required criterion to reach the next closest contracted provider outside of the service area and (ii) provides contact information, including names, addresses, and phone numbers for the next closest contracted provider

or facility;

(2) if patterns of care in the service area do not support the need for the requested number of provider or facility type and the insurer provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where the physicians currently refer beneficiaries, or both; or

(3) other circumstances deemed appropriate by the Department consistent with the requirements of this Act.

(h) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23.)

Section 20. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to

the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 355.2, 355.3, 355b, 355c, 356f, 356g.5-1, 356m, 356q, 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.30a, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.65, 356z.67, 356z.68, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

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

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

(2) a corporation organized under the laws of this

State; or

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

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

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

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

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

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance

Organization sought to be acquired;

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

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

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

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

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees

and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

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

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be

made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

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

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint

Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.
(Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

Section 25. The Limited Health Service Organization Act is amended by changing Section 4003 as follows:

(215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

Sec. 4003. Illinois Insurance Code provisions. Limited health service organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, <u>143.31,</u> 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 355.2, 355.3, 355b, 356q, 356v, 356z.4, 356z.4a, 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.57, 356z.59, 356z.61, <u>356z.64, 356z.67, 356z.68,</u>

364.3, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code. Nothing in this Section shall require a limited health care plan to cover any service that is not a limited health service. For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited health service organizations in the following categories are deemed to be domestic companies:

(1) a corporation under the laws of this State; or

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

(Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; revised 8-29-23.)

Section 30. The Managed Care Reform and Patient Rights Act is amended by changing Sections 10, 45, and 85 as follows:

(215 ILCS 134/10)

Sec. 10. Definitions. In this Act:

For a health care plan under Section 45 or for a utilization review program under Section 85, "adverse determination" has the meaning given to that term in Section 10 of the Health Carrier External Review Act ~~"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) except with respect to subsections (a) and (b) of Section 65 and subsection (a-5) of Section 70, 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<u>, including any evaluation based on an algorithmic automated process,</u> 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. 102-409, eff. 1-1-22; 103-426, eff. 8-4-23.)

(215 ILCS 134/45)

Sec. 45. Health care services appeals, complaints, and external independent reviews.

(a) A health care plan shall establish and maintain an appeals procedure as outlined in this Act. Compliance with this Act's appeals procedures shall satisfy a health care plan's obligation to provide appeal procedures under any other State law or rules. All appeals of a health care plan's administrative determinations and complaints regarding its administrative decisions shall be handled as required under Section 50.

(b) When an appeal concerns a decision or action by a health care plan, its employees, or its subcontractors that relates to (i) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, or (ii) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, the health care plan must allow for the filing of an appeal

either orally or in writing. Upon submission of the appeal, a health care plan must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 24 hours after receipt of the required information. The health care plan shall notify the party filing the appeal and the enrollee, enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal of its decision orally followed-up by a written notice of the determination.

(c) For all appeals related to health care services including, but not limited to, procedures or treatments for an enrollee and not covered by subsection (b) above, the health care plan shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection, a health care plan must notify the party filing an appeal, within 3 business days, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 15 business days after receipt of the required information. The health care plan shall notify the party filing the appeal, the enrollee, the enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal orally of its decision followed-up by a written

notice of the determination.

(d) An appeal under subsection (b) or (c) may be filed by the enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health care provider. A health care plan shall designate a clinical peer to review appeals, because these appeals pertain to medical or clinical matters and such an appeal must be reviewed by an appropriate health care professional. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal. The written notice of determination required under subsections (b) and (c) shall include (i) clear and detailed reasons for the determination, (ii) the medical or clinical criteria for the determination, which shall be based upon sound clinical evidence and reviewed on a periodic basis, and (iii) in the case of an adverse determination, the procedures for requesting an external independent review as provided by the Illinois Health Carrier External Review Act.

(e) If an appeal filed under subsection (b) or (c) is denied for a reason including, but not limited to, the service, procedure, or treatment is not viewed as medically necessary, denial of specific tests or procedures, denial of referral to specialist physicians or denial of hospitalization requests or length of stay requests, any involved party may request an external independent review as provided by the Illinois Health Carrier External Review Act.

(f) Until July 1, 2013, if an external independent review decision made pursuant to the Illinois Health Carrier External Review Act upholds a determination adverse to the covered person, the covered person has the right to appeal the final decision to the Department; if the external review decision is found by the Director to have been arbitrary and capricious, then the Director, with consultation from a licensed medical professional, may overturn the external review decision and require the health carrier to pay for the health care service or treatment; such decision, if any, shall be made solely on the legal or medical merits of the claim. If an external review decision is overturned by the Director pursuant to this Section and the health carrier so requests, then the Director shall assign a new independent review organization to reconsider the overturned decision. The new independent review organization shall follow subsection (d) of Section 40 of the Health Carrier External Review Act in rendering a decision.

(g) Future contractual or employment action by the health care plan regarding the patient's physician or other health care provider shall not be based solely on the physician's or other health care provider's participation in health care services appeals, complaints, or external independent reviews under the Illinois Health Carrier External Review Act.

(h) Nothing in this Section shall be construed to require a health care plan to pay for a health care service not covered under the enrollee's certificate of coverage or policy.

(i) Even if a health care plan or other utilization review program uses an algorithmic automated process in the course of utilization review for medical necessity, the health care plan or other utilization review program shall ensure that only a clinical peer makes any adverse determination based on medical necessity and that any subsequent appeal is processed as required by this Section, including the restriction that only a clinical peer may review an appeal. A health care plan or other utilization review program using an automated process shall have the accreditation and the policies and procedures required by subsection (b-10) of Section 85 of this Act.

(Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 134/85)

Sec. 85. Utilization review program registration.

(a) No person may conduct a utilization review program in this State unless once every 2 years the person registers the utilization review program with the Department and provides proof of current accreditation for itself and its subcontractors ~~certifies compliance~~ with the Health Utilization Management Standards of the Utilization Review Accreditation Commission, the National Committee for Quality Assurance, or another accreditation entity authorized under this Section ~~Health Utilization Management Standards of the American Accreditation Healthcare Commission (URAC) sufficient to achieve American Accreditation Healthcare Commission (URAC)~~

~~accreditation or submits evidence of accreditation by the American Accreditation Healthcare Commission (URAC) for its Health Utilization Management Standards. Nothing in this Act shall be construed to require a health care plan or its subcontractors to become American Accreditation Healthcare Commission (URAC) accredited~~.

(b) In addition, the Director of the Department, in consultation with the Director of the Department of Public Health, may certify alternative utilization review standards of national accreditation organizations or entities in order for plans to comply with this Section. Any alternative utilization review standards shall meet or exceed those standards required under subsection (a).

(b-5) The Department shall recognize the Accreditation Association for Ambulatory Health Care among the list of accreditors from which utilization organizations may receive accreditation and qualify for reduced registration and renewal fees.

(b-10) Utilization review programs that use algorithmic automated processes to decide whether to render adverse determinations based on medical necessity in the course of utilization review shall use objective, evidence-based criteria compliant with the accreditation requirements of the Health Utilization Management Standards of the Utilization Review Accreditation Commission or the National Committee for Quality Assurance (NCQA) and shall provide proof of such

compliance to the Department with the registration required under subsection (a), including any renewal registrations. Nothing in this subsection supersedes paragraph (2) of subsection (e). The utilization review program shall include, with its registration materials, attachments that contain policies and procedures:

(1) to ensure that licensed physicians with relevant board certifications establish all criteria that the algorithmic automated process uses for utilization review; and

(2) for a program integrity system that, both before new or revised criteria are used for utilization review and when implementation errors in the algorithmic automated process are identified after new or revised criteria go into effect, requires licensed physicians with relevant board certifications to verify that the algorithmic automated process and corrections to it yield results consistent with the criteria for their certified field.

(c) The provisions of this Section do not apply to:

(1) persons providing utilization review program services only to the federal government;

(2) self-insured health plans under the federal Employee Retirement Income Security Act of 1974, however, this Section does apply to persons conducting a utilization review program on behalf of these health

plans;

(3) hospitals and medical groups performing utilization review activities for internal purposes unless the utilization review program is conducted for another person.

Nothing in this Act prohibits a health care plan or other entity from contractually requiring an entity designated in item (3) of this subsection to adhere to the utilization review program requirements of this Act.

(d) This registration shall include submission of all of the following information regarding utilization review program activities:

(1) The name, address, and telephone number of the utilization review programs.

(2) The organization and governing structure of the utilization review programs.

(3) The number of lives for which utilization review is conducted by each utilization review program.

(4) Hours of operation of each utilization review program.

(5) Description of the grievance process for each utilization review program.

(6) Number of covered lives for which utilization review was conducted for the previous calendar year for each utilization review program.

(7) Written policies and procedures for protecting

confidential information according to applicable State and federal laws for each utilization review program.

(e) (1) A utilization review program shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

(A) kept confidential in accordance with applicable State and federal laws; and

(B) shared only with the enrollee, the enrollee's designee, the enrollee's health care provider, and those who are authorized by law to receive the information.

Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients or health care providers.

(2) Only a clinical peer ~~health care professional~~ may make adverse determinations regarding the medical necessity of health care services during the course of utilization review. Either a health care professional or an accredited algorithmic automated process, or both in combination, may certify the medical necessity of a health care service in accordance with accreditation standards. Nothing in this subsection prohibits an accredited algorithmic automated process from being used to refer a case to a clinical peer for a potential adverse determination.

(3) When making retrospective reviews, utilization review programs shall base reviews solely on the medical

information available to the attending physician or ordering provider at the time the health care services were provided. This paragraph includes billing records and diagnosis or procedure codes that substantively contain the same medical information to an equal or lesser degree of specificity as the records the attending physician or ordering provider directly consulted at the time health care services were provided.

(4) When making prospective, concurrent, and retrospective determinations, utilization review programs shall collect only information that is necessary to make the determination and shall not routinely require health care providers to numerically code diagnoses or procedures to be considered for certification, unless required under State or federal Medicare or Medicaid rules or regulations, but may request such code if available, or routinely request copies of medical records of all enrollees reviewed. During prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to review are medically necessary. In these cases, only the necessary or relevant sections of the medical record shall be required.

(f) If the Department finds that a utilization review program is not in compliance with this Section, the Department shall issue a corrective action plan and allow a reasonable

amount of time for compliance with the plan. If the utilization review program does not come into compliance, the Department may issue a cease and desist order. Before issuing a cease and desist order under this Section, the Department shall provide the utilization review program with a written notice of the reasons for the order and allow a reasonable amount of time to supply additional information demonstrating compliance with requirements of this Section and to request a hearing. The hearing notice shall be sent by certified mail, return receipt requested, and the hearing shall be conducted in accordance with the Illinois Administrative Procedure Act.

(g) A utilization review program subject to a corrective action may continue to conduct business until a final decision has been issued by the Department.

(h) Any adverse determination made by a health care plan or its subcontractors may be appealed in accordance with subsection (f) of Section 45.

(i) The Director may by rule establish a registration fee for each person conducting a utilization review program. All fees paid to and collected by the Director under this Section shall be deposited into the Insurance Producer Administration Fund.

(Source: P.A. 99-111, eff. 1-1-16.)

Section 35. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143.31, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b, 356g, 356g.5, 356g.5-1, 356q, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.40, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 364.01, 364.3, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

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

(Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804,

eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

Section 40. The Health Carrier External Review Act is amended by changing Section 10 as follows:

(215 ILCS 180/10)

Sec. 10. Definitions. For the purposes of this Act:

"Adverse determination" means:

(1) a determination by a health carrier or its designee utilization review organization that, based upon the health information provided for a covered person, a request for a benefit, including any quantity, frequency, duration, or other measurement of a benefit, under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;

(2) the denial, reduction, or termination of or

failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization that a preexisting condition was present before the effective date of coverage; or

(3) a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

"Adverse determination" includes unilateral determinations that replace the requested health care service with an approval of an alternative health care service without the agreement of the covered person or the covered person's attending provider for the requested health care service, or that condition approval of the requested service on first trying an alternative health care service, either if the request was made under a medical exceptions procedure, or if all of the following are true: (1) the requested service was not excluded by name, description, or service category under the written terms of coverage, (2) the alternative health care service poses no greater risk to the patient based on generally accepted standards of care, and (3) the alternative health care service is at least as likely to produce the same or better effect on the covered person's health as the requested service based on generally accepted standards of care. "Adverse determination" includes determinations made

based on any source of health information pertaining to the covered person that is used to deny, reduce, replace, condition, or terminate the benefit or payment. "Adverse determination" includes determinations made in response to a request for authorization when the request was submitted by the health care provider regardless of whether the provider gave notice to or obtained the consent of the covered person or authorized representative to file the request. "Adverse determination" does not include substitutions performed under Section 19.5 or 25 of the Pharmacy Practice Act.

"Authorized representative" means:

(1) a person to whom a covered person has given express written consent to represent the covered person for purposes of this Law;

(2) a person authorized by law to provide substituted consent for a covered person;

(3) a family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(4) a health care provider when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care provider; or

(5) in the case of an urgent care request, a health care provider with knowledge of the covered person's medical condition.

"Best evidence" means evidence based on:

(1) randomized clinical trials;

(2) if randomized clinical trials are not available, then cohort studies or case-control studies;

(3) if items (1) and (2) are not available, then case-series; or

(4) if items (1), (2), and (3) are not available, then expert opinion.

"Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

"Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

"Cohort study" means a prospective evaluation of 2 groups of patients with only one group of patients receiving specific intervention.

"Concurrent review" means a review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

"Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health

benefit plan.

"Director" means the Director of the Department of Insurance.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, 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.

"Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

"Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on an overall systematic review of the research in making decisions about the care of individual patients.

"Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

"Facility" means an institution providing health care

services or a health care setting.

"Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth by the Managed Care Reform and Patient Rights Act or as set forth for any additional authorization or internal appeal process provided by contract between the health carrier and the provider. "Final adverse determination" includes determinations made in an appeal of a denial of prior authorization when the appeal was submitted by the health care provider regardless of whether the provider gave notice to or obtained the consent of the covered person or authorized representative to file an internal appeal.

"Health benefit plan" means a policy, contract, certificate, plan, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care provider" or "provider" means a physician, hospital facility, or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with State law, responsible for recommending health care services on behalf of a covered person.

"Health care services" means services for the diagnosis,

prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, or any other entity providing a plan of health insurance, health benefits, or health care services. "Health carrier" also means Limited Health Service Organizations (LHSO) and Voluntary Health Service Plans.

"Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relate to:

(1) the past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(2) the provision of health care services to an individual; or

(3) payment for the provision of health care services to an individual.

"Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

"Medical or scientific evidence" means evidence found in

the following sources:

(1) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(3) medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;

(4) the following standard reference compendia:

(a) The American Hospital Formulary Service-Drug Information;

(b) Drug Facts and Comparisons;

(c) The American Dental Association Accepted Dental Therapeutics; and

(d) The United States Pharmacopoeia-Drug Information;

(5) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(a) the federal Agency for Healthcare Research and Quality;

(b) the National Institutes of Health;

(c) the National Cancer Institute;

(d) the National Academy of Sciences;

(e) the Centers for Medicare & Medicaid Services;

(f) the federal Food and Drug Administration; and

(g) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(6) any other medical or scientific evidence that is comparable to the sources listed in items (1) through (5).

"Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

"Prospective review" means a review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

"Protected health information" means health information

(i) that identifies an individual who is the subject of the information; or (ii) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

"Randomized clinical trial" means a controlled prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

"Retrospective review" means any review of a request for a benefit that is not a concurrent or prospective review request. "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

"Utilization review" has the meaning provided by the Managed Care Reform and Patient Rights Act.

"Utilization review organization" means a utilization review program as defined in the Managed Care Reform and Patient Rights Act.

(Source: P.A. 97-574, eff. 8-26-11; 97-813, eff. 7-13-12; 98-756, eff. 7-16-14.)

Section 45. The Prior Authorization Reform Act is amended by changing Section 55 as follows:

(215 ILCS 200/55)

Sec. 55. Denial or penalty.

(a) The health insurance issuer or its contracted utilization review organization may not revoke or further limit, condition, or restrict a previously issued prior authorization approval while it remains valid under this Act.

(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 according to the terms of coverage 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 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, health care professional, 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.

(c) Nothing in this Section shall preclude a utilization review organization or a health insurance issuer from performing post-service reviews of health care claims for purposes of payment integrity or for the prevention of fraud, waste, or abuse.

(d) If a health insurance issuer imposes a monetary penalty on the enrollee for the enrollee's, health care professional's, or health care provider's failure to obtain any form of prior authorization for a health care service, the penalty may not exceed the lesser of:

(1) the actual cost of the health care service; or

(2) $1,000 per occurrence in addition to the plan cost-sharing provisions.

(e) A health insurance issuer may not require both the enrollee and the health care professional or health care

provider to obtain any form of prior authorization for the same instance of a health care service, nor otherwise require more than one prior authorization for the same instance of a health care service.

(Source: P.A. 102-409, eff. 1-1-22.)

Section 99. Effective date. This Act takes effect January 1, 2025.".