AN ACT concerning regulation.

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

Section 5. The Managed Care Reform and Patient Rights Act is amended by changing Section 10 as follows:

(215 ILCS 134/10)

Sec. 10. Definitions. In this Act:

For a health care plan under Section 45 or for a utilization review program under Section 85, "adverse determination" has the meaning given to that term in Section 10 of the Health Carrier External Review Act.

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

"Department" means the Department of Insurance.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, regardless of the final diagnosis given, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual (or, with

respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) inadequately controlled pain; or

(5) with respect to a pregnant woman who is having contractions:

(A) inadequate time to complete a safe transfer to another hospital before delivery; or

(B) a transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

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

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

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

"Generally accepted standards of care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties for the illness, injury, or condition or its symptoms and comorbidities. Valid, evidence-based sources reflecting generally accepted standards of care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

"Health care plan" means a plan, including, but not limited to, a health maintenance organization, a managed care community network as defined in the Illinois Public Aid Code, or an accountable care entity as defined in the Illinois Public Aid Code that receives capitated payments to cover medical services from the Department of Healthcare and Family Services, that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational

arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that subcontracts with a health care plan is, for purposes of that subcontract, a health care plan.

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

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

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

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

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

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

(6) except with respect to subsections (a) and (b) of Section 65 and subsection (a-5) of Section 70, not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999 that are affiliated with a union and that only extend coverage to union members and their

dependents; and.

(7) any intergovernmental joint self-insurance pool providing health benefits under Section 6 of the Intergovernmental Cooperation Act.

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

"Health care provider" means any physician, hospital facility, facility licensed under the Nursing Home Care Act, long-term care facility as defined in Section 1-113 of the Nursing Home Care Act, or other person that is licensed or otherwise authorized to deliver health care services. Nothing in this Act shall be construed to define Independent Practice Associations or Physician-Hospital Organizations as health care providers.

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

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

"Medically necessary" means that a service or product addresses the specific needs of a patient for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, or condition or its symptoms and comorbidities, including minimizing the progression of an illness, injury, or condition or its symptoms and comorbidities, in a manner that is all of the following:

(1) in accordance with generally accepted standards of care;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for the economic benefit of the health care plan, purchaser, or utilization review organization~~,~~ or for the convenience of the patient, treating physician, or other health care provider.

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

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

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

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

"Step therapy requirement" means a utilization review or formulary requirement that specifies, as a condition of coverage under a health care plan, the order in which certain health care services must be used to treat or manage an enrollee's health condition.

"Step therapy requirement" does not include:

(1) utilization review to identify when a treatment or health care service is contraindicated or clinically appropriate or to limit quantity or dosage for an enrollee based on utilization review criteria consistent with generally accepted standards of care developed in accordance with Section 87 of this Act;

(2) the removal of a drug from a formulary or changing the drug's preferred or cost-sharing tier to higher cost sharing;

(3) use of the medical exceptions process under Section 45.1 of this Act; any decision during a medical exceptions process based on cost is step therapy and prohibited;

(4) a requirement to obtain prior authorization for the requested treatment; or

(5) for health care plans operated or overseen by the Department of Healthcare and Family Services, including Medicaid managed care plans, any utilization controls mandated by 42 CFR 456.703 or a preferred drug list as described in Section 5-30.14 of the Illinois Public Aid Code.

"Utilization review" means the evaluation, including any evaluation based on an algorithmic automated process, of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

"Utilization review" includes either of the following:

(1) prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based, in whole or in part, on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services before, retrospectively, or concurrently with the provision of health care services to enrollees; or

(2) evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care plan is covered as medically necessary for an enrollee.

"Utilization review criteria" means criteria, standards,

protocols, or guidelines used by a utilization review program to conduct utilization review to ensure that a patient's care is aligned with generally accepted standards of care and consistent with State law.

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

(Source: P.A. 102-409, eff. 1-1-22; 103-426, eff. 8-4-23; 103-650, eff. 1-1-25; 103-656, eff. 1-1-25; revised 11-26-24.)

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