HB3833

LRB10009858SMS20028b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB3833

by Rep. Dan Brady

SYNOPSIS AS INTRODUCED:

105 ILCS 145/10	
215 ILCS 5/512-7	from Ch. 73, par. 1065.59-7
215 ILCS 125/1-2	from Ch. 111 1/2, par. 1402
215 ILCS 130/1002	from Ch. 73, par. 1501-2
215 ILCS 134/10	
215 ILCS 165/2	from Ch. 32, par. 596
770 ILCS 23/5	

Amends the Care of Students with Diabetes Act, the Illinois Insurance Code, the Health Maintenance Organization Act, the Limited Health Service Organization Act, the Managed Care Reform and Patient Rights Act, the Voluntary Health Services Plans Act, and the Health Care Services Lien Act to add pharmacy or pharmacist-provided services to the types of health services under the Acts and to add pharmacists as health care providers or health care professionals under the Acts. Effective January 1, 2018.

LRB100 09858 SMS 20028 b

A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Care of Students with Diabetes Act is amended by changing Section 10 as follows:

(105 ILCS 145/10)

Sec. 10. Definitions. As used in this Act:

"Delegated care aide" means a school employee who has agreed to receive training in diabetes care and to assist students in implementing their diabetes care plan and has entered into an agreement with a parent or guardian and the school district or private school.

"Diabetes care plan" means a document that specifies the diabetes-related services needed by a student at school and at school-sponsored activities and identifies the appropriate staff to provide and supervise these services.

"Health care provider" means a physician licensed to practice medicine in all of its branches, advanced practice nurse who has a written agreement with a collaborating physician who authorizes the provision of diabetes care, ~~or a~~ physician assistant who has a written supervision agreement with a supervising physician who authorizes the provision of diabetes care, or pharmacist licensed to practice pharmacy.

"Principal" means the principal of the school.

"School" means any primary or secondary public, charter, or private school located in this State.

"School employee" means a person who is employed by a public school district or private school, a person who is employed by a local health department and assigned to a school, or a person who contracts with a school or school district to perform services in connection with a student's diabetes care plan. This definition must not be interpreted as requiring a school district or private school to hire additional personnel for the sole purpose of serving as a designated care aide.

(Source: P.A. 96-1485, eff. 12-1-10.)

Section 10. The Illinois Insurance Code is amended by changing Section 512-7 as follows:

(215 ILCS 5/512-7) (from Ch. 73, par. 1065.59-7)

Sec. 512-7. Contractual provisions.

(a) Any agreement or contract entered into in this State between the entity ~~administrator of a program~~ and a pharmacy or pharmacist shall include a statement of the method and amount of reimbursement to the pharmacy or pharmacist for services rendered to persons enrolled in the program, the frequency of payment by the program administrator to the pharmacy or pharmacist for those services, and a method for the adjudication of complaints and the settlement of disputes

between the contracting parties.

(b)(1) A program shall provide an annual period of at least 30 days during which any pharmacy or pharmacist licensed under the Pharmacy Practice Act may elect to participate in the program under the program terms for at least one year.

(2) If compliance with the requirements of this subsection (b) would impair any provision of a contract between a program and any other person, and if the contract provision was in existence before January 1, 1990, then immediately after the expiration of those contract provisions the program shall comply with the requirements of this subsection (b).

(3) This subsection (b) does not apply if:

(A) the program administrator is a licensed health maintenance organization that owns or controls a pharmacy and that enters into an agreement or contract with that pharmacy in accordance with subsection (a); or

(B) the program administrator is a licensed health maintenance organization that is owned or controlled by another entity that also owns or controls a pharmacy, and the administrator enters into an agreement or contract with that pharmacy in accordance with subsection (a).

(4) This subsection (b) shall be inoperative after October 31, 1992.

(c) The entity ~~program administrator~~ shall cause to be issued an identification card to each person enrolled in the program. The identification card shall include:

(1) the name of the individual enrolled in the program; and

(2) an expiration date if required under the contractual arrangement or agreement between a provider of pharmaceutical services and prescription drug products and the entity ~~third party prescription program administrator~~.

(Source: P.A. 95-689, eff. 10-29-07.)

Section 15. The Health Maintenance Organization Act is amended by changing Section 1-2 as follows:

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

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

(1) "Advertisement" means any printed or published material, audiovisual material and descriptive literature of the health care plan used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards and similar displays; and any descriptive literature or sales aids of all kinds disseminated by a representative of the health care plan for presentation to the public including, but not limited to, circulars, leaflets, booklets, depictions,

illustrations, form letters and prepared sales presentations.

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

(3) "Basic health care services" means emergency care, and inpatient hospital and physician care, outpatient medical services, mental health services and care for alcohol and drug abuse, including any reasonable deductibles and co-payments, all of which are subject to the limitations described in Section 4-20 of this Act and as determined by the Director pursuant to rule.

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

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

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

(7) "Health care plan" means any arrangement whereby any organization undertakes to provide or arrange for and pay for or reimburse the cost of basic health care services, excluding any reasonable deductibles and copayments, from providers selected by the Health Maintenance Organization and such arrangement consists of arranging for or the provision of such health care services, as distinguished from mere indemnification against the cost of such services, except as

otherwise authorized by Section 2-3 of this Act, on a per capita prepaid basis, through insurance or otherwise. A "health care plan" also includes any arrangement whereby an organization undertakes to provide or arrange for or pay for or reimburse the cost of any health care service for persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act through providers selected by the organization and the arrangement consists of making provision for the delivery of health care services, as distinguished from mere indemnification. A "health care plan" also includes any arrangement pursuant to Section 4-17. Nothing in this definition, however, affects the total medical services available to persons eligible for medical assistance under the Illinois Public Aid Code.

(8) "Health care services" means any services included in the furnishing to any individual of medical care, ~~or~~ dental care, pharmacist-provided services or the hospitalization or incident to the furnishing of such care or hospitalization 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.

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

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

(11) "Organization" means any insurance company, a nonprofit corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act, or a corporation organized under the laws of this or another state for the purpose of operating one or more health care plans and doing no business other than that of a Health Maintenance Organization or an insurance company. "Organization" shall also mean the University of Illinois Hospital as defined in the University of Illinois Hospital Act or a unit of local government health system operating within a county with a population of 3,000,000 or more.

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

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

(14) "Per capita prepaid" means a basis of prepayment by which a fixed amount of money is prepaid per individual or any other enrollment unit to the Health Maintenance Organization or

for health care services which are provided during a definite time period regardless of the frequency or extent of the services rendered by the Health Maintenance Organization, except for copayments and deductibles and except as provided in subsection (f) of Section 5-3 of this Act.

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

(Source: P.A. 98-651, eff. 6-16-14; 98-841, eff. 8-1-14; 99-78, eff. 7-20-15.)

Section 20. The Limited Health Service Organization Act is amended by changing Section 1002 as follows:

(215 ILCS 130/1002) (from Ch. 73, par. 1501-2)

Sec. 1002. Definitions. As used in this Act, unless the context otherwise requires, the following terms shall have the meanings ascribed to them:

"Advertisement" means any printed or published material, audiovisual material and descriptive literature of the limited health care plan used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards and similar displays; and any descriptive literature or sales aids of all kinds disseminated by a representative of the limited health

care plan for presentation to the public including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, form letters and prepared sales presentations.

"Copayment" means the amount that an enrollee must pay in order to receive a specific service that is not fully prepaid.

"Director" means the Director of Insurance.

"Enrollee" means an individual who has been enrolled in a limited health care plan.

"Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting out the coverage to which that enrollee is entitled in exchange for a per capita prepaid sum.

"Group contract" means a contract for limited health services which by its terms limits eligibility to members of a specified group.

"In-plan covered services" means covered limited health services obtained from providers who are employed by, under contract with, referred by, or otherwise affiliated with the LHSO and emergency services.

"Limited health care plan" means any arrangement whereby an organization undertakes to provide or arrange for and, pay for or reimburse the cost of any limited health services from providers selected by the limited health service organization and such arrangement consists of arranging for or the provision of such limited health services on a per capita prepaid basis, as distinguished from mere indemnification against the cost of

such limited services on a per capita prepaid basis through insurance except as otherwise provided under Section 3009.

"Limited health service" means ambulance care services, dental care services, vision care services, pharmaceutical services, pharmacist-provided services, clinical laboratory services, and podiatric care services. Limited health service shall not include hospital, medical, surgical or emergency services except when those services are essential to the delivery of the limited health service. Essential hospital, medical, surgical, or emergency services shall be covered unless specifically excluded.

"Limited health service organization" (LHSO) means any organization formed under the laws of this or another state to provide or arrange for one or more limited health care plans under a system which causes any part of the risk of limited health care delivery to be borne by the organization or its providers.

"Net worth" means admitted assets, as defined in Section 1003 of this Act, minus liabilities.

"Organization" means any insurance company or other corporation organized under the laws of this or another state for the purpose of operating one or more limited health care plans and doing no business other than that of a health maintenance organization or a limited health service organization or an insurance company. Organization does not include (1) any entity otherwise authorized on the effective

date of this Act pursuant to the laws of this State either to provide any limited health service on a prepayment basis or to indemnity for any limited health service; nor does it include (2) any provider or other entity when providing or arranging for the provision of limited health services pursuant to a contract with a limited health service organization or with any entity described in (1) of this definition.

"Out-of-plan covered services" means non-emergency, self-referred covered limited health services obtained from providers who are not otherwise employed by, under contract with, or otherwise affiliated with the LHSO or services obtained without a referral from providers who have contracted to provide limited health services to the enrollee on behalf of the limited health care plan.

"Point-of-service product" (POS) means a group contract that includes both in-plan covered services and out-of-plan covered services as well as a POS contract in which the risk for out-of-plan covered services is borne through reinsurance. This term does not apply to indemnity benefits offered through an LHSO that are underwritten in whole by a licensed insurance carrier and offered in conjunction with the LHSO benefit package.

"Provider" means any physician, dentist, <u>pharmacist,</u> health facility, or other person or institution which is duly licensed or otherwise authorized to deliver or furnish limited health services and also includes any other entity that

arranges for the delivery or furnishing of limited health service.

"Per capita prepaid" means a basis of payment by which a fixed amount of money is prepaid per individual or any other enrollment unit to the limited health service organization or for limited health services which are provided during a definite time period regardless of the frequency or extent of the services rendered, except for copayments of a fixed amount by the limited health service organization.

"Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an organization authorized to provide or arrange for such services under this Act.

"Uncovered expense" means the cost of limited health services that are the obligation of a limited health service organization for which an enrollee may be liable in the event of the insolvency of the organization. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, shall be considered covered expenses.

(Source: P.A. 87-1079; 88-568, eff. 8-5-94; 88-667, eff. 9-16-94.)

Section 25. The Managed Care Reform and Patient Rights Act is amended by changing Section 10 as follows:

(215 ILCS 134/10)

Sec. 10. Definitions.

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

"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 (including, but not limited to, severe pain) 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; or

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

"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.

"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) 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.

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

health care services.

"Health care provider" means any physician, pharmacist, 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 or pharmacist 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 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.

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

"Pharmacist" has the meaning given to that term in the Pharmacy Practice Act.

"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.

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

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

(Source: P.A. 98-651, eff. 6-16-14; 98-841, eff. 8-1-14; 99-78, eff. 7-20-15.)

Section 30. The Voluntary Health Services Plans Act is amended by changing Sections 2 and 7 as follows:

(215 ILCS 165/2) (from Ch. 32, par. 596)

Sec. 2. For the purposes of this Act, the following terms have the respective meanings set forth in this section, unless different meanings are plainly indicated by the context:

(a) "Health Services Plan Corporation" means a corporation organized under the terms of this Act for the purpose of establishing and operating a voluntary health services plan and providing other medically related services.

(b) "Voluntary health services plan" means either a plan or system under which medical, hospital, nursing and relating health services may be rendered to a subscriber or beneficiary at the expense of a health services plan corporation, or any contractual arrangement to provide, either directly or through arrangements with others, dental care services to subscribers and beneficiaries.

(c) "Subscriber" means a natural person to whom a subscription certificate has been issued by a health services plan corporation. Persons eligible under Section 5-2 of the Illinois Public Aid Code may be subscribers if a written agreement exists, as specified in Section 25 of this Act, between the Health Services Plan Corporation and the Department of Healthcare and Family Services. A subscription certificate may be issued to such persons at no cost.

(d) "Beneficiary" means a person designated in a subscription certificate as one entitled to receive health services.

(e) "Health services" means those services ordinarily rendered by physicians licensed in Illinois to practice medicine in all of its branches, by podiatric physicians licensed in Illinois to practice podiatric medicine, by

dentists and dental surgeons licensed to practice in Illinois, by nurses registered in Illinois, by dental hygienists licensed to practice in Illinois, by pharmacists licensed in Illinois to practice pharmacy, and by assistants and technicians acting under professional supervision; it likewise means hospital services as usually and customarily rendered in Illinois, and the compounding and dispensing of drugs and medicines by pharmacists and assistant pharmacists registered in Illinois.

(f) "Subscription certificate" means a certificate issued to a subscriber by a health services plan corporation, setting forth the terms and conditions upon which health services shall be rendered to a subscriber or a beneficiary.

(g) "Physician rendering service for a plan" means a physician licensed in Illinois to practice medicine in all of its branches who has undertaken or agreed, upon terms and conditions acceptable both to himself and to the health services plan corporation involved, to furnish medical service to the plan's subscribers and beneficiaries.

(h) "Dentist or dental surgeon rendering service for a plan" means a dentist or dental surgeon licensed in Illinois to practice dentistry or dental surgery who has undertaken or agreed, upon terms and conditions acceptable both to himself and to the health services plan corporation involved, to furnish dental or dental surgical services to the plan's subscribers and beneficiaries.

(i) "Director" means the Director of Insurance of the State

of Illinois.

(j) "Person" means any of the following: a natural person, corporation, partnership or unincorporated association.

(k) "Podiatric physician or podiatric surgeon rendering service for a plan" means any podiatric physician or podiatric surgeon licensed in Illinois to practice podiatry, who has undertaken or agreed, upon terms and conditions acceptable both to himself and to the health services plan corporation involved, to furnish podiatric or podiatric surgical services to the plan's subscribers and beneficiaries.

(l) "Pharmacist rendering service for a plan" means a pharmacist licensed in Illinois to practice pharmacy who has undertaken or agreed, upon terms and conditions acceptable both to the pharmacist and to the health services plan corporation involved, to furnish pharmacy and pharmacist-provided service to the plan's subscribers and beneficiaries.

(Source: P.A. 98-214, eff. 8-9-13.)

Section 35. The Health Care Services Lien Act is amended by changing Section 5 as follows:

(770 ILCS 23/5)

Sec. 5. Definitions. In this Act:

"Health care professional" means any individual in any of the following license categories: licensed physician, licensed dentist, licensed optometrist, licensed naprapath, licensed

clinical psychologist, ~~or~~ licensed physical therapist, or licensed pharmacist.

"Health care provider" means any entity in any of the following license categories: licensed hospital, licensed home health agency, licensed ambulatory surgical treatment center, licensed long-term care facilities, ~~or~~ licensed emergency medical services personnel, or licensed pharmacy.

This amendatory Act of the 94th General Assembly applies to causes of action accruing on or after its effective date.

(Source: P.A. 93-51, eff. 7-1-03; 94-403, eff. 1-1-06.)

Section 99. Effective date. This Act takes effect January 1, 2018.