

1 AN ACT concerning regulation.

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

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

6 (215 ILCS 125/1-2) (from Ch. 111 1/2, par. 1402)

7 Sec. 1-2. Definitions. As used in this Act, unless the
8 context otherwise requires, the following terms shall have the
9 meanings ascribed to them:

10 (1) "Advertisement" means any printed or published
11 material, audiovisual material and descriptive literature of
12 the health care plan used in direct mail, newspapers,
13 magazines, radio scripts, television scripts, billboards and
14 similar displays; and any descriptive literature or sales aids
15 of all kinds disseminated by a representative of the health
16 care plan for presentation to the public including, but not
17 limited to, circulars, leaflets, booklets, depictions,
18 illustrations, form letters and prepared sales presentations.

19 (2) "Director" means the Director of Insurance.

20 (3) "Basic health care services" means emergency care, and
21 inpatient hospital and physician care, outpatient medical
22 services, mental health services and care for alcohol and drug
23 abuse, including any reasonable deductibles and co-payments,

1 all of which are subject to the limitations described in
2 Section 4-20 of this Act and as determined by the Director
3 pursuant to rule.

4 (4) "Enrollee" means an individual who has been enrolled in
5 a health care plan.

6 (5) "Evidence of coverage" means any certificate,
7 agreement, or contract issued to an enrollee setting out the
8 coverage to which he is entitled in exchange for a per capita
9 prepaid sum.

10 (6) "Group contract" means a contract for health care
11 services which by its terms limits eligibility to members of a
12 specified group.

13 (7) "Health care plan" means any arrangement whereby any
14 organization undertakes to provide or arrange for and pay for
15 or reimburse the cost of basic health care services, excluding
16 any reasonable deductibles and copayments, from providers
17 selected by the Health Maintenance Organization and such
18 arrangement consists of arranging for or the provision of such
19 health care services, as distinguished from mere
20 indemnification against the cost of such services, except as
21 otherwise authorized by Section 2-3 of this Act, on a per
22 capita prepaid basis, through insurance or otherwise. A "health
23 care plan" also includes any arrangement whereby an
24 organization undertakes to provide or arrange for or pay for or
25 reimburse the cost of any health care service for persons who
26 are enrolled under Article V of the Illinois Public Aid Code or

1 under the Children's Health Insurance Program Act through
2 providers selected by the organization and the arrangement
3 consists of making provision for the delivery of health care
4 services, as distinguished from mere indemnification. A
5 "health care plan" also includes any arrangement pursuant to
6 Section 4-17. Nothing in this definition, however, affects the
7 total medical services available to persons eligible for
8 medical assistance under the Illinois Public Aid Code.

9 (8) "Health care services" means any services included in
10 the furnishing to any individual of medical or dental care, or
11 the hospitalization or incident to the furnishing of such care
12 or hospitalization as well as the furnishing to any person of
13 any and all other services for the purpose of preventing,
14 alleviating, curing or healing human illness or injury.

15 (9) "Health Maintenance Organization" means any
16 organization formed under the laws of this or another state to
17 provide or arrange for one or more health care plans under a
18 system which causes any part of the risk of health care
19 delivery to be borne by the organization or its providers.

20 (10) "Net worth" means admitted assets, as defined in
21 Section 1-3 of this Act, minus liabilities.

22 (11) "Organization" means any insurance company, a
23 nonprofit corporation authorized under the Dental Service Plan
24 Act or the Voluntary Health Services Plans Act, or a
25 corporation organized under the laws of this or another state
26 for the purpose of operating one or more health care plans and

1 doing no business other than that of a Health Maintenance
2 Organization or an insurance company. "Organization" shall
3 also mean the University of Illinois Hospital as defined in the
4 University of Illinois Hospital Act.

5 (12) "Provider" means any physician, hospital facility, or
6 facility or long-term care facility as those terms are defined
7 in the Nursing Home Care Act or other person which is licensed
8 or otherwise authorized to furnish health care services and
9 also includes any other entity that arranges for the delivery
10 or furnishing of health care service.

11 (13) "Producer" means a person directly or indirectly
12 associated with a health care plan who engages in solicitation
13 or enrollment.

14 (14) "Per capita prepaid" means a basis of prepayment by
15 which a fixed amount of money is prepaid per individual or any
16 other enrollment unit to the Health Maintenance Organization or
17 for health care services which are provided during a definite
18 time period regardless of the frequency or extent of the
19 services rendered by the Health Maintenance Organization,
20 except for copayments and deductibles and except as provided in
21 subsection (f) of Section 5-3 of this Act.

22 (15) "Subscriber" means a person who has entered into a
23 contractual relationship with the Health Maintenance
24 Organization for the provision of or arrangement of at least
25 basic health care services to the beneficiaries of such
26 contract.

1 (Source: P.A. 97-1148, eff. 1-24-13.)

2 Section 10. The Managed Care Reform and Patient Rights Act
3 is amended by changing Section 10 as follows:

4 (215 ILCS 134/10)

5 Sec. 10. Definitions:

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

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

14 "Department" means the Department of Insurance.

15 "Emergency medical condition" means a medical condition
16 manifesting itself by acute symptoms of sufficient severity
17 (including, but not limited to, severe pain) such that a
18 prudent layperson, who possesses an average knowledge of health
19 and medicine, could reasonably expect the absence of immediate
20 medical attention to result in:

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

24 (2) serious impairment to bodily functions; or

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

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

9 "Emergency services" means, with respect to an enrollee of
10 a health care plan, transportation services, including but not
11 limited to ambulance services, and covered inpatient and
12 outpatient hospital services furnished by a provider qualified
13 to furnish those services that are needed to evaluate or
14 stabilize an emergency medical condition. "Emergency services"
15 does not refer to post-stabilization medical services.

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

18 "Health care plan" means a plan that establishes, operates,
19 or maintains a network of health care providers that has
20 entered into an agreement with the plan to provide health care
21 services to enrollees to whom the plan has the ultimate
22 obligation to arrange for the provision of or payment for
23 services through organizational arrangements for ongoing
24 quality assurance, utilization review programs, or dispute
25 resolution. Nothing in this definition shall be construed to
26 mean that an independent practice association or a physician

1 hospital organization that subcontracts with a health care plan
2 is, for purposes of that subcontract, a health care plan.

3 For purposes of this definition, "health care plan" shall
4 not include the following:

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

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

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

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

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

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

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

25 "Health care provider" means any physician, hospital
26 facility, long-term care facility as defined in Section 1-113

1 of the Nursing Home Care Act, or other person that is licensed
2 or otherwise authorized to deliver health care services.
3 Nothing in this Act shall be construed to define Independent
4 Practice Associations or Physician-Hospital Organizations as
5 health care providers.

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

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

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

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

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

1 "Stabilization" means, with respect to an emergency
2 medical condition, to provide such medical treatment of the
3 condition as may be necessary to assure, within reasonable
4 medical probability, that no material deterioration of the
5 condition is likely to result.

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

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

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

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