Rep. Greg Harris

Filed: 3/3/2011

1 AMENDMENT TO HOUSE BILL 1191

2 AMENDMENT NO. ______. Amend House Bill 1191 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, 356z.13,
15 356z.14, 356z.15, ~~and~~ 356z.17, 356z.19, and 364.01 of the
16 Illinois Insurance Code. The program of health benefits must

1 comply with Section 155.37 of the Illinois Insurance Code.
2 Rulemaking authority to implement Public Act 95-1045, if
3 any, is conditioned on the rules being adopted in accordance
4 with all provisions of the Illinois Administrative Procedure
5 Act and all rules and procedures of the Joint Committee on
6 Administrative Rules; any purported rule not so adopted, for
7 whatever reason, is unauthorized.
8 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
9 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff.
10 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1044,
11 eff. 3-26-09; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10;
12 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10;
13 96-1000, eff. 7-2-10.)

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

16 (55 ILCS 5/5-1069.3)
17 Sec. 5-1069.3. Required health benefits. If a county,
18 including a home rule county, is a self-insurer for purposes of
19 providing health insurance coverage for its employees, the
20 coverage shall include coverage for the post-mastectomy care
21 benefits required to be covered by a policy of accident and
22 health insurance under Section 356t and the coverage required
23 under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x,
24 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,

1 356z.14, ~~and~~ 356z.15, 356z.19, and 364.01 of the Illinois
2 Insurance Code. The requirement that health benefits be covered
3 as provided in this Section is an exclusive power and function
4 of the State and is a denial and limitation under Article VII,
5 Section 6, subsection (h) of the Illinois Constitution. A home
6 rule county to which this Section applies must comply with
7 every provision of this Section.

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

14 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
15 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff.
16 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045,
17 eff. 3-27-09; 95-1049, eff. 1-1-10; 96-139, eff. 1-1-10;
18 96-328, eff. 8-11-09; 96-1000, eff. 7-2-10.)

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

21 (65 ILCS 5/10-4-2.3)

22 Sec. 10-4-2.3. Required health benefits. If a
23 municipality, including a home rule municipality, is a
24 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, 356z.19, and 364.01 of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this 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 municipality 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 20. The School Code is amended by changing Section 10-22.3f as follows:

1 (105 ILCS 5/10-22.3f)
2 Sec. 10-22.3f. Required health benefits. Insurance
3 protection and benefits for employees shall provide the
4 post-mastectomy care benefits required to be covered by a
5 policy of accident and health insurance under Section 356t and
6 the coverage required under Sections 356g, 356g.5, 356g.5-1,
7 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12,
8 356z.13, 356z.14, ~~and~~ 356z.15, 356z.19, and 364.01 of the
9 Illinois Insurance Code.
10 Rulemaking authority to implement Public Act 95-1045, if
11 any, is conditioned on the rules being adopted in accordance
12 with all provisions of the Illinois Administrative Procedure
13 Act and all rules and procedures of the Joint Committee on
14 Administrative Rules; any purported rule not so adopted, for
15 whatever reason, is unauthorized.
16 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
17 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;
18 95-1005, 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff.
19 1-1-10; 96-139, eff. 1-1-10; 96-328, eff. 8-11-09; 96-1000,
20 eff. 7-2-10.)

21 Section 25. The Illinois Insurance Code is amended by
22 changing Section 364.01 and by adding Section 356z.19 as
23 follows:

1 (215 ILCS 5/356z.19 new)
2 Sec. 356z.19. Routine patient care.
3 (a) For the purposes of this Section, the term "qualified
4 individual" means an individual who is a participant or
5 beneficiary in a health plan or with coverage described in
6 paragraph (1) of subsection (c) and who meets the following
7 conditions:
8 (1) the individual is eligible to participate in an
9 approved clinical trial according to the trial protocol
10 with respect to treatment of cancer or other
11 life-threatening disease or condition; and
12 (2) either:
13 (A) the referring health care professional is a
14 participating health care provider and has concluded
15 that the individual's participation in such trial
16 would be appropriate based upon the individual meeting
17 the conditions described in paragraph (1) of this
18 subsection; or
19 (B) the participant or beneficiary provides
20 medical and scientific information establishing that
21 the individual's participation in such trial would be
22 appropriate based upon the individual meeting the
23 conditions described in paragraph (1) of this
24 subsection.
25 (b) For the purposes of this Section, the term
26 "life-threatening condition" or "life-threatening disease"

1 means any condition or disease from which the likelihood of
2 death is probable unless the course of the disease or condition
3 is interrupted.
4 (c) Coverage for routine patient care must comply with the
5 following provisions:
6 (1) If a group health plan or a health insurance issuer
7 offering group or individual health insurance coverage
8 provides coverage to a qualified individual, then such plan
9 or issuer:
10 (A) may not deny the individual participation in
11 the clinical trial referred to in subsection (a) of
12 this Section;
13 (B) subject to subsection (d) of this Section, may
14 not deny or limit or impose additional conditions on
15 the coverage of routine patient care costs for items
16 and services furnished in connection with
17 participation in the trial; and
18 (C) may not discriminate against the individual on
19 the basis of the individual's participation in the
20 trial.
21 (2) The following provisions concerning routine
22 patient costs shall apply:
23 (A) For purposes of and, subject to subparagraph
24 (B) of paragraph (1) of this subsection, routine
25 patient care costs include all items and services
26 consistent with the coverage provided in the plan or

1 coverage that is typically provided for a qualified
2 individual who is not enrolled in a clinical trial.
3 (B) For purposes of subparagraph (B) of paragraph
4 (1) of this subsection, routine patient care costs do
5 not include the following:
6 (i) the investigational item, device, or
7 service itself;
8 (ii) items and services that are provided
9 solely to satisfy data collection and analysis
10 needs and that are not used in the direct clinical
11 management of the patient; or
12 (iii) a service that is clearly inconsistent
13 with widely accepted and established standards of
14 care for a particular diagnosis.
15 (3) If one or more participating providers are
16 participating in a clinical trial, then nothing in
17 paragraph (1) of this subsection shall be construed as
18 preventing a plan or issuer from requiring that a qualified
19 individual participate in the trial through a
20 participating provider if the provider will accept the
21 individual as a participant in the trial.
22 (4) Notwithstanding paragraph (3) of this subsection,
23 paragraph (1) shall apply to a qualified individual
24 participating in an approved clinical trial that is
25 conducted outside the state in which the qualified
26 individual resides.

1 (d) This Section shall not be construed to require a group
2 health plan or a health insurance issuer offering group or
3 individual health insurance coverage to provide benefits for
4 routine patient care services provided outside of the plan's or
5 coverage's health care provider network unless out-of-network
6 benefits are otherwise provided under the plan or coverage.
7 (e) The following provisions concerning approved clinical
8 trials shall apply:
9 (1) In this Section, the term "approved clinical trial"
10 means a phase I, phase II, phase III, or phase IV clinical
11 trial that is conducted in relation to the prevention,
12 detection, or treatment of cancer or other
13 life-threatening disease or condition and is described in
14 any of the following provisions:
15 (A) The study or investigation is approved or
16 funded (which may include funding through in-kind
17 contributions) by one or more of the following:
18 (i) The National Institutes of Health.
19 (ii) The Centers for Disease Control and
20 Prevention.
21 (iii) The Agency for Health Care Research and
22 Quality.
23 (iv) The Centers for Medicare and Medicaid
24 Services.
25 (v) A cooperative group or center of any of the
26 entities described in items (i) through (iv) of

1 this subparagraph or the U.S. Department of
2 Defense or Department of Veterans Affairs.
3 (vi) A qualified non-governmental research
4 entity identified in the guidelines issued by the
5 National Institutes of Health for center support
6 grants.
7 (vii) Any of the following if the conditions
8 described in paragraph (2) of this subsection are
9 met:
10 (I) The U.S. Department of Veterans
11 Affairs.
12 (II) The U.S. Department of Defense.
13 (III) The U.S. Department of Energy.
14 (B) The study or investigation is conducted under
15 an investigational new drug application reviewed by
16 the U.S. Food and Drug Administration.
17 (C) The study or investigation is a drug trial that
18 is exempt from having such an investigational new drug
19 application.
20 (2) A study or investigation under item (1)(A)(vii) of
21 this subsection is subject to the condition that it must be
22 reviewed and approved through a system of peer review that:
23 (A) is comparable to the system of peer review of
24 studies and investigations used by the National
25 Institutes of Health; and
26 (B) ensures unbiased review of the highest

1 scientific standard by qualified individuals who have
2 no interest in the outcome of the review.
3 (f) Nothing in this Section shall be construed to limit a
4 plan's or issuer's coverage with respect to clinical trials.

5 (215 ILCS 5/364.01)
6 Sec. 364.01. Qualified clinical cancer trials.
7 (a) No individual or group policy of accident and health
8 insurance issued or renewed in this State may be cancelled or
9 non-renewed for any individual based on that individual's
10 participation in a qualified clinical cancer trial.
11 (b) Qualified clinical cancer trials must meet the
12 following criteria:
13 (1) the effectiveness of the treatment has not been
14 determined relative to established therapies;
15 (2) the trial is under clinical investigation as part
16 of an approved cancer research trial in Phase II, Phase
17 III, or Phase IV of investigation;
18 (3) the trial is:
19 (A) approved by the Food and Drug Administration;
20 or
21 (B) approved and funded by the National Institutes
22 of Health, the Centers for Disease Control and
23 Prevention, the Agency for Healthcare Research and
24 Quality, the United States Department of Defense, the
25 United States Department of Veterans Affairs, or the

1 United States Department of Energy in the form of an
2 investigational new drug application, or a cooperative
3 group or center of any entity described in this
4 subdivision (B); and
5 (4) the patient's primary care physician, if any, is
6 involved in the coordination of care.
7 (c) No group policy of accident and health insurance shall
8 exclude coverage for any routine patient care administered to
9 an insured who is a qualified individual participating in a
10 qualified clinical cancer trial if the policy covers that same
11 routine patient care of insureds not enrolled in a qualified
12 clinical cancer trial.
13 (d) The coverage that may not be excluded under subsection
14 (c) of this Section is subject to all terms, conditions,
15 restrictions, exclusions, and limitations that apply to the
16 same routine patient care received by an insured not enrolled
17 in a qualified clinical cancer trial, including the application
18 of any authorization requirement, utilization review, or
19 medical management practices. The insured or enrollee shall
20 incur no greater out-of-pocket liability than had the insured
21 or enrollee not enrolled in a qualified clinical cancer trial.
22 (e) If the group policy of accident and health insurance
23 uses a preferred provider program and a preferred provider
24 provides routine patient care in connection with a qualified
25 clinical cancer trial, then the insurer may require the insured
26 to use the preferred provider if the preferred provider agrees

1 to provide to the insured that routine patient care.
2 (f) A qualified clinical cancer trial may not pay or refuse
3 to pay for routine patient care of a individual participating
4 in the trial, based in whole or in part on the person's having
5 or not having coverage for routine patient care under a group
6 policy of accident and health insurance.
7 (g) Nothing in this Section shall be construed to limit an
8 insurer's coverage with respect to clinical trials.
9 (h) Nothing in this Section shall require coverage for
10 out-of-network services where the underlying health benefit
11 plan does not provide coverage for out-of-network services.
12 (i) As used in this Section, "routine patient care" means
13 all health care services provided in the qualified clinical
14 cancer trial that are otherwise generally covered under the
15 policy if those items or services were not provided in
16 connection with a qualified clinical cancer trial consistent
17 with the standard of care for the treatment of cancer,
18 including the type and frequency of any diagnostic modality,
19 that a provider typically provides to a cancer patient who is
20 not enrolled in a qualified clinical cancer trial. "Routine
21 patient care" does not include, and a group policy of accident
22 and health insurance may exclude, coverage for:
23 (1) a health care service, item, or drug that is the
24 subject of the cancer clinical trial;
25 (2) a health care service, item, or drug provided
26 solely to satisfy data collection and analysis needs for

1 the qualified clinical cancer trial that is not used in the
2 direct clinical management of the patient;
3 (3) an investigational drug or device that has not been
4 approved for market by the United States Food and Drug
5 Administration;
6 (4) transportation, lodging, food, or other expenses
7 for the patient or a family member or companion of the
8 patient that are associated with the travel to or from a
9 facility providing the qualified clinical cancer trial,
10 unless the policy covers these expenses for a cancer
11 patient who is not enrolled in a qualified clinical cancer
12 trial;
13 (5) a health care service, item, or drug customarily
14 provided by the qualified clinical cancer trial sponsors
15 free of charge for any patient;
16 (6) a health care service or item that, except for the
17 fact that it is being provided in a qualified clinical
18 cancer trial, is otherwise specifically excluded from
19 coverage under the insured's policy, including:
20 (A) costs of extra treatments, services,
21 procedures, tests, or drugs that would not be performed
22 or administered except for the fact that the insured is
23 participating in the cancer clinical trial; and
24 (B) costs of nonhealth care services that the
25 patient is required to receive as a result of
26 participation in the approved cancer clinical trial;

1 (7) costs for services, items, or drugs that are
2 eligible for reimbursement from a source other than a
3 patient's contract or policy providing for third-party
4 payment or prepayment of health or medical expenses,
5 including the sponsor of the approved cancer clinical
6 trial; or
7 (8) costs associated with approved cancer clinical
8 trials designed exclusively to test toxicity or disease
9 pathophysiology, unless the policy covers these expenses
10 for a cancer patient who is not enrolled in a qualified
11 clinical cancer trial; or
12 (9) a health care service or item that is eligible for
13 reimbursement by a source other than the insured's policy,
14 including the sponsor of the qualified clinical cancer
15 trial.
16 The definitions of the terms "health care services",
17 "Non-Preferred Provider", "Preferred Provider", and "Preferred
18 Provider Program", stated in 50 IL Adm. Code Part 2051
19 Preferred Provider Programs apply to these terms in this
20 Section.
21 (j) The external review procedures established under the
22 Health Carrier External Review Act shall apply to the
23 provisions under this Section.
24 (Source: P.A. 93-1000, eff. 1-1-05.)

25 Section 30. The Health Maintenance Organization Act is

1 amended by changing Section 5-3 as follows:

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

substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

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

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

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

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

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

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be

acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

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

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

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

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

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

1 account the refund period and the immediately preceding 2
2 plan years.
3 The Health Maintenance Organization shall include a
4 statement in the evidence of coverage issued to each enrollee
5 describing the possibility of a refund or additional premium,
6 and upon request of any group or enrollment unit, provide to
7 the group or enrollment unit a description of the method used
8 to calculate (1) the Health Maintenance Organization's
9 profitable experience with respect to the group or enrollment
10 unit and the resulting refund to the group or enrollment unit
11 or (2) the Health Maintenance Organization's unprofitable
12 experience with respect to the group or enrollment unit and the
13 resulting additional premium to be paid by the group or
14 enrollment unit.
15 In no event shall the Illinois Health Maintenance
16 Organization Guaranty Association be liable to pay any
17 contractual obligation of an insolvent organization to pay any
18 refund authorized under this Section.
19 (g) Rulemaking authority to implement Public Act 95-1045,
20 if any, is conditioned on the rules being adopted in accordance
21 with all provisions of the Illinois Administrative Procedure
22 Act and all rules and procedures of the Joint Committee on
23 Administrative Rules; any purported rule not so adopted, for
24 whatever reason, is unauthorized.
25 (Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07;
26 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; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; 96-833, eff. 6-1-10; 96-1000, eff. 7-2-10.)

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

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

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

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

(Source: P.A. 95-189, eff. 8-16-07; 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.

1 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005,
2 eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10;
3 96-328, eff. 8-11-09; 96-833, eff. 6-1-10; 96-1000, eff.
4 7-2-10.)

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

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

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

1 wilful and wanton manner upon a woman who was not pregnant at
2 the time such abortion procedure was performed. The term "any
3 other type of remedial care" shall include nursing care and
4 nursing home service for persons who rely on treatment by
5 spiritual means alone through prayer for healing.

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

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

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

26 (1) dental services provided by or under the

1 supervision of a dentist; and
2 (2) eyeglasses prescribed by a physician skilled in the
3 diseases of the eye, or by an optometrist, whichever the
4 person may select.
5 Notwithstanding any other provision of this Code and
6 subject to federal approval, the Department may adopt rules to
7 allow a dentist who is volunteering his or her service at no
8 cost to render dental services through an enrolled
9 not-for-profit health clinic without the dentist personally
10 enrolling as a participating provider in the medical assistance
11 program. A not-for-profit health clinic shall include a public
12 health clinic or Federally Qualified Health Center or other
13 enrolled provider, as determined by the Department, through
14 which dental services covered under this Section are performed.
15 The Department shall establish a process for payment of claims
16 for reimbursement for covered dental services rendered under
17 this provision.
18 Notwithstanding any other provision of this Code, the
19 Illinois Department shall ensure that cancer patients in need
20 of dental treatment prior to the administration of chemotherapy
21 have access to such dental services and shall ensure that
22 treatment is not delayed due to an inability to locate a
23 provider willing to accept the Department's rates. The
24 Department shall ensure that healthcare providers treating
25 such patients, including medical oncologists, cancer centers,
26 and cancer advocacy organizations, are aware of the mechanisms

available to the Department to ensure such access.

The Illinois Department shall develop a mechanism whereby mammography providers may download a standing order via the Internet for screening mammography for any woman eligible for mammography coverage who has not had a screening mammogram within the last 12 months. This mechanism shall be available for all women covered by any program administered by this State that includes mammography coverage.

The Illinois Department, by rule, may distinguish and classify the medical services to be provided only in accordance with the classes of persons designated in Section 5-2.

The Department of Healthcare and Family Services must provide coverage and reimbursement for amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

The Illinois Department shall authorize the provision of, and shall authorize payment for, screening by low-dose mammography for the presence of occult breast cancer for women 35 years of age or older who are eligible for medical assistance under this Article, as follows:

(A) A baseline mammogram for women 35 to 39 years of age.

(B) An annual mammogram for women 40 years of age or

1 older.

2 (C) A mammogram at the age and intervals considered
3 medically necessary by the woman's health care provider for
4 women under 40 years of age and having a family history of
5 breast cancer, prior personal history of breast cancer,
6 positive genetic testing, or other risk factors.

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

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

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

26 The Department shall convene an expert panel including

representatives of hospitals, free-standing mammography 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 be outside the metropolitan Chicago area. An evaluation of the pilot program shall be carried out measuring health outcomes and cost of care for those served by the pilot program compared to similarly situated patients who are not served by the pilot program.

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

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

for addiction.

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

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

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

Notwithstanding any other provision of law, a health care provider under the medical assistance program may elect, in lieu of receiving direct payment for services provided under that program, to participate in the State Employees Deferred Compensation Plan adopted under Article 24 of the Illinois

Pension Code. A health care provider who elects to participate in the plan does not have a cause of action against the State for any damages allegedly suffered by the provider as a result of any delay by the State in crediting the amount of any contribution to the provider's plan account.

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

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

(1) Physicians participating in a Partnership and providing certain services, which shall be determined by

1 the Illinois Department, to persons in areas covered by the
2 Partnership may receive an additional surcharge for such
3 services.

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

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

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

20 Nothing in this Section shall limit the free choice of
21 practitioners, hospitals, and other providers of medical
22 services by clients. In order to ensure patient freedom of
23 choice, the Illinois Department shall immediately promulgate
24 all rules and take all other necessary actions so that provided
25 services may be accessed from therapeutically certified
26 optometrists to the full extent of the Illinois Optometric

Practice Act of 1987 without discriminating between service providers.

The Department shall apply for a waiver from the United States Health Care Financing Administration to allow for the implementation of Partnerships under this Section.

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put

1 into effect and shall be operating a system of post-payment
2 audit and review which shall, on a sampling basis, be deemed
3 adequate by the Illinois Department to assure that such drugs,
4 dentures, prosthetic devices and eyeglasses for which payment
5 is being made are actually being received by eligible
6 recipients. Within 90 days after the effective date of this
7 amendatory Act of 1984, the Illinois Department shall establish
8 a current list of acquisition costs for all prosthetic devices
9 and any other items recognized as medical equipment and
10 supplies reimbursable under this Article and shall update such
11 list on a quarterly basis, except that the acquisition costs of
12 all prescription drugs shall be updated no less frequently than
13 every 30 days as required by Section 5-5.12.
14 The rules and regulations of the Illinois Department shall
15 require that a written statement including the required opinion
16 of a physician shall accompany any claim for reimbursement for
17 abortions, or induced miscarriages or premature births. This
18 statement shall indicate what procedures were used in providing
19 such medical services.
20 The Illinois Department shall require all dispensers of
21 medical services, other than an individual practitioner or
22 group of practitioners, desiring to participate in the Medical
23 Assistance program established under this Article to disclose
24 all financial, beneficial, ownership, equity, surety or other
25 interests in any and all firms, corporations, partnerships,
26 associations, business enterprises, joint ventures, agencies,

institutions or other legal entities providing any form of health care services in this State under this Article.

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

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

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients without medical authorization; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the

recipient's medical prognosis, the extent of the recipient's needs, and the requirements and costs for maintaining such equipment. Such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department.

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

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

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

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

1 (b) actual statistics and trends in the provision of
2 the various medical services by medical vendors;
3 (c) current rate structures and proposed changes in
4 those rate structures for the various medical vendors; and
5 (d) efforts at utilization review and control by the
6 Illinois Department.
7 The period covered by each report shall be the 3 years
8 ending on the June 30 prior to the report. The report shall
9 include suggested legislation for consideration by the General
10 Assembly. The filing of one copy of the report with the
11 Speaker, one copy with the Minority Leader and one copy with
12 the Clerk of the House of Representatives, one copy with the
13 President, one copy with the Minority Leader and one copy with
14 the Secretary of the Senate, one copy with the Legislative
15 Research Unit, and such additional copies with the State
16 Government Report Distribution Center for the General Assembly
17 as is required under paragraph (t) of Section 7 of the State
18 Library Act shall be deemed sufficient to comply with this
19 Section.
20 Rulemaking authority to implement Public Act 95-1045, if
21 any, is conditioned on the rules being adopted in accordance
22 with all provisions of the Illinois Administrative Procedure
23 Act and all rules and procedures of the Joint Committee on
24 Administrative Rules; any purported rule not so adopted, for
25 whatever reason, is unauthorized.
26 (Source: P.A. 95-331, eff. 8-21-07; 95-520, eff. 8-28-07;

1 95-1045, eff. 3-27-09; 96-156, eff. 1-1-10; 96-806, eff.
2 7-1-10; 96-926, eff. 1-1-11; 96-1000, eff. 7-2-10.)

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

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

Practice Act of 1987. No person authorized by this Section to 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.

(c) Every operator of a radiation installation at which mammography services are provided shall ensure and have confirmed by each mammography patient that the patient is provided with a pamphlet which is orally reviewed with the patient and which contains the following:

(1) how to perform breast self-examination;

(2) that early detection of breast cancer is maximized through a combined approach, using monthly breast self-examination, a thorough physical examination performed by a physician, and mammography performed at recommended intervals;

(3) that mammography is the most accurate method for making an early detection of breast cancer, however, no diagnostic tool is 100% effective;

(4) that if the patient is self-referred and does not have a primary care physician, or if the patient is unfamiliar with the breast examination procedures, that the patient has received information regarding public health services where she can obtain a breast examination and instructions.

(d) Each facility that performs mammograms shall upon request by or on behalf of the patient permanently or temporarily transfer the original mammograms and copies of the patient's reports to a medical institution or to a physician or

1 health care provider of the patient or to the patient directly
2 without charge to the patient. Such a transfer must be done
3 within 2 weeks after the request or within one week if the
4 patient has already had a mammogram that shows potential
5 abnormality. Transfer may not be delayed as a means of debt
6 collection.
7 (Source: P.A. 93-149, eff. 7-10-03; 94-104, eff. 7-1-05.)".