



Rep. Mary E. Flowers

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09600HB6417ham001

LRB096 21045 AMC 39407 a

1 AMENDMENT TO HOUSE BILL 6417

2 AMENDMENT NO. _____. Amend House Bill 6417 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The State Employees Group Insurance Act of 1971
5 is amended by changing Section 6.11 as follows:

6 (5 ILCS 375/6.11)

7 Sec. 6.11. Required health benefits; Illinois Insurance
8 Code requirements. The program of health benefits shall provide
9 the post-mastectomy care benefits required to be covered by a
10 policy of accident and health insurance under Section 356t of
11 the Illinois Insurance Code. The program of health benefits
12 shall provide the coverage required under Sections 356g,
13 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4,
14 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, ~~and~~
15 356z.13, ~~and~~ 356z.14, 356z.15 ~~and 356z.14~~, ~~and~~ 356z.17, ~~356z.15~~
16 356z.19, 356z.20, and 356z.21 of the Illinois Insurance Code.

1 The program of health benefits must comply with Section 155.37
2 of the Illinois Insurance Code.

3 Rulemaking authority to implement Public Act 95-1045 ~~this~~
4 ~~amendatory Act of the 95th General Assembly~~, if any, is
5 conditioned on the rules being adopted in accordance with all
6 provisions of the Illinois Administrative Procedure Act and all
7 rules and procedures of the Joint Committee on Administrative
8 Rules; any purported rule not so adopted, for whatever reason,
9 is unauthorized.

10 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
11 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff.
12 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1044,
13 eff. 3-26-09; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10;
14 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10;
15 revised 10-22-09.)

16 Section 10. The Counties Code is amended by changing
17 Section 5-1069.3 as follows:

18 (55 ILCS 5/5-1069.3)

19 Sec. 5-1069.3. Required health benefits. If a county,
20 including a home rule county, is a self-insurer for purposes of
21 providing health insurance coverage for its employees, the
22 coverage shall include coverage for the post-mastectomy care
23 benefits required to be covered by a policy of accident and
24 health insurance under Section 356t and the coverage required

1 under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x,
2 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, ~~and~~
3 356z.13, ~~and~~ 356z.14, ~~and~~ 356z.15, ~~356z.14~~ 356z.19, 356z.20,
4 and 356z.21 of the Illinois Insurance Code. The requirement
5 that health benefits be covered as provided in this Section is
6 an exclusive power and function of the State and is a denial
7 and limitation under Article VII, Section 6, subsection (h) of
8 the Illinois Constitution. A home rule county to which this
9 Section applies must comply with every provision of this
10 Section.

11 Rulemaking authority to implement Public Act 95-1045 ~~this~~
12 ~~amendatory Act of the 95th General Assembly~~, if any, is
13 conditioned on the rules being adopted in accordance with all
14 provisions of the Illinois Administrative Procedure Act and all
15 rules and procedures of the Joint Committee on Administrative
16 Rules; any purported rule not so adopted, for whatever reason,
17 is unauthorized.

18 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
19 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff.
20 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045,
21 eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10;
22 96-328, eff. 8-11-09; revised 10-22-09.)

23 Section 15. The Illinois Municipal Code is amended by
24 changing Section 10-4-2.3 as follows:

1 (65 ILCS 5/10-4-2.3)

2 Sec. 10-4-2.3. Required health benefits. If a
3 municipality, including a home rule municipality, is a
4 self-insurer for purposes of providing health insurance
5 coverage for its employees, the coverage shall include coverage
6 for the post-mastectomy care benefits required to be covered by
7 a policy of accident and health insurance under Section 356t
8 and the coverage required under Sections 356g, 356g.5,
9 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10,
10 356z.11, 356z.12, ~~and~~ 356z.13, ~~and~~ 356z.14, ~~and~~ 356z.15,
11 ~~356z.14~~ 356z.19, 356z.20, and 356z.21 of the Illinois Insurance
12 Code. The requirement that health benefits be covered as
13 provided in this is an exclusive power and function of the
14 State and is a denial and limitation under Article VII, Section
15 6, subsection (h) of the Illinois Constitution. A home rule
16 municipality to which this Section applies must comply with
17 every provision of this Section.

18 Rulemaking authority to implement Public Act 95-1045 ~~this~~
19 ~~amendatory Act of the 95th General Assembly~~, if any, is
20 conditioned on the rules being adopted in accordance with all
21 provisions of the Illinois Administrative Procedure Act and all
22 rules and procedures of the Joint Committee on Administrative
23 Rules; any purported rule not so adopted, for whatever reason,
24 is unauthorized.

25 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
26 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff.

1 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045,
2 eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10;
3 96-328, eff. 8-11-09; revised 10-23-09.)

4 Section 20. The School Code is amended by changing Section
5 10-22.3f as follows:

6 (105 ILCS 5/10-22.3f)

7 Sec. 10-22.3f. Required health benefits. Insurance
8 protection and benefits for employees shall provide the
9 post-mastectomy care benefits required to be covered by a
10 policy of accident and health insurance under Section 356t and
11 the coverage required under Sections 356g, 356g.5, 356g.5-1,
12 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12,
13 356z.13, ~~and 356z.14, and 356z.15, 356z.14~~ 356z.19, and 356z.20
14 of the Illinois Insurance Code.

15 Rulemaking authority to implement Public Act 95-1045 ~~this~~
16 ~~amendatory Act of the 95th General Assembly~~, if any, is
17 conditioned on the rules being adopted in accordance with all
18 provisions of the Illinois Administrative Procedure Act and all
19 rules and procedures of the Joint Committee on Administrative
20 Rules; any purported rule not so adopted, for whatever reason,
21 is unauthorized.

22 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
23 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;
24 95-1005, 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.

1 1-1-10; 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; revised
2 10-23-09.)

3 Section 25. The Emergency Medical Treatment Act is amended
4 by changing Section 1 as follows:

5 (210 ILCS 70/1) (from Ch. 111 1/2, par. 6151)

6 Sec. 1. No hospital, physician, dentist or other provider
7 of professional health care licensed under the laws of this
8 State may refuse to provide needed emergency treatment to any
9 person whose life would be threatened in the absence of such
10 treatment, because of that person's inability to pay therefor,
11 nor because of the source of any payment promised therefor.
12 Every hospital licensed under the Hospital Licensing Act shall
13 comply with the Hospital Emergency Service Act.

14 (Source: P.A. 83-723.)

15 Section 30. The Hospital Emergency Service Act is amended
16 by changing Section 1 as follows:

17 (210 ILCS 80/1) (from Ch. 111 1/2, par. 86)

18 Sec. 1. Every hospital required to be licensed by the
19 Department of Public Health pursuant to the Hospital Licensing
20 Act which provides general medical and surgical hospital
21 services shall provide a hospital emergency service in
22 accordance with rules and regulations adopted by the Department

1 of Public Health which shall be consistent with the federal
2 Emergency Medical Treatment and Active Labor Act (42 U.S.C.
3 1395dd) and ~~shall furnish such hospital emergency services to~~
4 ~~any applicant who applies for the same in case of injury or~~
5 ~~acute medical condition where the same is liable to cause death~~
6 ~~or severe injury or serious illness. For purposes of this Act,~~
7 ~~"applicant" includes any person who is brought to a hospital by~~
8 ~~ambulance or specialized emergency medical services vehicle as~~
9 ~~defined in~~ the Emergency Medical Services (EMS) Systems Act.

10 (Source: P.A. 86-1461.)

11 Section 35. The Illinois Insurance Code is amended by
12 adding Sections 356z.19, 356z.20, and 356z.21 as follows:

13 (215 ILCS 5/356z.19 new)

14 Sec. 356z.19. Intravenous feeding. A group or individual
15 policy of accident and health insurance or managed care plan
16 amended, delivered, issued, or renewed after the effective date
17 of this amendatory Act of the 96th General Assembly must
18 provide coverage for intravenous feeding. The benefits under
19 this Section shall be at least as favorable as for other
20 coverages under the policy and may be subject to the same
21 dollar amount limits, deductibles, and co-insurance
22 requirements applicable generally to other coverages under the
23 policy.

1 (215 ILCS 5/356z.20 new)

2 Sec. 356z.20. Prescription nutritional supplements. A
3 group or individual policy of accident and health insurance or
4 managed care plan amended, delivered, issued, or renewed after
5 the effective date of this amendatory Act of the 96th General
6 Assembly that provides coverage for prescription drugs must
7 provide coverage for reimbursement for medically appropriate
8 prescription nutritional supplements when ordered by a
9 physician licensed to practice medicine in all its branches and
10 the insured suffers from a condition that prevents him or her
11 from taking sufficient oral nourishment to sustain life.

12 (215 ILCS 5/356z.21 new)

13 Sec. 356z.21. Hospital patient assessments. A group or
14 individual policy of accident and health insurance or managed
15 care plan amended, delivered, issued, or renewed after the
16 effective date of this amendatory Act of the 96th General
17 Assembly that provides coverage for hospital care shall include
18 in that coverage all services ordered by a physician and
19 provided in the hospital that are considered medically
20 necessary for the evaluation, assessment, and diagnosis of the
21 illness or condition that resulted in the hospital stay of the
22 enrollee or recipient. Such services are subject to reasonable
23 review and utilization standards required by the policy or plan
24 for all hospital services, as defined by the Department of
25 Insurance or its successor agency.

1 Section 40. The Health Maintenance Organization Act is
2 amended by changing Section 5-3 as follows:

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

4 (Text of Section before amendment by P.A. 96-833)

5 Sec. 5-3. Insurance Code provisions.

6 (a) Health Maintenance Organizations shall be subject to
7 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
8 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
9 154.6, 154.7, 154.8, 155.04, 355.2, 356g.5-1, 356m, 356v, 356w,
10 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9,
11 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15 ~~356z.14,~~
12 356z.17 ~~356z.15,~~ 356z.19, 356z.20, 364.01, 367.2, 367.2-5,
13 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403,
14 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of
15 subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII,
16 XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois
17 Insurance Code.

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

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

24 (2) a corporation organized under the laws of this

1 State; or

2 (3) a corporation organized under the laws of another
3 state, 30% or more of the enrollees of which are residents
4 of this State, except a corporation subject to
5 substantially the same requirements in its state of
6 organization as is a "domestic company" under Article VIII
7 1/2 of the Illinois Insurance Code.

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

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

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

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

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

1 Organization sought to be acquired;

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

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

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

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

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

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

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

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

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

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

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

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

23 (g) Rulemaking authority to implement Public Act 95-1045
24 ~~this amendatory Act of the 95th General Assembly~~, if any, is
25 conditioned on the rules being adopted in accordance with all
26 provisions of the Illinois Administrative Procedure Act and all

1 rules and procedures of the Joint Committee on Administrative
2 Rules; any purported rule not so adopted, for whatever reason,
3 is unauthorized.

4 (Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07;
5 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;
6 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.
7 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; revised
8 10-23-09.)

9 (Text of Section after amendment by P.A. 96-833)

10 Sec. 5-3. Insurance Code provisions.

11 (a) Health Maintenance Organizations shall be subject to
12 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
13 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
14 154.6, 154.7, 154.8, 155.04, 355.2, 356g.5-1, 356m, 356v, 356w,
15 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9,
16 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
17 356z.18, 356z.19, 356z.20, 364.01, 367.2, 367.2-5, 367i, 368a,
18 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408,
19 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection
20 (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2,
21 XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

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

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

3 (2) a corporation organized under the laws of this
4 State; or

5 (3) a corporation organized under the laws of another
6 state, 30% or more of the enrollees of which are residents
7 of this State, except a corporation subject to
8 substantially the same requirements in its state of
9 organization as is a "domestic company" under Article VIII
10 1/2 of the Illinois Insurance Code.

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

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

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

26 (3) the Director shall have the power to require the

1 following information:

2 (A) certification by an independent actuary of the
3 adequacy of the reserves of the Health Maintenance
4 Organization sought to be acquired;

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

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

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

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

24 (e) In considering any management contract or service
25 agreement subject to Section 141.1 of the Illinois Insurance
26 Code, the Director (i) shall, in addition to the criteria

1 specified in Section 141.2 of the Illinois Insurance Code, take
2 into account the effect of the management contract or service
3 agreement on the continuation of benefits to enrollees and the
4 financial condition of the health maintenance organization to
5 be managed or serviced, and (ii) need not take into account the
6 effect of the management contract or service agreement on
7 competition.

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

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

21 (ii) the amount of the refund or additional premium
22 shall not exceed 20% of the Health Maintenance
23 Organization's profitable or unprofitable experience with
24 respect to the group or other enrollment unit for the
25 period (and, for purposes of a refund or additional
26 premium, the profitable or unprofitable experience shall

1 be calculated taking into account a pro rata share of the
2 Health Maintenance Organization's administrative and
3 marketing expenses, but shall not include any refund to be
4 made or additional premium to be paid pursuant to this
5 subsection (f)). The Health Maintenance Organization and
6 the group or enrollment unit may agree that the profitable
7 or unprofitable experience may be calculated taking into
8 account the refund period and the immediately preceding 2
9 plan years.

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

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

26 (g) Rulemaking authority to implement Public Act 95-1045,

1 if any, is conditioned on the rules being adopted in accordance
2 with all provisions of the Illinois Administrative Procedure
3 Act and all rules and procedures of the Joint Committee on
4 Administrative Rules; any purported rule not so adopted, for
5 whatever reason, is unauthorized.

6 (Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07;
7 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;
8 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.
9 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; 96-833, eff.
10 6-1-10.)

11 Section 45. The Voluntary Health Services Plans Act is
12 amended by changing Section 10 as follows:

13 (215 ILCS 165/10) (from Ch. 32, par. 604)

14 (Text of Section before amendment by P.A. 96-833)

15 Sec. 10. Application of Insurance Code provisions. Health
16 services plan corporations and all persons interested therein
17 or dealing therewith shall be subject to the provisions of
18 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,
19 149, 155.37, 354, 355.2, 356g, 356g.5, 356g.5-1, 356r, 356t,
20 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5,
21 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
22 356z.14, 356z.15 ~~356z.14~~, 356z.19, 356z.20, 364.01, 367.2,
23 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and
24 paragraphs (7) and (15) of Section 367 of the Illinois

1 Insurance Code.

2 Rulemaking authority to implement Public Act 95-1045 ~~this~~
3 ~~amendatory Act of the 95th General Assembly~~, if any, is
4 conditioned on the rules being adopted in accordance with all
5 provisions of the Illinois Administrative Procedure Act and all
6 rules and procedures of the Joint Committee on Administrative
7 Rules; any purported rule not so adopted, for whatever reason,
8 is unauthorized.

9 (Source: P.A. 95-189, eff. 8-16-07; 95-331, eff. 8-21-07;
10 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.
11 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005,
12 eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10;
13 96-328, eff. 8-11-09; revised 9-25-09.)

14 (Text of Section after amendment by P.A. 96-833)

15 Sec. 10. Application of Insurance Code provisions. Health
16 services plan corporations and all persons interested therein
17 or dealing therewith shall be subject to the provisions of
18 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,
19 149, 155.37, 354, 355.2, 356g, 356g.5, 356g.5-1, 356r, 356t,
20 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5,
21 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
22 356z.14, 356z.15, 356z.18, 356z.19, 356z.20, 364.01, 367.2,
23 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and
24 paragraphs (7) and (15) of Section 367 of the Illinois
25 Insurance Code.

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

7 (Source: P.A. 95-189, eff. 8-16-07; 95-331, eff. 8-21-07;
8 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.
9 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005,
10 eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10;
11 96-328, eff. 8-11-09; 96-833, eff. 6-1-10.)

12 Section 50. The Health Carrier External Review Act is
13 amended by changing Section 35 and by adding Sections 25.1,
14 25.2, 25.3, 25.4, 25.5, and 25.6 as follows:

15 (215 ILCS 180/25.1 new)

16 Sec. 25.1. Standard information for application forms.

17 (a) The Director shall establish standard information and
18 health history questions that shall be used by all health care
19 service plans for their individual health care coverage
20 application forms for individual health plan contracts and
21 individual health insurance policies. The health care service
22 plan and health insurance application forms for individual
23 health plan contracts and health insurance policies may only
24 contain questions approved by the Director.

1 (b) The standard information and health history questions
2 developed by the Director shall contain clear and unambiguous
3 information and questions designed to ascertain the health
4 history of the applicant and shall be based on the medical
5 information that is reasonable and necessary for medical
6 underwriting purposes.

7 (c) The application form shall include a prominently
8 displayed notice that shall read: "Illinois law prohibits an
9 HIV test from being required or used by health care service
10 plans as a condition of obtaining coverage."

11 (d) No later than 6 months after the adoption of the
12 regulation under subsection (a) of this Section, all individual
13 health care service plan application forms shall utilize only
14 the pool of approved questions and the standardized information
15 established pursuant to subsection (a).

16 (e) On and after January 1, 2011, all individual health
17 care service plan applications shall be reviewed and approved
18 by the Director before they may be used by a health care
19 service plan.

20 (215 ILCS 180/25.2 new)

21 Sec. 25.2. Medical underwriting.

22 (a) "Medical underwriting" means the completion of a
23 reasonable investigation of the applicant's health history
24 information, which includes, but is not limited to, the
25 following:

1 (1) Ensuring that the information submitted on the
2 application form and the material submitted with the
3 application form are complete and accurate.

4 (2) Resolving all reasonable questions arising from
5 the application form or any materials submitted with the
6 application form or any information obtained by the health
7 care service plan as part of its verification of the
8 accuracy and completeness of the application form.

9 (b) A health care service plan shall complete medical
10 underwriting prior to issuing an enrollee or subscriber health
11 care service plan contract.

12 (c) A health care service plan shall adopt and implement
13 written medical underwriting policies and procedures to ensure
14 that the health care service plan does all of the following
15 with respect to an application for health care coverage:

16 (1) Reviews all of the following:

17 (A) Information on the application and any
18 materials submitted with the application form for
19 accuracy and completeness.

20 (B) Claims information about the applicant that is
21 within the health care service plan's own claims
22 information.

23 (C) At least one commercially available
24 prescription drug database for information about the
25 applicant.

26 (2) Identifies and makes inquiries, including

1 contacting the applicant about any questions raised by
2 omissions, ambiguities, or inconsistencies based upon the
3 information collected pursuant to item (1) of this
4 subsection (c).

5 (d) The plan shall document all information collected
6 during the underwriting review process.

7 (e) On or before January 1, 2011, a health care service
8 plan shall file its medical underwriting policies and
9 procedures with the Department.

10 (215 ILCS 180/25.3 new)

11 Sec. 25.3. Copies of application and contract; notice.

12 (a) Within 10 business days after issuing a health care
13 service plan contract, the health care service plan shall send
14 a copy of the completed written application to the applicant
15 with a copy of the health care service plan contract issued by
16 the health care service plan, along with a notice that states
17 all of the following:

18 (1) The applicant should review the completed
19 application carefully and notify the health care service
20 plan within 30 days of any inaccuracy in the application.

21 (2) Any intentional material misrepresentation or
22 intentional material omission in the information submitted
23 in the application may result in the cancellation or
24 rescission of the plan contract.

25 (3) The applicant should retain a copy of the completed

1 written application for the applicant's records.

2 (b) If new information is provided by the applicant within
3 the 30-day period permitted by subsection (a), then the
4 provisions concerning medical underwriting shall apply to the
5 new information.

6 (215 ILCS 180/25.4 new)

7 Sec. 25.4. Rescission; cancellation.

8 (a) Once a plan has issued an individual health care
9 service plan contract, the health care service plan shall not
10 rescind or cancel the health care service plan contract unless
11 all of the following apply:

12 (1) There was a material misrepresentation or material
13 omission in the information submitted by the applicant in
14 the written application to the health care service plan
15 prior to the issuance of the health care service plan
16 contract that would have prevented the contract from being
17 entered into.

18 (2) The health care service plan completed medical
19 underwriting before issuing the plan contract.

20 (3) The health care service plan demonstrates that the
21 applicant intentionally misrepresented or intentionally
22 omitted material information on the application prior to
23 the issuance of the plan contract with the purpose of
24 misrepresenting his or her health history in order to
25 obtain health care coverage.

1 (4) The application form was approved by the
2 Department.

3 (5) The health care service plan sent a copy of the
4 completed written application to the applicant with a copy
5 of the health care service plan contract issued by the
6 health care service plan.

7 (b) Notwithstanding subsection (a) of this Section, an
8 enrollment or subscription may be canceled or not renewed for
9 failure to pay the fees for that coverage.

10 (215 ILCS 180/25.5 new)

11 Sec. 25.5. Postcontract investigation.

12 (a) If a health care service plan obtains information after
13 issuing an individual health care service plan contract that
14 the subscriber or enrollee may have intentionally omitted or
15 intentionally misrepresented material information during the
16 application for coverage process, then the health care service
17 plan may investigate the potential omissions or
18 misrepresentations in order to determine whether the
19 subscriber's or enrollee's health care service plan contract
20 may be rescinded or canceled.

21 (b) The following provisions shall apply to a postcontract
22 issuance investigation:

23 (1) Upon initiating a postcontract issuance
24 investigation for potential rescission or cancellation of
25 health care coverage, the plan shall provide a written

1 notice to the enrollee or subscriber by regular and
2 certified mail that it has initiated an investigation of
3 intentional material misrepresentation or intentional
4 material omission on the part of the enrollee or subscriber
5 and that the investigation could lead to the rescission or
6 cancellation of the enrollee's or subscriber's health care
7 service plan contract. The notice shall be provided by the
8 health care service plan within 5 days of the initiation of
9 the investigation.

10 (2) The written notice required under item (1) of this
11 subsection (b) shall include full disclosure of the
12 allegedly intentional material omission or
13 misrepresentation and a clear and concise explanation of
14 why the information has resulted in the health care service
15 plan's initiation of an investigation to determine whether
16 rescission or cancellation is warranted. The notice shall
17 invite the enrollee or subscriber to provide any evidence
18 or information within 45 business days to negate the plan's
19 reasons for initiating the postissuance investigation.

20 (3) The plan shall complete its investigation no later
21 than 90 days after the date that the notice is sent to the
22 enrollee or subscriber pursuant to item (1) of this
23 subsection (b).

24 (4) Upon completion of its postissuance investigation,
25 the plan shall provide written notice by regular and
26 certified mail to the subscriber or enrollee that it has

1 concluded its investigation and has made one of the
2 following determinations:

3 (A) The plan has determined that the enrollee or
4 subscriber did not intentionally misrepresent or
5 intentionally omit material information during the
6 application process and that the subscriber's or
7 enrollee's health care coverage will not be canceled or
8 rescinded.

9 (B) The plan intends to seek approval from the
10 Director to cancel or rescind the enrollee's or
11 subscriber's health care service plan contract for
12 intentional misrepresentation or intentional omission
13 of material information during the application for
14 coverage process.

15 (5) The written notice required under paragraph (B) of
16 item (4) of this subsection (b) shall do all of the
17 following:

18 (A) Include full disclosure of the nature and
19 substance of any information that led to the plan's
20 determination that the enrollee or subscriber
21 intentionally misrepresented or intentionally omitted
22 material information on the application form.

23 (B) Provide the enrollee or subscriber with
24 information indicating that the health plan's
25 determination shall not become final until it is
26 reviewed and approved by the Department's independent

1 review process.

2 (C) Provide the enrollee or subscriber with
3 information regarding the Department's independent
4 review process and the right of the enrollee or
5 subscriber to opt out of that review process within 45
6 days of the date upon which an independent review
7 organization receives a request for independent
8 review.

9 (D) Provide a statement that the health care
10 service plan's proposed decision to cancel or rescind
11 the health care service plan contract shall not become
12 effective unless the Department's independent review
13 organization upholds the health care service plan's
14 decision or unless the enrollee or subscriber has opted
15 out of the independent review.

16 (215 ILCS 180/25.6 new)

17 Sec. 25.6. Continuation.

18 (a) A health care service plan shall continue to authorize
19 and provide all medically necessary health care services
20 required to be covered under an enrollee's or subscriber's
21 health care service plan contract until the effective date of
22 cancellation or rescission.

23 (b) The effective date of the health care service plan's
24 cancellation or the date upon which the plan may initiate a
25 rescission shall be no earlier than the date that the enrollee

1 or subscriber receives notification via regular and certified
2 mail that the independent review organization has made a
3 determination upholding the health care service plan's
4 decision to rescind or cancel.

5 (215 ILCS 180/35)

6 (This Section may contain text from a Public Act with a
7 delayed effective date)

8 Sec. 35. Standard external review.

9 (a) Within 4 months after the date of receipt of a notice
10 of an adverse determination or final adverse determination, a
11 covered person or the covered person's authorized
12 representative may file a request for an external review with
13 the health carrier.

14 (b) Within 5 business days following the date of receipt of
15 the external review request, the health carrier shall complete
16 a preliminary review of the request to determine whether:

17 (1) the individual is or was a covered person in the
18 health benefit plan at the time the health care service was
19 requested or at the time the health care service was
20 provided;

21 (2) the health care service that is the subject of the
22 adverse determination or the final adverse determination
23 is a covered service under the covered person's health
24 benefit plan, but the health carrier has determined that
25 the health care service is not covered because it does not

1 meet the health carrier's requirements for medical
2 necessity, appropriateness, health care setting, level of
3 care, or effectiveness;

4 (3) the covered person has exhausted the health
5 carrier's internal grievance process as set forth in this
6 Act;

7 (4) for appeals relating to a determination based on
8 treatment being experimental or investigational, the
9 requested health care service or treatment that is the
10 subject of the adverse determination or final adverse
11 determination is a covered benefit under the covered
12 person's health benefit plan except for the health
13 carrier's determination that the service or treatment is
14 experimental or investigational for a particular medical
15 condition and is not explicitly listed as an excluded
16 benefit under the covered person's health benefit plan with
17 the health carrier and that the covered person's health
18 care provider, who is a physician licensed to practice
19 medicine in all its branches, has certified that one of the
20 following situations is applicable:

21 (A) standard health care services or treatments
22 have not been effective in improving the condition of
23 the covered person;

24 (B) standard health care services or treatments
25 are not medically appropriate for the covered person;

26 (C) there is no available standard health care

1 service or treatment covered by the health carrier that
2 is more beneficial than the recommended or requested
3 health care service or treatment;

4 (D) the health care service or treatment is likely
5 to be more beneficial to the covered person, in the
6 health care provider's opinion, than any available
7 standard health care services or treatments; or

8 (E) that scientifically valid studies using
9 accepted protocols demonstrate that the health care
10 service or treatment requested is likely to be more
11 beneficial to the covered person than any available
12 standard health care services or treatments; and

13 (5) the covered person has provided all the information
14 and forms required to process an external review, as
15 specified in this Act.

16 (c) Within one business day after completion of the
17 preliminary review, the health carrier shall notify the covered
18 person and, if applicable, the covered person's authorized
19 representative in writing whether the request is complete and
20 eligible for external review. If the request:

21 (1) is not complete, the health carrier shall inform
22 the covered person and, if applicable, the covered person's
23 authorized representative in writing and include in the
24 notice what information or materials are required by this
25 Act to make the request complete; or

26 (2) is not eligible for external review, the health

1 carrier shall inform the covered person and, if applicable,
2 the covered person's authorized representative in writing
3 and include in the notice the reasons for its
4 ineligibility.

5 The notice of initial determination of ineligibility shall
6 include a statement informing the covered person and, if
7 applicable, the covered person's authorized representative
8 that a health carrier's initial determination that the external
9 review request is ineligible for review may be appealed to the
10 Director by filing a complaint with the Director.

11 Notwithstanding a health carrier's initial determination
12 that the request is ineligible for external review, the
13 Director may determine that a request is eligible for external
14 review and require that it be referred for external review. In
15 making such determination, the Director's decision shall be in
16 accordance with the terms of the covered person's health
17 benefit plan and shall be subject to all applicable provisions
18 of this Act.

19 (d) Whenever a request is eligible for external review the
20 health carrier shall, within 5 business days:

21 (1) assign an independent review organization from the
22 list of approved independent review organizations compiled
23 and maintained by the Director; and

24 (2) notify in writing the covered person and, if
25 applicable, the covered person's authorized representative
26 of the request's eligibility and acceptance for external

1 review and the name of the independent review organization.

2 The health carrier shall include in the notice provided to
3 the covered person and, if applicable, the covered person's
4 authorized representative a statement that the covered person
5 or the covered person's authorized representative may, within 5
6 business days following the date of receipt of the notice
7 provided pursuant to item (2) of this subsection (d), submit in
8 writing to the assigned independent review organization
9 additional information that the independent review
10 organization shall consider when conducting the external
11 review. The independent review organization is not required to,
12 but may, accept and consider additional information submitted
13 after 5 business days.

14 (e) The assignment of an approved independent review
15 organization to conduct an external review in accordance with
16 this Section shall be made from those approved independent
17 review organizations qualified to conduct external review as
18 required by Sections 50 and 55 of this Act.

19 (f) Upon assignment of an independent review organization,
20 the health carrier or its designee utilization review
21 organization shall, within 5 business days, provide to the
22 assigned independent review organization the documents and any
23 information considered in making the adverse determination or
24 final adverse determination; in such cases, the following
25 provisions shall apply:

26 (1) Except as provided in item (2) of this subsection

1 (f), failure by the health carrier or its utilization
2 review organization to provide the documents and
3 information within the specified time frame shall not delay
4 the conduct of the external review.

5 (2) If the health carrier or its utilization review
6 organization fails to provide the documents and
7 information within the specified time frame, the assigned
8 independent review organization may terminate the external
9 review and make a decision to reverse the adverse
10 determination or final adverse determination.

11 (3) Within one business day after making the decision
12 to terminate the external review and make a decision to
13 reverse the adverse determination or final adverse
14 determination under item (2) of this subsection (f), the
15 independent review organization shall notify the health
16 carrier, the covered person and, if applicable, the covered
17 person's authorized representative, of its decision to
18 reverse the adverse determination.

19 (g) Upon receipt of the information from the health carrier
20 or its utilization review organization, the assigned
21 independent review organization shall review all of the
22 information and documents and any other information submitted
23 in writing to the independent review organization by the
24 covered person and the covered person's authorized
25 representative.

26 (h) Upon receipt of any information submitted by the

1 covered person or the covered person's authorized
2 representative, the independent review organization shall
3 forward the information to the health carrier within 1 business
4 day.

5 (1) Upon receipt of the information, if any, the health
6 carrier may reconsider its adverse determination or final
7 adverse determination that is the subject of the external
8 review.

9 (2) Reconsideration by the health carrier of its
10 adverse determination or final adverse determination shall
11 not delay or terminate the external review.

12 (3) The external review may only be terminated if the
13 health carrier decides, upon completion of its
14 reconsideration, to reverse its adverse determination or
15 final adverse determination and provide coverage or
16 payment for the health care service that is the subject of
17 the adverse determination or final adverse determination.
18 In such cases, the following provisions shall apply:

19 (A) Within one business day after making the
20 decision to reverse its adverse determination or final
21 adverse determination, the health carrier shall notify
22 the covered person and if applicable, the covered
23 person's authorized representative, and the assigned
24 independent review organization in writing of its
25 decision.

26 (B) Upon notice from the health carrier that the

1 health carrier has made a decision to reverse its
2 adverse determination or final adverse determination,
3 the assigned independent review organization shall
4 terminate the external review.

5 (i) In addition to the documents and information provided
6 by the health carrier or its utilization review organization
7 and the covered person and the covered person's authorized
8 representative, if any, the independent review organization,
9 to the extent the information or documents are available and
10 the independent review organization considers them
11 appropriate, shall consider the following in reaching a
12 decision:

13 (1) the covered person's pertinent medical records;

14 (2) the covered person's health care provider's
15 recommendation;

16 (3) consulting reports from appropriate health care
17 providers and other documents submitted by the health
18 carrier, the covered person, the covered person's
19 authorized representative, or the covered person's
20 treating provider;

21 (4) the terms of coverage under the covered person's
22 health benefit plan with the health carrier to ensure that
23 the independent review organization's decision is not
24 contrary to the terms of coverage under the covered
25 person's health benefit plan with the health carrier;

26 (5) the most appropriate practice guidelines, which

1 shall include applicable evidence-based standards and may
2 include any other practice guidelines developed by the
3 federal government, national or professional medical
4 societies, boards, and associations;

5 (6) any applicable clinical review criteria developed
6 and used by the health carrier or its designee utilization
7 review organization; and

8 (7) the opinion of the independent review
9 organization's clinical reviewer or reviewers after
10 considering items (1) through (6) of this subsection (i) to
11 the extent the information or documents are available and
12 the clinical reviewer or reviewers considers the
13 information or documents appropriate; and

14 (8) for a denial of coverage based on a determination
15 that the health care service or treatment recommended or
16 requested is experimental or investigational, whether and
17 to what extent:

18 (A) the recommended or requested health care
19 service or treatment has been approved by the federal
20 Food and Drug Administration, if applicable, for the
21 condition;

22 (B) medical or scientific evidence or
23 evidence-based standards demonstrate that the expected
24 benefits of the recommended or requested health care
25 service or treatment is more likely than not to be
26 beneficial to the covered person than any available

1 standard health care service or treatment and the
2 adverse risks of the recommended or requested health
3 care service or treatment would not be substantially
4 increased over those of available standard health care
5 services or treatments; or

6 (C) the terms of coverage under the covered
7 person's health benefit plan with the health carrier to
8 ensure that the health care service or treatment that
9 is the subject of the opinion is experimental or
10 investigational would otherwise be covered under the
11 terms of coverage of the covered person's health
12 benefit plan with the health carrier.

13 (j) Within 5 days after the date of receipt of all
14 necessary information, the assigned independent review
15 organization shall provide written notice of its decision to
16 uphold or reverse the adverse determination or the final
17 adverse determination to the health carrier, the covered person
18 and, if applicable, the covered person's authorized
19 representative. In reaching a decision, the assigned
20 independent review organization is not bound by any claim
21 determinations reached prior to the submission of information
22 to the independent review organization. The assigned
23 independent review organization shall independently determine
24 if the health care services under review are the medically
25 necessary health care services that a physician, exercising
26 prudent clinical judgment, would provide to a patient for the

1 purpose of preventing, evaluating, diagnosing, or treating an
2 illness, injury, disease, or its symptoms and are: (i) in
3 accordance with generally accepted standards of medical
4 practice; (ii) clinically appropriate, in terms of type,
5 frequency, extent, site, and duration and considered effective
6 for the patient's illness, injury, or disease; and (iii) not
7 primarily for the convenience of the patient, physician, or
8 other health care provider. For the purposes of this subsection
9 (j), "generally accepted standards of medical practice" means
10 standards that are based on credible scientific evidence
11 published in peer-reviewed medical literature generally
12 recognized by the relevant medical community, physician
13 specialty society recommendations, and the views of physicians
14 practicing in relevant clinical areas and any other relevant
15 factors. In such cases, the following provisions shall apply:

16 (1) The independent review organization shall include
17 in the notice:

18 (A) a general description of the reason for the
19 request for external review;

20 (B) the date the independent review organization
21 received the assignment from the health carrier to
22 conduct the external review;

23 (C) the time period during which the external
24 review was conducted;

25 (D) references to the evidence or documentation,
26 including the evidence-based standards, considered in

1 reaching its decision;

2 (E) the date of its decision; and

3 (F) the principal reason or reasons for its
4 decision, including what applicable, if any,
5 evidence-based standards that were a basis for its
6 decision.

7 (2) For reviews of experimental or investigational
8 treatments, the notice shall include the following
9 information:

10 (A) a description of the covered person's medical
11 condition;

12 (B) a description of the indicators relevant to
13 whether there is sufficient evidence to demonstrate
14 that the recommended or requested health care service
15 or treatment is more likely than not to be more
16 beneficial to the covered person than any available
17 standard health care services or treatments and the
18 adverse risks of the recommended or requested health
19 care service or treatment would not be substantially
20 increased over those of available standard health care
21 services or treatments;

22 (C) a description and analysis of any medical or
23 scientific evidence considered in reaching the
24 opinion;

25 (D) a description and analysis of any
26 evidence-based standards;

1 (E) whether the recommended or requested health
2 care service or treatment has been approved by the
3 federal Food and Drug Administration, for the
4 condition;

5 (F) whether medical or scientific evidence or
6 evidence-based standards demonstrate that the expected
7 benefits of the recommended or requested health care
8 service or treatment is more likely than not to be more
9 beneficial to the covered person than any available
10 standard health care service or treatment and the
11 adverse risks of the recommended or requested health
12 care service or treatment would not be substantially
13 increased over those of available standard health care
14 services or treatments; and

15 (G) the written opinion of the clinical reviewer,
16 including the reviewer's recommendation as to whether
17 the recommended or requested health care service or
18 treatment should be covered and the rationale for the
19 reviewer's recommendation.

20 (3) In reaching a decision, the assigned independent
21 review organization is not bound by any decisions or
22 conclusions reached during the health carrier's
23 utilization review process or the health carrier's
24 internal grievance or appeals process.

25 (4) Upon receipt of a notice of a decision reversing
26 the adverse determination or final adverse determination,

1 the health carrier immediately shall approve the coverage
2 that was the subject of the adverse determination or final
3 adverse determination.

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

5 Section 55. The Illinois Public Aid Code is amended by
6 changing Section 5-16.8 as follows:

7 (305 ILCS 5/5-16.8)

8 Sec. 5-16.8. Required health benefits. The medical
9 assistance program shall (i) provide the post-mastectomy care
10 benefits required to be covered by a policy of accident and
11 health insurance under Section 356t and the coverage required
12 under Sections 356g.5, 356u, 356w, 356x, ~~and~~ 356z.6, and
13 356z.21 of the Illinois Insurance Code and (ii) be subject to
14 the provisions of Section 364.01 of the Illinois Insurance
15 Code.

16 (Source: P.A. 95-189, eff. 8-16-07; 95-331, eff. 8-21-07.)

17 Section 60. The Medical Patient Rights Act is amended by
18 changing Sections 2.04, 3, and 5 and adding Sections 2.06, 5.1,
19 and 5.2 as follows:

20 (410 ILCS 50/2.04) (from Ch. 111 1/2, par. 5402.04)

21 Sec. 2.04. "Insurance company" means (1) an insurance
22 company, fraternal benefit society, and any other insurer

1 subject to regulation under the Illinois Insurance Code; or (2)
2 a health maintenance organization, a limited health service
3 organization under the Limited Health Service Organization
4 Act, or a voluntary health services plan under the Voluntary
5 Health Services Plans Act.

6 (Source: P.A. 85-677; 85-679.)

7 (410 ILCS 50/2.06 new)

8 Sec. 2.06. "Health insurance policy or health care plan"
9 means any policy of health or accident insurance provided by a
10 health insurance company or under the Counties Code, the
11 Municipal Code, the State Employees Group Insurance Act or
12 Medical Assistance provided under the Public Aid Code.

13 (410 ILCS 50/3) (from Ch. 111 1/2, par. 5403)

14 Sec. 3. The following rights are hereby established:

15 (a) The right of each patient to care consistent with sound
16 nursing and medical practices, to be informed of the name of
17 the physician responsible for coordinating his or her care, to
18 receive information concerning his or her condition and
19 proposed treatment, to refuse any treatment to the extent
20 permitted by law, and to privacy and confidentiality of records
21 except as otherwise provided by law. Each patient has a right
22 to be informed of his or her inpatient or outpatient status
23 while undergoing evaluation, assessment, diagnosis, treatment,
24 or observation in a hospital. The patient must be informed of

1 this status and put on notice that this admission status may
2 affect coverage by his or her health insurance policy or health
3 care plan or his or her personal responsibility for payment.

4 (b) The right of each patient, regardless of source of
5 payment, to examine and receive a reasonable explanation of his
6 total bill for services rendered by his physician or health
7 care provider, including the itemized charges for specific
8 services received. Each physician or health care provider shall
9 be responsible only for a reasonable explanation of those
10 specific services provided by such physician or health care
11 provider.

12 (c) In the event an insurance company or health services
13 corporation cancels or refuses to renew an individual policy or
14 plan, the insured patient shall be entitled to timely, prior
15 notice of the termination of such policy or plan.

16 An insurance company or health services corporation that
17 requires any insured patient or applicant for new or continued
18 insurance or coverage to be tested for infection with human
19 immunodeficiency virus (HIV) or any other identified causative
20 agent of acquired immunodeficiency syndrome (AIDS) shall (1)
21 give the patient or applicant prior written notice of such
22 requirement, (2) proceed with such testing only upon the
23 written authorization of the applicant or patient, and (3) keep
24 the results of such testing confidential. Notice of an adverse
25 underwriting or coverage decision may be given to any
26 appropriately interested party, but the insurer may only

1 disclose the test result itself to a physician designated by
2 the applicant or patient, and any such disclosure shall be in a
3 manner that assures confidentiality.

4 The Department of Insurance shall enforce the provisions of
5 this subsection.

6 (d) The right of each patient to privacy and
7 confidentiality in health care. Each physician, health care
8 provider, health services corporation and insurance company
9 shall refrain from disclosing the nature or details of services
10 provided to patients, except that such information may be
11 disclosed to the patient, the party making treatment decisions
12 if the patient is incapable of making decisions regarding the
13 health services provided, those parties directly involved with
14 providing treatment to the patient or processing the payment
15 for that treatment, those parties responsible for peer review,
16 utilization review and quality assurance, and those parties
17 required to be notified under the Abused and Neglected Child
18 Reporting Act, the Illinois Sexually Transmissible Disease
19 Control Act or where otherwise authorized or required by law.
20 This right may be waived in writing by the patient or the
21 patient's guardian, but a physician or other health care
22 provider may not condition the provision of services on the
23 patient's or guardian's agreement to sign such a waiver.

24 (Source: P.A. 86-895; 86-902; 86-1028; 87-334.)

1 Sec. 5. Statement of hospital patient's rights.

2 (a) Each patient admitted to a hospital, and the guardian
3 or authorized representative or parent of a minor patient,
4 shall be given a written statement of all the rights enumerated
5 in this Act, or a similar statement of patients' rights
6 required of the hospital by the Joint Commission on
7 Accreditation of Healthcare Organizations or a similar
8 accrediting organization. The statement shall be given at the
9 time of admission or as soon thereafter as the condition of the
10 patient permits.

11 (b) If a patient is unable to read the written statement, a
12 hospital shall make a reasonable effort to provide it to the
13 guardian or authorized representative of the patient.

14 (c) The statement shall also include the right not to be
15 discriminated against by the hospital due to the patient's
16 race, color, or national origin where such characteristics are
17 not relevant to the patient's medical diagnosis and treatment.
18 The statement shall further provide each admitted patient or
19 the patient's representative or guardian with notice of how to
20 initiate a grievance regarding improper discrimination with
21 the hospital and how the patient may lodge a grievance with the
22 Illinois Department of Public Health regardless of whether the
23 patient has first used the hospital's grievance process.

24 (Source: P.A. 88-56; 88-670, eff. 12-2-94.)

25 (410 ILCS 50/5.1 new)

1 Sec. 5.1. Discrimination grievance procedures. Upon
2 receipt of a grievance alleging unlawful discrimination on the
3 basis of race, color, or national origin, the hospital must
4 investigate the claim and work with the patient to address
5 valid or proven concerns in accordance with the hospital's
6 grievance process. At the conclusion of the hospital's
7 grievance process, the hospital shall inform the patient that
8 such grievances may be reported to the Illinois Department of
9 Public Health if not resolved to the patient's satisfaction at
10 the hospital level.

11 (410 ILCS 50/5.2 new)

12 Sec. 5.2. Emergency room antidiscrimination notice. Every
13 hospital shall post a sign next to or in close proximity of its
14 sign required by Section 489.20 (g) (1) of Title 42 of the Code
15 of Federal Regulations stating the following:

16 "You have the right not to be discriminated against by the
17 hospital due to your race, color, or national origin if these
18 characteristics are unrelated to your diagnosis or treatment.
19 If you believe this right has been violated, please call
20 (insert number for hospital grievance officer)."

21 Section 90. The State Mandates Act is amended by adding
22 Section 8.34 as follows:

23 (30 ILCS 805/8.34 new)

1 Sec. 8.34. Exempt mandate. Notwithstanding Sections 6 and 8
2 of this Act, no reimbursement by the State is required for the
3 implementation of any mandate created by this amendatory Act of
4 the 96th General Assembly.

5 Section 95. No acceleration or delay. Where this Act makes
6 changes in a statute that is represented in this Act by text
7 that is not yet or no longer in effect (for example, a Section
8 represented by multiple versions), the use of that text does
9 not accelerate or delay the taking effect of (i) the changes
10 made by this Act or (ii) provisions derived from any other
11 Public Act.

12 Section 99. Effective date. This Act takes effect upon
13 becoming law.".