Rep. Mary E. Flowers

Filed: 3/4/2015

AMENDMENT TO HOUSE BILL 122

AMENDMENT NO. _____. Amend House Bill 122 by replacing everything after the enacting clause with the following:

"Section 5. 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, 356z.15, ~~and~~ 356z.22, 356z.23, 356z.24, and 356z.25 of the Illinois Insurance Code. The coverage shall comply with

Sections 155.22a, 355b, 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. 97-282, eff. 8-9-11; 97-343, eff. 1-1-12; 97-813, eff. 7-13-12; 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15.)

Section 10. 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, 356z.15, ~~and~~ 356z.22, 356z.23, 356z.24, and 356z.25 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, and 356z.19 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. 97-282, eff. 8-9-11; 97-343, eff. 1-1-12; 97-813, eff. 7-13-12; 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15.)

Section 15. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide 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.11, 356z.12, 356z.13, 356z.14, 356z.15, ~~and~~ 356z.22, 356z.23, and 356z.24 of the Illinois Insurance Code. Insurance policies shall comply with Section 356z.19 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a and 355b 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. 97-282, eff. 8-9-11; 97-343, eff. 1-1-12; 97-813, eff. 7-13-12; 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15.)

Section 20. The Emergency Medical Treatment Act is amended by changing Section 1 as follows:

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

Sec. 1. No hospital, physician, dentist or other provider of professional health care licensed under the laws of this State may refuse to provide needed emergency treatment to any person whose life would be threatened in the absence of such

treatment, because of that person's inability to pay therefor, nor because of the source of any payment promised therefor. Every hospital licensed under the Hospital Licensing Act shall comply with the Hospital Emergency Service Act.

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

Section 25. The Hospital Emergency Service Act is amended by changing Section 1 as follows:

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

Sec. 1. Every hospital required to be licensed by the Department of Public Health pursuant to the Hospital Licensing Act which provides general medical and surgical hospital services~~, except long term acute care hospitals and rehabilitation hospitals identified in Section 1.3 of this Act,~~ shall provide a hospital emergency service in accordance with rules and regulations adopted by the Department of Public Health which shall be consistent with the federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd) and ~~shall furnish such hospital emergency services to any applicant who applies for the same in case of injury or acute medical condition where the same is liable to cause death or severe injury or serious illness. For purposes of this Act, "applicant" includes any person who is brought to a hospital by ambulance or specialized emergency medical services vehicle as defined in~~ the Emergency Medical Services (EMS) Systems Act.

(Source: P.A. 97-667, eff. 1-13-12; 98-683, eff. 6-30-14.)

Section 30. The Illinois Insurance Code is amended by adding Sections 356z.23, 356z.24, and 356z.25 as follows:

(215 ILCS 5/356z.23 new)

Sec. 356z.23. Intravenous feeding. A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 99th General Assembly must provide coverage for intravenous feeding. The benefits under this Section shall be at least as favorable as for other coverages under the policy and may be subject to the same dollar amount limits, deductibles, and co-insurance requirements applicable generally to other coverages under the policy.

(215 ILCS 5/356z.24 new)

Sec. 356z.24. Prescription nutritional supplements. A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 99th General Assembly that provides coverage for prescription drugs must provide coverage for reimbursement for medically appropriate prescription nutritional supplements when ordered by a physician licensed to practice medicine in all its branches and

the insured suffers from a condition that prevents him or her from taking sufficient oral nourishment to sustain life.

(215 ILCS 5/356z.25 new)

Sec. 356z.25. Hospital patient assessments. A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 99th General Assembly that provides coverage for hospital care shall include in that coverage all services ordered by a physician and provided in the hospital that are considered medically necessary for the evaluation, assessment, and diagnosis of the illness or condition that resulted in the hospital stay of the enrollee or recipient. Such services are subject to reasonable review and utilization standards required by the policy or plan for all hospital services, as defined by the Department of Insurance or its successor agency.

Section 35. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154,

154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2, 355.3, 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 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.17, 356z.18, 356z.19, 356z.21, 356z.22, 356z.23, 356z.24, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

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

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

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

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents 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.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or

other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

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

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium,

and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

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

(g) 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. 97-282, eff. 8-9-11; 97-343, eff. 1-1-12; 97-437, eff. 8-18-11; 97-486, eff. 1-1-12; 97-592, eff. 1-1-12; 97-805, eff. 1-1-13; 97-813, eff. 7-13-12; 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15.)

Section 40. 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, 136, 139, 140, 143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b, 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, 356z.21, 356z.22, 356z.23, 356z.24, 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. 97-282, eff. 8-9-11; 97-343, eff. 1-1-12; 97-486, eff. 1-1-12; 97-592, eff. 1-1-12; 97-805, eff. 1-1-13; 97-813, eff. 7-13-12; 98-189, eff. 1-1-14; 98-1091, eff. 1-1-15.)

Section 45. The Health Carrier External Review Act is amended by changing Section 35 and by adding Sections 25.1,

25.2, 25.3, 25.4, 25.5, and 25.6 as follows:

(215 ILCS 180/25.1 new)

Sec. 25.1. Standard information for application forms.

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

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

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

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

established pursuant to subsection (a).

(e) On and after January 1, 2015, all individual health care service plan applications shall be reviewed and approved by the Director before they may be used by a health care service plan.

(215 ILCS 180/25.2 new)

Sec. 25.2. Medical underwriting.

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

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

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

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

(c) A health care service plan shall adopt and implement written medical underwriting policies and procedures to ensure that the health care service plan does all of the following

with respect to an application for health care coverage:

(1) Reviews all of the following:

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

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

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

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

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

(e) On or before January 1, 2015, a health care service plan shall file its medical underwriting policies and procedures with the Department.

(215 ILCS 180/25.3 new)

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

(a) Within 10 business days after issuing a health care service plan contract, the health care service plan shall send

a copy of the completed written application to the applicant with a copy of the health care service plan contract issued by the health care service plan, along with a notice that states all of the following:

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

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

(3) The applicant should retain a copy of the completed written application for the applicant's records.

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

(215 ILCS 180/25.4 new)

Sec. 25.4. Rescission; cancellation.

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

(1) There was a material misrepresentation or material omission in the information submitted by the applicant in

the written application to the health care service plan prior to the issuance of the health care service plan contract that would have prevented the contract from being entered into.

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

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

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

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

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

(215 ILCS 180/25.5 new)

Sec. 25.5. Postcontract investigation.

(a) If a health care service plan obtains information after issuing an individual health care service plan contract that

the subscriber or enrollee may have intentionally omitted or intentionally misrepresented material information during the application for coverage process, then the health care service plan may investigate the potential omissions or misrepresentations in order to determine whether the subscriber's or enrollee's health care service plan contract may be rescinded or canceled.

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

(1) Upon initiating a postcontract issuance investigation for potential rescission or cancellation of health care coverage, the plan shall provide a written notice to the enrollee or subscriber by regular and certified mail that it has initiated an investigation of intentional material misrepresentation or intentional material omission on the part of the enrollee or subscriber and that the investigation could lead to the rescission or cancellation of the enrollee's or subscriber's health care service plan contract. The notice shall be provided by the health care service plan within 5 days of the initiation of the investigation.

(2) The written notice required under item (1) of this subsection (b) shall include full disclosure of the allegedly intentional material omission or misrepresentation and a clear and concise explanation of why the information has resulted in the health care service

plan's initiation of an investigation to determine whether rescission or cancellation is warranted. The notice shall invite the enrollee or subscriber to provide any evidence or information within 45 business days to negate the plan's reasons for initiating the postissuance investigation.

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

(4) Upon completion of its postissuance investigation, the plan shall provide written notice by regular and certified mail to the subscriber or enrollee that it has concluded its investigation and has made one of the following determinations:

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

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

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

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

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

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

(D) Provide a statement that the health care service plan's proposed decision to cancel or rescind the health care service plan contract shall not become effective unless the Department's independent review organization upholds the health care service plan's decision or unless the enrollee or subscriber has opted

out of the independent review.

(215 ILCS 180/25.6 new)

Sec. 25.6. Continuation.

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

(b) The effective date of the health care service plan's cancellation or the date upon which the plan may initiate a rescission shall be no earlier than the date that the enrollee or subscriber receives notification via regular and certified mail that the independent review organization has made a determination upholding the health care service plan's decision to rescind or cancel.

(215 ILCS 180/35)

Sec. 35. Standard external review.

(a) Within 4 months after the date of receipt of a notice of an adverse determination or final adverse determination, a covered person or the covered person's authorized representative may file a request for an external review with the Director. Within one business day after the date of receipt of a request for external review, the Director shall send a copy of the request to the health carrier.

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

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

(2) the health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but the health carrier has determined that the health care service is not covered;

(3) the covered person has exhausted the health carrier's internal appeal process unless the covered person is not required to exhaust the health carrier's internal appeal process pursuant to this Act;

(4) (blank); and

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

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

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

(2) is not eligible for external review, the health carrier shall inform the Director and covered person and, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for its ineligibility.

The Department may specify the form for the health carrier's notice of initial determination under this subsection (c) and any supporting information to be included in the notice.

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

Notwithstanding a health carrier's initial determination that the request is ineligible for external review, the Director may determine that a request is eligible for external review and require that it be referred for external review. In making such determination, the Director's decision shall be in accordance with the terms of the covered person's health

benefit plan, unless such terms are inconsistent with applicable law, and shall be subject to all applicable provisions of this Act.

(d) Whenever the Director receives notice that a request is eligible for external review following the preliminary review conducted pursuant to this Section, within one business day after the date of receipt of the notice, the Director shall:

(1) assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director pursuant to this Act and notify the health carrier of the name of the assigned independent review organization; and

(2) notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review and the name of the independent review organization.

The Director shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may, within 5 business days following the date of receipt of the notice provided pursuant to item (2) of this subsection (d), submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to,

but may, accept and consider additional information submitted after 5 business days.

(e) The assignment by the Director of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those independent review organizations approved by the Director pursuant to this Act.

(f) Within 5 business days after the date of receipt of the notice provided pursuant to item (1) of subsection (d) of this Section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination; in such cases, the following provisions shall apply:

(1) Except as provided in item (2) of this subsection (f), failure by the health carrier or its utilization review organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.

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

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

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

(h) Upon receipt of any information submitted by the covered person or the covered person's authorized representative, the independent review organization shall forward the information to the health carrier within 1 business day.

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

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination shall

not delay or terminate the external review.

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

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

(B) Upon notice from the health carrier that the health carrier has made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

(i) In addition to the documents and information provided by the health carrier or its utilization review organization and the covered person and the covered person's authorized representative, if any, the independent review organization, to the extent the information or documents are available and the independent review organization considers them

appropriate, shall consider the following in reaching a decision:

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

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

(3) consulting reports from appropriate health care providers and other documents submitted by the health carrier or its designee utilization review organization, the covered person, the covered person's authorized representative, or the covered person's treating provider;

(4) the terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier, unless the terms are inconsistent with applicable law;

(5) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

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

(7) the opinion of the independent review organization's clinical reviewer or reviewers after

considering items (1) through (6) of this subsection (i) to the extent the information or documents are available and the clinical reviewer or reviewers considers the information or documents appropriate; and

(8) (blank).

(j) Within 5 days after the date of receipt of all necessary information, but in no event more than 45 days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the Director, the health carrier, the covered person, and, if applicable, the covered person's authorized representative. In reaching a decision, the assigned independent review organization is not bound by any claim determinations reached prior to the submission of information to the independent review organization. The assigned independent review organization shall independently determine if the health care services under review are the medically necessary health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and are: (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient's

illness, injury, or disease; and (iii) not primarily for the convenience of the patient, physician, or other health care provider. For the purposes of this subsection (j), "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of physicians practicing in relevant clinical areas and any other relevant factors. In such cases, the following provisions shall apply:

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

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

(B) the date the independent review organization received the assignment from the Director to conduct the external review;

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

(D) references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision;

(E) the date of its decision;

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

decision; and

(G) the rationale for its decision.

(2) (Blank).

(3) (Blank).

(4) Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

(Source: P.A. 96-857, eff. 7-1-10; 96-967, eff. 1-1-11; 97-574, eff. 8-26-11.)

Section 50. The Illinois Public Aid Code is amended by changing Section 5-16.8 as follows:

(305 ILCS 5/5-16.8)

Sec. 5-16.8. Required health benefits. The medical assistance program shall (i) provide 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.5, 356u, 356w, 356x, ~~and~~ 356z.6, and 356z.25 of the Illinois Insurance Code and (ii) be subject to the provisions of Sections 356z.19 and 364.01 of the Illinois Insurance Code.

On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter

any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

(Source: P.A. 97-282, eff. 8-9-11; 97-689, eff. 6-14-12.)

Section 55. The Medical Patient Rights Act is amended by changing Sections 2.04 and 3 and by adding Section 2.06 as follows:

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

Sec. 2.04. "Insurance company" means (1) an insurance company, fraternal benefit society, and any other insurer subject to regulation under the Illinois Insurance Code; or (2) a health maintenance organization, a limited health service organization under the Limited Health Service Organization Act, or a voluntary health services plan under the Voluntary Health Services Plans Act.

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

(410 ILCS 50/2.06 new)

Sec. 2.06. Health insurance policy or health care plan. "Health insurance policy or health care plan" means any policy of health or accident insurance provided by a health insurance company or under the Counties Code, or the Illinois Municipal Code or medical assistance provided under the Illinois Public Aid Code.

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

Sec. 3. The following rights are hereby established:

(a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law. Each patient has a right to be informed of his or her inpatient or outpatient status while undergoing evaluation, assessment, diagnosis, treatment, or observation in a hospital. The patient must be informed of this status and put on notice that this admission status may affect coverage by his or her health insurance policy or health care plan or his or her personal responsibility for payment.

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

(c) In the event an insurance company or health services corporation cancels or refuses to renew an individual policy or

plan, the insured patient shall be entitled to timely, prior notice of the termination of such policy or plan.

An insurance company or health services corporation that requires any insured patient or applicant for new or continued insurance or coverage to be tested for infection with human immunodeficiency virus (HIV) or any other identified causative agent of acquired immunodeficiency syndrome (AIDS) shall (1) give the patient or applicant prior written notice of such requirement, (2) proceed with such testing only upon the written authorization of the applicant or patient, and (3) keep the results of such testing confidential. Notice of an adverse underwriting or coverage decision may be given to any appropriately interested party, but the insurer may only disclose the test result itself to a physician designated by the applicant or patient, and any such disclosure shall be in a manner that assures confidentiality.

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

(d) The right of each patient to privacy and confidentiality in health care. Each physician, health care provider, health services corporation and insurance company shall refrain from disclosing the nature or details of services provided to patients, except that such information may be disclosed: (1) to the patient, (2) to the party making treatment decisions if the patient is incapable of making decisions regarding the health services provided, (3) for

treatment in accordance with 45 CFR 164.501 and 164.506, (4) for payment in accordance with 45 CFR 164.501 and 164.506, (5) to those parties responsible for peer review, utilization review, and quality assurance, (6) for health care operations in accordance with 45 CFR 164.501 and 164.506, (7) to those parties required to be notified under the Abused and Neglected Child Reporting Act or the Illinois Sexually Transmissible Disease Control Act, or (8) as otherwise permitted, authorized, or required by State or federal law. This right may be waived in writing by the patient or the patient's guardian or legal representative, but a physician or other health care provider may not condition the provision of services on the patient's, guardian's, or legal representative's agreement to sign such a waiver. In the interest of public health, safety, and welfare, patient information, including, but not limited to, health information, demographic information, and information about the services provided to patients, may be transmitted to or through a health information exchange, as that term is defined in Section 2 of the Mental Health and Developmental Disabilities Confidentiality Act, in accordance with the disclosures permitted pursuant to this Section. Patients shall be provided the opportunity to opt out of their health information being transmitted to or through a health information exchange in accordance with the regulations, standards, or contractual obligations adopted by the Illinois Health Information Exchange Authority in accordance with

Section 9.6 of the Mental Health and Developmental Disabilities Confidentiality Act, Section 9.6 of the AIDS Confidentiality Act, or Section 31.8 of the Genetic Information Privacy Act, as applicable. In the case of a patient choosing to opt out of having his or her information available on an HIE, nothing in this Act shall cause the physician or health care provider to be liable for the release of a patient's health information by other entities that may possess such information, including, but not limited to, other health professionals, providers, laboratories, pharmacies, hospitals, ambulatory surgical centers, and nursing homes.

(Source: P.A. 98-1046, eff. 1-1-15.)

Section 90. The State Mandates Act is amended by adding Section 8.39 as follows:

(30 ILCS 805/8.39 new)

Sec. 8.39. Exempt mandate. Notwithstanding Sections 6 and 8 of this Act, no reimbursement by the State is required for the implementation of any mandate created by this amendatory Act of the 99th General Assembly.

(210 ILCS 80/1.3 rep.)

Section 95. The Hospital Emergency Service Act is amended by repealing Section 1.3.

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