HB1191

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB1191

Introduced 02/08/11, by Rep. Greg Harris

SYNOPSIS AS INTRODUCED:

See Index

Amends the State Employees Group Insurance Act of 1971, Counties Code, Illinois Municipal Code, School Code, Illinois Insurance Code, Health Maintenance Organization Act, and Voluntary Health Services Plans Act. Sets forth definitions for "qualified individual" and "life-threatening condition". Sets forth provisions concerning coverage for routine patient care with regard to denial, limits, additional conditions, and discrimination concerning approved clinical trials according to the trial protocol with respect to the treatment of cancer or other life-threatening diseases or conditions. Amends the Illinois Public Aid Code in the provision concerning medical services to provide that the Department of Healthcare and Family Services shall ensure that cancer patients in need of dental treatment prior to the administration of chemotherapy have access to such dental services and shall develop a mechanism whereby mammography providers may download a standing order via the Internet for screening mammography for certain women eligible for mammography coverage. Amends the Radiation Protection Act of 1990 in the provision concerning limitations on application of radiation to human beings and requirements for radiation installation operators providing mammography services. Provides that each facility that performs mammograms shall upon request by or on behalf of the patient transfer the original mammograms and copies of the reports without charge to the patient. Makes other changes.

LRB097 06572 RPM 46657 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning insurance.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

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

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, ~~and~~ 356z.17, and 356z.19 of the Illinois Insurance Code. The program of health benefits must comply with Section 155.37 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. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1044, eff. 3-26-09; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; 96-1000, eff. 7-2-10.)

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

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, ~~and~~ 356z.15, and 356z.19 of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

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. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; 96-1000, eff. 7-2-10.)

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

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, ~~and~~ 356z.15, and 356z.19 of the Illinois Insurance Code. The requirement that health

1 benefits be covered as provided in this is an exclusive power
2 and function of the State and is a denial and limitation under
3 Article VII, Section 6, subsection (h) of the Illinois
4 Constitution. A home rule municipality to which this Section
5 applies must comply with every provision of this Section.

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

12 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
13 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff.
14 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045,
15 eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10;
16 96-328, eff. 8-11-09; 96-1000, eff. 7-2-10.)

17 Section 20. The School Code is amended by changing Section
18 10-22.3f as follows:

19 (105 ILCS 5/10-22.3f)

20 Sec. 10-22.3f. Required health benefits. Insurance
21 protection and benefits for employees shall provide the
22 post-mastectomy care benefits required to be covered by a
23 policy of accident and health insurance under Section 356t and
24 the coverage required under Sections 356g, 356g.5, 356g.5-1,

1 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12,
2 356z.13, 356z.14, ~~and~~ 356z.15, and 356z.19 of the Illinois
3 Insurance Code.

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

10 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
11 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;
12 95-1005, 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.
13 1-1-10; 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; 96-1000,
14 eff. 7-2-10.)

15 Section 25. The Illinois Insurance Code is amended by
16 adding Section 356z.19 as follows:

17 (215 ILCS 5/356z.19 new)

18 Sec. 356z.19. Routine patient care.

19 (a) For the purposes of this Section, the term "qualified
20 individual" means an individual who is a participant or
21 beneficiary in a health plan or with coverage described in
22 paragraph (1) of subsection (c) and who meets the following
23 conditions:

24 (1) the individual is eligible to participate in an

1 approved clinical trial according to the trial protocol
2 with respect to treatment of cancer or other
3 life-threatening disease or condition; and
4 (2) either:
5 (A) the referring health care professional is a
6 participating health care provider and has concluded
7 that the individual's participation in such trial
8 would be appropriate based upon the individual meeting
9 the conditions described in paragraph (1) of this
10 subsection; or
11 (B) the participant or beneficiary provides
12 medical and scientific information establishing that
13 the individual's participation in such trial would be
14 appropriate based upon the individual meeting the
15 conditions described in paragraph (1) of this
16 subsection.
17 (b) For the purposes of this Section, the term
18 "life-threatening condition" or "life-threatening disease"
19 means any condition or disease from which the likelihood of
20 death is probable unless the course of the disease or condition
21 is interrupted.
22 (c) Coverage for routine patient care must comply with the
23 following provisions:
24 (1) If a group health plan or a health insurance issuer
25 offering group or individual health insurance coverage
26 provides coverage to a qualified individual, then such plan

1 or issuer:
2 (A) may not deny the individual participation in
3 the clinical trial referred to in subsection (a) of
4 this Section;
5 (B) subject to subsection (d) of this Section, may
6 not deny or limit or impose additional conditions on
7 the coverage of routine patient care costs for items
8 and services furnished in connection with
9 participation in the trial; and
10 (C) may not discriminate against the individual on
11 the basis of the individual's participation in the
12 trial.
13 (2) The following provisions concerning routine
14 patient costs shall apply:
15 (A) For purposes of and, subject to subparagraph
16 (B) of paragraph (1) of this subsection, routine
17 patient care costs include all items and services
18 consistent with the coverage provided in the plan or
19 coverage that is typically provided for a qualified
20 individual who is not enrolled in a clinical trial.
21 (B) For purposes of subparagraph (B) of paragraph
22 (1) of this subsection, routine patient care costs do
23 not include the following:
24 (i) the investigational item, device, or
25 service itself;
26 (ii) items and services that are provided

1 solely to satisfy data collection and analysis
2 needs and that are not used in the direct clinical
3 management of the patient; or
4 (iii) a service that is clearly inconsistent
5 with widely accepted and established standards of
6 care for a particular diagnosis.
7 (3) If one or more participating providers are
8 participating in a clinical trial, then nothing in
9 paragraph (1) of this subsection shall be construed as
10 preventing a plan or issuer from requiring that a qualified
11 individual participate in the trial through a
12 participating provider if the provider will accept the
13 individual as a participant in the trial.
14 (4) Notwithstanding paragraph (3) of this subsection,
15 paragraph (1) shall apply to a qualified individual
16 participating in an approved clinical trial that is
17 conducted outside the state in which the qualified
18 individual resides.
19 (d) This Section shall not be construed to require a group
20 health plan or a health insurance issuer offering group or
21 individual health insurance coverage to provide benefits for
22 routine patient care services provided outside of the plan's or
23 coverage's health care provider network unless out-of-network
24 benefits are otherwise provided under the plan or coverage.
25 (e) The following provisions concerning approved clinical
26 trials shall apply:

1 (1) In this Section, the term "approved clinical trial"
2 means a phase I, phase II, phase III, or phase IV clinical
3 trial that is conducted in relation to the prevention,
4 detection, or treatment of cancer or other
5 life-threatening disease or condition and is described in
6 any of the following provisions:
7 (A) The study or investigation is approved or
8 funded (which may include funding through in-kind
9 contributions) by one or more of the following:
10 (i) The National Institutes of Health.
11 (ii) The Centers for Disease Control and
12 Prevention.
13 (iii) The Agency for Health Care Research and
14 Quality.
15 (iv) The Centers for Medicare and Medicaid
16 Services.
17 (v) A cooperative group or center of any of the
18 entities described in items (i) through (iv) of
19 this subparagraph or the U.S. Department of
20 Defense or Department of Veterans Affairs.
21 (vi) A qualified non-governmental research
22 entity identified in the guidelines issued by the
23 National Institutes of Health for center support
24 grants.
25 (vii) Any of the following if the conditions
26 described in paragraph (2) of this subsection are

1 met:
2 (I) The U.S. Department of Veterans
3 Affairs.
4 (II) The U.S. Department of Defense.
5 (III) The U.S. Department of Energy.
6 (B) The study or investigation is conducted under
7 an investigational new drug application reviewed by
8 the U.S. Food and Drug Administration.
9 (C) The study or investigation is a drug trial that
10 is exempt from having such an investigational new drug
11 application.
12 (2) A study or investigation under item (1)(A)(vii) of
13 this subsection is subject to the condition that it must be
14 reviewed and approved through a system of peer review that:
15 (A) is comparable to the system of peer review of
16 studies and investigations used by the National
17 Institutes of Health; and
18 (B) ensures unbiased review of the highest
19 scientific standard by qualified individuals who have
20 no interest in the outcome of the review.
21 (f) Nothing in this Section shall be construed to limit a
22 plan's or issuer's coverage with respect to clinical trials.

23 Section 30. The Health Maintenance Organization Act is
24 amended by changing Section 5-3 as follows:

1 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)
2 Sec. 5-3. Insurance Code provisions.
3 (a) Health Maintenance Organizations shall be subject to
4 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
5 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
6 154.6, 154.7, 154.8, 155.04, 355.2, 356g.5-1, 356m, 356v, 356w,
7 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9,
8 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
9 356z.18, 356z.19, 364.01, 367.2, 367.2-5, 367i, 368a, 368b,
10 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2,
11 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of
12 Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII,
13 XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.
14 (b) For purposes of the Illinois Insurance Code, except for
15 Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health
16 Maintenance Organizations in the following categories are
17 deemed to be "domestic companies":
18 (1) a corporation authorized under the Dental Service
19 Plan Act or the Voluntary Health Services Plans Act;
20 (2) a corporation organized under the laws of this
21 State; or
22 (3) a corporation organized under the laws of another
23 state, 30% or more of the enrollees of which are residents
24 of this State, except a corporation subject to
25 substantially the same requirements in its state of
26 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

1 Insurance Act and except for medicare supplement policies as
2 defined in Section 363 of the Illinois Insurance Code, a Health
3 Maintenance Organization may by contract agree with a group or
4 other enrollment unit to effect refunds or charge additional
5 premiums under the following terms and conditions:
6 (i) the amount of, and other terms and conditions with
7 respect to, the refund or additional premium are set forth
8 in the group or enrollment unit contract agreed in advance
9 of the period for which a refund is to be paid or
10 additional premium is to be charged (which period shall not
11 be less than one year); and
12 (ii) the amount of the refund or additional premium
13 shall not exceed 20% of the Health Maintenance
14 Organization's profitable or unprofitable experience with
15 respect to the group or other enrollment unit for the
16 period (and, for purposes of a refund or additional
17 premium, the profitable or unprofitable experience shall
18 be calculated taking into account a pro rata share of the
19 Health Maintenance Organization's administrative and
20 marketing expenses, but shall not include any refund to be
21 made or additional premium to be paid pursuant to this
22 subsection (f)). The Health Maintenance Organization and
23 the group or enrollment unit may agree that the profitable
24 or unprofitable experience may be calculated taking into
25 account the refund period and the immediately preceding 2
26 plan years.

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

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

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

23 (Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07;
24 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;
25 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.
26 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; 96-833, eff.

1 6-1-10; 96-1000, eff. 7-2-10.)

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

4 (215 ILCS 165/10) (from Ch. 32, par. 604)
5 Sec. 10. Application of Insurance Code provisions. Health
6 services plan corporations and all persons interested therein
7 or dealing therewith shall be subject to the provisions of
8 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,
9 149, 155.37, 354, 355.2, 356g, 356g.5, 356g.5-1, 356r, 356t,
10 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5,
11 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
12 356z.14, 356z.15, 356z.18, 356z.19, 364.01, 367.2, 368a, 401,
13 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7)
14 and (15) of Section 367 of the Illinois Insurance Code.
15 ~~Rulemaking authority to implement Public Act 95-1045, if~~
16 ~~any, is conditioned on the rules being adopted in accordance~~
17 ~~with all provisions of the Illinois Administrative Procedure~~
18 ~~Act and all rules and procedures of the Joint Committee on~~
19 ~~Administrative Rules; any purported rule not so adopted, for~~
20 ~~whatever reason, is unauthorized.~~
21 (Source: P.A. 95-189, eff. 8-16-07; 95-331, eff. 8-21-07;
22 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.
23 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005,
24 eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10;

1 96-328, eff. 8-11-09; 96-833, eff. 6-1-10; 96-1000, eff.
2 7-2-10.)

3 Section 40. The Illinois Public Aid Code is amended by
4 changing Section 5-5 as follows:

5 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)
6 Sec. 5-5. Medical services. The Illinois Department, by
7 rule, shall determine the quantity and quality of and the rate
8 of reimbursement for the medical assistance for which payment
9 will be authorized, and the medical services to be provided,
10 which may include all or part of the following: (1) inpatient
11 hospital services; (2) outpatient hospital services; (3) other
12 laboratory and X-ray services; (4) skilled nursing home
13 services; (5) physicians' services whether furnished in the
14 office, the patient's home, a hospital, a skilled nursing home,
15 or elsewhere; (6) medical care, or any other type of remedial
16 care furnished by licensed practitioners; (7) home health care
17 services; (8) private duty nursing service; (9) clinic
18 services; (10) dental services, including prevention and
19 treatment of periodontal disease and dental caries disease for
20 pregnant women, provided by an individual licensed to practice
21 dentistry or dental surgery; for purposes of this item (10),
22 "dental services" means diagnostic, preventive, or corrective
23 procedures provided by or under the supervision of a dentist in
24 the practice of his or her profession; (11) physical therapy

1 and related services; (12) prescribed drugs, dentures, and
2 prosthetic devices; and eyeglasses prescribed by a physician
3 skilled in the diseases of the eye, or by an optometrist,
4 whichever the person may select; (13) other diagnostic,
5 screening, preventive, and rehabilitative services; (14)
6 transportation and such other expenses as may be necessary;
7 (15) medical treatment of sexual assault survivors, as defined
8 in Section 1a of the Sexual Assault Survivors Emergency
9 Treatment Act, for injuries sustained as a result of the sexual
10 assault, including examinations and laboratory tests to
11 discover evidence which may be used in criminal proceedings
12 arising from the sexual assault; (16) the diagnosis and
13 treatment of sickle cell anemia; and (17) any other medical
14 care, and any other type of remedial care recognized under the
15 laws of this State, but not including abortions, or induced
16 miscarriages or premature births, unless, in the opinion of a
17 physician, such procedures are necessary for the preservation
18 of the life of the woman seeking such treatment, or except an
19 induced premature birth intended to produce a live viable child
20 and such procedure is necessary for the health of the mother or
21 her unborn child. The Illinois Department, by rule, shall
22 prohibit any physician from providing medical assistance to
23 anyone eligible therefor under this Code where such physician
24 has been found guilty of performing an abortion procedure in a
25 wilful and wanton manner upon a woman who was not pregnant at
26 the time such abortion procedure was performed. The term "any

1 other type of remedial care" shall include nursing care and
2 nursing home service for persons who rely on treatment by
3 spiritual means alone through prayer for healing.

4 Notwithstanding any other provision of this Section, a
5 comprehensive tobacco use cessation program that includes
6 purchasing prescription drugs or prescription medical devices
7 approved by the Food and Drug Administration shall be covered
8 under the medical assistance program under this Article for
9 persons who are otherwise eligible for assistance under this
10 Article.

11 Notwithstanding any other provision of this Code, the
12 Illinois Department may not require, as a condition of payment
13 for any laboratory test authorized under this Article, that a
14 physician's handwritten signature appear on the laboratory
15 test order form. The Illinois Department may, however, impose
16 other appropriate requirements regarding laboratory test order
17 documentation.

18 The Department of Healthcare and Family Services shall
19 provide the following services to persons eligible for
20 assistance under this Article who are participating in
21 education, training or employment programs operated by the
22 Department of Human Services as successor to the Department of
23 Public Aid:

24 (1) dental services provided by or under the
25 supervision of a dentist; and

26 (2) eyeglasses prescribed by a physician skilled in the

diseases of the eye, or by an optometrist, whichever the person may select.

Notwithstanding any other provision of this Code and subject to federal approval, the Department may adopt rules to allow a dentist who is volunteering his or her service at no cost to render dental services through an enrolled not-for-profit health clinic without the dentist personally enrolling as a participating provider in the medical assistance program. A not-for-profit health clinic shall include a public health clinic or Federally Qualified Health Center or other enrolled provider, as determined by the Department, through which dental services covered under this Section are performed. The Department shall establish a process for payment of claims for reimbursement for covered dental services rendered under this provision.

<u>Notwithstanding any other provision of this Code, the Illinois Department shall ensure that cancer patients in need of dental treatment prior to the administration of chemotherapy have access to such dental services and shall ensure that treatment is not delayed due to an inability to locate a provider willing to accept the Department's rates. The Department shall ensure that healthcare providers treating such patients, including medical oncologists, cancer centers, and cancer advocacy organizations, are aware of the mechanisms available to the Department to ensure such access.</u>

<u>The Illinois Department shall develop a mechanism whereby</u>

1 mammography providers may download a standing order via the
2 Internet for screening mammography for any woman eligible for
3 mammography coverage who has not had a screening mammogram
4 within the last 12 months. This mechanism shall be available
5 for all women covered by any program administered by this State
6 that includes mammography coverage.
7 The Illinois Department, by rule, may distinguish and
8 classify the medical services to be provided only in accordance
9 with the classes of persons designated in Section 5-2.
10 The Department of Healthcare and Family Services must
11 provide coverage and reimbursement for amino acid-based
12 elemental formulas, regardless of delivery method, for the
13 diagnosis and treatment of (i) eosinophilic disorders and (ii)
14 short bowel syndrome when the prescribing physician has issued
15 a written order stating that the amino acid-based elemental
16 formula is medically necessary.
17 The Illinois Department shall authorize the provision of,
18 and shall authorize payment for, screening by low-dose
19 mammography for the presence of occult breast cancer for women
20 35 years of age or older who are eligible for medical
21 assistance under this Article, as follows:
22 (A) A baseline mammogram for women 35 to 39 years of
23 age.
24 (B) An annual mammogram for women 40 years of age or
25 older.
26 (C) A mammogram at the age and intervals considered

1 medically necessary by the woman's health care provider for
2 women under 40 years of age and having a family history of
3 breast cancer, prior personal history of breast cancer,
4 positive genetic testing, or other risk factors.

5 (D) A comprehensive ultrasound screening of an entire
6 breast or breasts if a mammogram demonstrates
7 heterogeneous or dense breast tissue, when medically
8 necessary as determined by a physician licensed to practice
9 medicine in all of its branches.

10 All screenings shall include a physical breast exam,
11 instruction on self-examination and information regarding the
12 frequency of self-examination and its value as a preventative
13 tool. For purposes of this Section, "low-dose mammography"
14 means the x-ray examination of the breast using equipment
15 dedicated specifically for mammography, including the x-ray
16 tube, filter, compression device, and image receptor, with an
17 average radiation exposure delivery of less than one rad per
18 breast for 2 views of an average size breast. The term also
19 includes digital mammography.

20 On and after July 1, 2008, screening and diagnostic
21 mammography shall be reimbursed at the same rate as the
22 Medicare program's rates, including the increased
23 reimbursement for digital mammography.

24 The Department shall convene an expert panel including
25 representatives of hospitals, free-standing mammography
26 facilities, and doctors, including radiologists, to establish

quality standards. Based on these quality standards, the Department shall provide for bonus payments to mammography facilities meeting the standards for screening and diagnosis. The bonus payments shall be at least 15% higher than the Medicare rates for mammography.

Subject to federal approval, the Department shall establish a rate methodology for mammography at federally qualified health centers and other encounter-rate clinics. These clinics or centers may also collaborate with other hospital-based mammography facilities.

The Department shall establish a methodology to remind women who are age-appropriate for screening mammography, but who have not received a mammogram within the previous 18 months, of the importance and benefit of screening mammography.

The Department shall establish a performance goal for primary care providers with respect to their female patients over age 40 receiving an annual mammogram. This performance goal shall be used to provide additional reimbursement in the form of a quality performance bonus to primary care providers who meet that goal.

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall

1 be outside the metropolitan Chicago area. An evaluation of the
2 pilot program shall be carried out measuring health outcomes
3 and cost of care for those served by the pilot program compared
4 to similarly situated patients who are not served by the pilot
5 program.

6 Any medical or health care provider shall immediately
7 recommend, to any pregnant woman who is being provided prenatal
8 services and is suspected of drug abuse or is addicted as
9 defined in the Alcoholism and Other Drug Abuse and Dependency
10 Act, referral to a local substance abuse treatment provider
11 licensed by the Department of Human Services or to a licensed
12 hospital which provides substance abuse treatment services.
13 The Department of Healthcare and Family Services shall assure
14 coverage for the cost of treatment of the drug abuse or
15 addiction for pregnant recipients in accordance with the
16 Illinois Medicaid Program in conjunction with the Department of
17 Human Services.

18 All medical providers providing medical assistance to
19 pregnant women under this Code shall receive information from
20 the Department on the availability of services under the Drug
21 Free Families with a Future or any comparable program providing
22 case management services for addicted women, including
23 information on appropriate referrals for other social services
24 that may be needed by addicted women in addition to treatment
25 for addiction.

26 The Illinois Department, in cooperation with the

1 Departments of Human Services (as successor to the Department
2 of Alcoholism and Substance Abuse) and Public Health, through a
3 public awareness campaign, may provide information concerning
4 treatment for alcoholism and drug abuse and addiction, prenatal
5 health care, and other pertinent programs directed at reducing
6 the number of drug-affected infants born to recipients of
7 medical assistance.

8 Neither the Department of Healthcare and Family Services
9 nor the Department of Human Services shall sanction the
10 recipient solely on the basis of her substance abuse.

11 The Illinois Department shall establish such regulations
12 governing the dispensing of health services under this Article
13 as it shall deem appropriate. The Department should seek the
14 advice of formal professional advisory committees appointed by
15 the Director of the Illinois Department for the purpose of
16 providing regular advice on policy and administrative matters,
17 information dissemination and educational activities for
18 medical and health care providers, and consistency in
19 procedures to the Illinois Department.

20 Notwithstanding any other provision of law, a health care
21 provider under the medical assistance program may elect, in
22 lieu of receiving direct payment for services provided under
23 that program, to participate in the State Employees Deferred
24 Compensation Plan adopted under Article 24 of the Illinois
25 Pension Code. A health care provider who elects to participate
26 in the plan does not have a cause of action against the State

1 for any damages allegedly suffered by the provider as a result
2 of any delay by the State in crediting the amount of any
3 contribution to the provider's plan account.

4 The Illinois Department may develop and contract with
5 Partnerships of medical providers to arrange medical services
6 for persons eligible under Section 5-2 of this Code.
7 Implementation of this Section may be by demonstration projects
8 in certain geographic areas. The Partnership shall be
9 represented by a sponsor organization. The Department, by rule,
10 shall develop qualifications for sponsors of Partnerships.
11 Nothing in this Section shall be construed to require that the
12 sponsor organization be a medical organization.

13 The sponsor must negotiate formal written contracts with
14 medical providers for physician services, inpatient and
15 outpatient hospital care, home health services, treatment for
16 alcoholism and substance abuse, and other services determined
17 necessary by the Illinois Department by rule for delivery by
18 Partnerships. Physician services must include prenatal and
19 obstetrical care. The Illinois Department shall reimburse
20 medical services delivered by Partnership providers to clients
21 in target areas according to provisions of this Article and the
22 Illinois Health Finance Reform Act, except that:

23 (1) Physicians participating in a Partnership and
24 providing certain services, which shall be determined by
25 the Illinois Department, to persons in areas covered by the
26 Partnership may receive an additional surcharge for such

1 services.

2 (2) The Department may elect to consider and negotiate
3 financial incentives to encourage the development of
4 Partnerships and the efficient delivery of medical care.

5 (3) Persons receiving medical services through
6 Partnerships may receive medical and case management
7 services above the level usually offered through the
8 medical assistance program.

9 Medical providers shall be required to meet certain
10 qualifications to participate in Partnerships to ensure the
11 delivery of high quality medical services. These
12 qualifications shall be determined by rule of the Illinois
13 Department and may be higher than qualifications for
14 participation in the medical assistance program. Partnership
15 sponsors may prescribe reasonable additional qualifications
16 for participation by medical providers, only with the prior
17 written approval of the Illinois Department.

18 Nothing in this Section shall limit the free choice of
19 practitioners, hospitals, and other providers of medical
20 services by clients. In order to ensure patient freedom of
21 choice, the Illinois Department shall immediately promulgate
22 all rules and take all other necessary actions so that provided
23 services may be accessed from therapeutically certified
24 optometrists to the full extent of the Illinois Optometric
25 Practice Act of 1987 without discriminating between service
26 providers.

1 The Department shall apply for a waiver from the United
2 States Health Care Financing Administration to allow for the
3 implementation of Partnerships under this Section.
4 The Illinois Department shall require health care
5 providers to maintain records that document the medical care
6 and services provided to recipients of Medical Assistance under
7 this Article. The Illinois Department shall require health care
8 providers to make available, when authorized by the patient, in
9 writing, the medical records in a timely fashion to other
10 health care providers who are treating or serving persons
11 eligible for Medical Assistance under this Article. All
12 dispensers of medical services shall be required to maintain
13 and retain business and professional records sufficient to
14 fully and accurately document the nature, scope, details and
15 receipt of the health care provided to persons eligible for
16 medical assistance under this Code, in accordance with
17 regulations promulgated by the Illinois Department. The rules
18 and regulations shall require that proof of the receipt of
19 prescription drugs, dentures, prosthetic devices and
20 eyeglasses by eligible persons under this Section accompany
21 each claim for reimbursement submitted by the dispenser of such
22 medical services. No such claims for reimbursement shall be
23 approved for payment by the Illinois Department without such
24 proof of receipt, unless the Illinois Department shall have put
25 into effect and shall be operating a system of post-payment
26 audit and review which shall, on a sampling basis, be deemed

adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after the effective date of this amendatory Act of 1984, the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

The rules and regulations of the Illinois Department shall require that a written statement including the required opinion of a physician shall accompany any claim for reimbursement for abortions, or induced miscarriages or premature births. This statement shall indicate what procedures were used in providing such medical services.

The Illinois Department shall require all dispensers of medical services, other than an individual practitioner or group of practitioners, desiring to participate in the Medical Assistance program established under this Article to disclose all financial, beneficial, ownership, equity, surety or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services in this State under this Article.

1 The Illinois Department may require that all dispensers of
2 medical services desiring to participate in the medical
3 assistance program established under this Article disclose,
4 under such terms and conditions as the Illinois Department may
5 by rule establish, all inquiries from clients and attorneys
6 regarding medical bills paid by the Illinois Department, which
7 inquiries could indicate potential existence of claims or liens
8 for the Illinois Department.

9 Enrollment of a vendor that provides non-emergency medical
10 transportation, defined by the Department by rule, shall be
11 conditional for 180 days. During that time, the Department of
12 Healthcare and Family Services may terminate the vendor's
13 eligibility to participate in the medical assistance program
14 without cause. That termination of eligibility is not subject
15 to the Department's hearing process.

16 The Illinois Department shall establish policies,
17 procedures, standards and criteria by rule for the acquisition,
18 repair and replacement of orthotic and prosthetic devices and
19 durable medical equipment. Such rules shall provide, but not be
20 limited to, the following services: (1) immediate repair or
21 replacement of such devices by recipients without medical
22 authorization; and (2) rental, lease, purchase or
23 lease-purchase of durable medical equipment in a
24 cost-effective manner, taking into consideration the
25 recipient's medical prognosis, the extent of the recipient's
26 needs, and the requirements and costs for maintaining such

1 equipment. Such rules shall enable a recipient to temporarily
2 acquire and use alternative or substitute devices or equipment
3 pending repairs or replacements of any device or equipment
4 previously authorized for such recipient by the Department.

5 The Department shall execute, relative to the nursing home
6 prescreening project, written inter-agency agreements with the
7 Department of Human Services and the Department on Aging, to
8 effect the following: (i) intake procedures and common
9 eligibility criteria for those persons who are receiving
10 non-institutional services; and (ii) the establishment and
11 development of non-institutional services in areas of the State
12 where they are not currently available or are undeveloped.

13 The Illinois Department shall develop and operate, in
14 cooperation with other State Departments and agencies and in
15 compliance with applicable federal laws and regulations,
16 appropriate and effective systems of health care evaluation and
17 programs for monitoring of utilization of health care services
18 and facilities, as it affects persons eligible for medical
19 assistance under this Code.

20 The Illinois Department shall report annually to the
21 General Assembly, no later than the second Friday in April of
22 1979 and each year thereafter, in regard to:

23 (a) actual statistics and trends in utilization of
24 medical services by public aid recipients;

25 (b) actual statistics and trends in the provision of
26 the various medical services by medical vendors;

(c) current rate structures and proposed changes in those rate structures for the various medical vendors; and

(d) efforts at utilization review and control by the Illinois Department.

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall include suggested legislation for consideration by the General Assembly. The filing of one copy of the report with the Speaker, one copy with the Minority Leader and one copy with the Clerk of the House of Representatives, one copy with the President, one copy with the Minority Leader and one copy with the Secretary of the Senate, one copy with the Legislative Research Unit, and such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act shall be deemed sufficient to comply with this Section.

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. 95-331, eff. 8-21-07; 95-520, eff. 8-28-07; 95-1045, eff. 3-27-09; 96-156, eff. 1-1-10; 96-806, eff. 7-1-10; 96-926, eff. 1-1-11; 96-1000, eff. 7-2-10.)

1 Section 45. The Radiation Protection Act of 1990 is amended
2 by changing Section 5 as follows:

3 (420 ILCS 40/5) (from Ch. 111 1/2, par. 210-5)
4 (Section scheduled to be repealed on January 1, 2021)
5 Sec. 5. Limitations on application of radiation to human
6 beings and requirements for radiation installation operators
7 providing mammography services.
8 (a) No person shall intentionally administer radiation to a
9 human being unless such person is licensed to practice a
10 treatment of human ailments by virtue of the Illinois Medical,
11 Dental or Podiatric Medical Practice Acts, or, as physician
12 assistant, advanced practice nurse, technician, nurse, or
13 other assistant, is acting under the supervision, prescription
14 or direction of such licensed person. However, no such
15 physician assistant, advanced practice nurse, technician,
16 nurse, or other assistant acting under the supervision of a
17 person licensed under the Medical Practice Act of 1987, shall
18 administer radiation to human beings unless accredited by the
19 Agency, except that persons enrolled in a course of education
20 approved by the Agency may apply ionizing radiation to human
21 beings as required by their course of study when under the
22 direct supervision of a person licensed under the Medical
23 Practice Act of 1987. No person authorized by this Section to
24 apply ionizing radiation shall apply such radiation except to

those parts of the human body specified in the Act under which such person or his supervisor is licensed. No person may operate a radiation installation where ionizing radiation is administered to human beings unless all persons who administer ionizing radiation in that radiation installation are licensed, accredited, or exempted in accordance with this Section. Nothing in this Section shall be deemed to relieve a person from complying with the provisions of Section 10.

(b) In addition, no person shall provide mammography services unless all of the following requirements are met:

(1) the mammography procedures are performed using a radiation machine that is specifically designed for mammography;

(2) the mammography procedures are performed using a radiation machine that is used solely for performing mammography procedures;

(3) the mammography procedures are performed using equipment that has been subjected to a quality assurance program that satisfies quality assurance requirements which the Agency shall establish by rule;

(4) beginning one year after the effective date of this amendatory Act of 1991, if the mammography procedure is performed by a radiologic technologist, that technologist, in addition to being accredited by the Agency to perform radiography, has satisfied training requirements specific to mammography, which the Agency shall establish by rule.

1 (c) Every operator of a radiation installation at which
2 mammography services are provided shall ensure and have
3 confirmed by each mammography patient that the patient is
4 provided with a pamphlet which is orally reviewed with the
5 patient and which contains the following:
6 (1) how to perform breast self-examination;
7 (2) that early detection of breast cancer is maximized
8 through a combined approach, using monthly breast
9 self-examination, a thorough physical examination
10 performed by a physician, and mammography performed at
11 recommended intervals;
12 (3) that mammography is the most accurate method for
13 making an early detection of breast cancer, however, no
14 diagnostic tool is 100% effective;
15 (4) that if the patient is self-referred and does not
16 have a primary care physician, or if the patient is
17 unfamiliar with the breast examination procedures, that
18 the patient has received information regarding public
19 health services where she can obtain a breast examination
20 and instructions.
21 (d) Each facility that performs mammograms shall upon
22 request by or on behalf of the patient permanently or
23 temporarily transfer the original mammograms and copies of the
24 patient's reports to a medical institution or to a physician or
25 health care provider of the patient or to the patient directly
26 without charge to the patient. Such a transfer must be done

1 within 2 weeks after the request or within one week if the
2 patient has already had a mammogram that shows potential
3 abnormality. Transfer may not be delayed as a means of debt
4 collection.
5 (Source: P.A. 93-149, eff. 7-10-03; 94-104, eff. 7-1-05.)

1 INDEX

2 Statutes amended in order of appearance

3	5 ILCS 375/6.11	
4	55 ILCS 5/5-1069.3	
5	65 ILCS 5/10-4-2.3	
6	105 ILCS 5/10-22.3f	
7	215 ILCS 5/356z.19 new	
8	215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2
9	215 ILCS 165/10	from Ch. 32, par. 604
10	305 ILCS 5/5-5	from Ch. 23, par. 5-5
11	420 ILCS 40/5	from Ch. 111 1/2, par. 210-5