Sen. William R. Haine

Filed: 4/25/2012

AMENDMENT TO SENATE BILL 2721

AMENDMENT NO. _____. Amend Senate Bill 2721 by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Exclusive Provider Benefit Plan Act.

Section 5. For the purposes of this 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.

"Director" means the Director of Insurance.

"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 include post-stabilization medical services.

"Enrollee" means any person and his or her dependents enrolled in or covered by an exclusive provider benefit plan.

"Exclusive provider" means a provider or health care provider, or an organization of providers or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy.

"Exclusive provider benefit plan" means a benefit plan in which an insurer contracts with a provider to provide some services to an insured, not including emergency care services required under Section 65 of the Managed Care Reform and Patients Right Act, provided by a health care provider who is a non-exclusive provider.

"Health care provider" means a provider, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this State.

"Health care services" means any services included in the furnishing of medical care to any individual, 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.

"Health insurance policy" means a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.

"Hospital" means an institution licensed under the Hospital Licensing Act, an institution that meets all comparable conditions and requirements in effect in the state in which it is located, or the University of Illinois Hospital as defined in the University of Illinois Hospital Act.

"Institutional provider" means a hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in a health insurance policy.

"Insurer" means an insurance company or a health service corporation authorized in this State to issue policies or subscriber contracts that reimburse for expense of health care services.

"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.

"Preauthorization" means a determination by an insurer that medical care or health care services proposed to be provided to a patient are medically necessary and appropriate.

"Provider" means an individual or entity duly licensed or legally authorized to provide health care services.

"Service area" means a geographic area or areas specified in an exclusive provider benefit contract in which a network of exclusive providers is offered and available.

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

Section 10. Exclusive provider benefit plans permitted. An exclusive provider benefit plan that meets the requirements of this Act shall be permitted. To the extent of any conflict between this Section and any other statutory provision, this Section prevails over the conflicting provision. The Director of Insurance may adopt rules necessary to implement the Department's responsibilities under this Act.

Section 15. Applicability of this Act.

(a) Except as otherwise specifically provided by this Section, this Section applies to each individual or group exclusive provider benefit plan in which an insurer provides, through the insurer's health insurance policy, for the payment of coverage only for the use of an exclusive provider network, other than the use of a non-exclusive provider for emergency

care services.

(b) Unless otherwise specified, an exclusive provider benefit plan is subject to this Section.

(c) This Act does not apply to:

(1) the Children's Health Insurance Program under the Children's Health Insurance Program Act;

(2) a Medicaid managed care program under Article V of the Illinois Public Aid Code; or

(3) an HMO under Article I of the Health Maintenance Organization Act.

(d) An insurer duly licensed under the laws of this State may offer exclusive provider benefit plans to individuals and group health plans in conformity with the terms set forth in this Section. An insurer shall not be required to be licensed as an HMO under the Health Maintenance Organization Act in order to offer exclusive provider benefit plans under this Section.

Section 20. Applicability of Health Carrier External Review Act. The Health Carrier External Review Act shall apply to an exclusive provider benefit plan, except to the extent that the Director determines the provision to be inconsistent with the function and purpose of an exclusive provider benefit plan.

Section 25. Construction of Act.

(a) This Act may not be construed to limit the level of reimbursement or the level of coverage, including deductibles, copayments, coinsurance, or other cost-sharing provisions, that are applicable to exclusive providers.

(b) Except as specifically provided for in this Act, this Act may not be construed to require an exclusive provider benefit plan to compensate a non-exclusive provider for services provided to an insured.

Section 30. Provision of information.

(a) An exclusive provider benefit plan shall provide annually to enrollees and prospective enrollees, upon request, a complete list of exclusive providers in the exclusive provider benefit plan service area and a description of the following terms of coverage:

(1) the service area;

(2) the covered benefits and services with all exclusions, exceptions, and limitations;

(3) the pre-certification and other utilization review, if applicable, procedures and requirements;

(4) a description of any limitation on access to specialists, and the plan's standing referral policy;

(5) the emergency coverage and benefits, including any restrictions on emergency care services;

(6) the out-of-area coverage and benefits, if any;

(7) the enrollee's financial responsibility for

copayments, deductibles, premiums, and any other out-of-pocket expenses;

(8) the provisions for continuity of treatment in the event an exclusive provider's participation terminates during the course of an enrollee's treatment by that exclusive provider;

(9) the appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, if applicable, including a phone number to call to receive more information from the exclusive provider benefits plan concerning the appeals process; and

(10) a statement of all basic health care services and all specific benefits and services mandated to be provided to enrollees by any State law or administrative rule.

In the event of an inconsistency between any separate written disclosure statement and the enrollee contract or certificate, the terms of the enrollee contract or certificate shall control.

(b) Upon written request, an exclusive provider benefit plan shall provide to enrollees a description of the financial relationships between the exclusive provider benefit plan and any health care provider and, if requested, the percentage of copayments, deductibles, and total premiums spent on healthcare related expenses and the percentage of copayments,

deductibles, and total premiums spent on other expenses, including administrative expenses, except that no exclusive provider benefit plan shall be required to disclose specific provider reimbursement.

(c) An exclusive provider shall provide all of the following, where applicable, to enrollees upon request:

(1) Information related to the exclusive provider's educational background, experience, training, specialty, and board certification, if applicable.

(2) The names of licensed facilities on the provider panel where the exclusive provider presently has privileges for the treatment, illness, or procedure that is the subject of the request.

(3) Information regarding the exclusive provider's participation in continuing education programs and compliance with any licensure, certification, or registration requirements, if applicable.

(d) An exclusive provider benefit plan shall provide the information required to be disclosed under this Act upon enrollment and annually thereafter in a legible and understandable format. The Department of Insurance shall adopt rules to establish the format based, to the extent practical, on the standards developed for supplemental insurance coverage under Title XVIII of the federal Social Security Act as a guide, so that a person can compare the attributes of the various health care plans.

(e) An identification card or similar document issued by an insurer to an insured in an exclusive provider benefit plan must display:

(1) a toll-free number that a physician or health care provider may use to obtain the date on which the insured became insured under the plan; and

(2) the acronym "EPO" or the phrase "Exclusive Provider Organization" on the card in a location of the insurer's choice.

(f) The written disclosure requirements of this Section may be met by disclosure to one enrollee in a household.

Section 35. Availability of exclusive providers.

(a) An insurer offering an exclusive provider benefit plan shall ensure that the exclusive provider benefits are reasonably available to all insureds within a designated service area.

(b) If services are not available through an exclusive provider within a designated service area under an exclusive provider benefit plan, an insurer shall reimburse a physician or health care provider who is a non-exclusive provider at the same percentage level of benefit as an exclusive provider would have been reimbursed had the insured been treated by an exclusive provider.

Section 40. Notice of nonrenewal or termination. An

exclusive provider benefit plan must give at least 60 days notice of nonrenewal or termination of an exclusive provider to the exclusive provider and to the enrollees served by the exclusive provider. The notice shall include a name and address to which an enrollee or exclusive provider may direct comments and concerns regarding the nonrenewal or termination. Immediate written notice may be provided without 60 days notice when a health care provider's license has been disciplined by a state licensing board.

Section 45. Transition of service.

(a) An exclusive provider benefit plan shall provide for continuity of care for its enrollees as follows:

(1) If an enrollee's physician leaves the exclusive provider benefit plan's network of health care providers for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by a state licensing board and the physician remains within the exclusive provider benefit plan's service area, the exclusive provider benefit plan shall permit the enrollee to continue an ongoing course of treatment with that physician during a transitional period:

(A) of 90 days after the date of the notice of the physician's termination from the health care plan to the enrollee of the physician's disaffiliation from

the health care plan if the enrollee has an ongoing course of treatment; or

(B) that includes the provision of post-partum care directly related to the delivery, if the enrollee has entered the third trimester of pregnancy at the time of the physician's disaffiliation.

(2) Notwithstanding the provisions in paragraph (1) of this subsection (a), such care shall be authorized by the exclusive provider benefit plan during the transitional period only if the physician agrees:

(A) to continue to accept reimbursement from the exclusive provider benefit plan at the rates applicable prior to the start of the transitional period;

(B) to adhere to the exclusive provider benefit plan's quality assurance requirements and to provide to the exclusive provider benefit plan necessary medical information related to such care; and

(C) to otherwise adhere to the exclusive provider benefit plan's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining preauthorizations for treatment.

(b) An exclusive provider benefit plan shall provide for continuity of care for new enrollees as follows:

(1) If a new enrollee whose physician is not a member of the exclusive provider benefit plan's provider network,

but is within the exclusive provider benefit plan's service area, enrolls in the exclusive provider benefit plan, the exclusive provider benefit plan shall permit the enrollee to continue an ongoing course of treatment with the enrollee's current physician during a transitional period:

(A) of 90 days after the effective date of enrollment if the enrollee has an ongoing course of treatment; or

(B) that includes the provision of post-partum care directly related to the delivery, if the enrollee has entered the third trimester of pregnancy at the effective date of enrollment.

(2) If an enrollee elects to continue to receive care from such physician pursuant to paragraph (1) of this subsection (a), such care shall be authorized by the exclusive provider benefit plan for the transitional period only if the physician agrees:

(A) to accept reimbursement from the exclusive provider benefit plan at rates established by the exclusive provider benefit plan; such rates shall be the level of reimbursement applicable to similar physicians within the exclusive provider benefit plan for such services;

(B) to adhere to the exclusive provider benefit plan's quality assurance requirements and to provide to the exclusive provider benefit plan necessary

medical information related to such care; and

(C) to otherwise adhere to the exclusive provider benefit plan's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining preauthorization for treatment.

(c) In no event shall this Section be construed to require an exclusive provider benefit plan to provide coverage for benefits not otherwise covered or to diminish or impair preexisting condition limitations contained in the enrollee's contract.

Section 50. Prohibitions.

(a) No exclusive provider benefit plan or its subcontractors may prohibit or discourage health care providers by contract or policy from discussing any health care services and health care providers, utilization review, if applicable, and quality assurance policies, terms, and conditions of plans, and plan policy with enrollees, prospective enrollees, providers, or the public.

(b) No exclusive provider benefit plan by contract, written policy, or procedure may permit or allow an individual or entity to dispense a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act.

Section 55. Exclusive provider benefit plans; access to specialists.

(a) When the type of specialist physician or other health care provider needed to provide care for a specific condition is not represented in the exclusive provider benefit plan's network, the exclusive provider benefit plan shall allow for the enrollee to have access to a non-exclusive provider within a reasonable distance and travel time at no additional cost beyond what the enrollee would otherwise pay for services received within the network if it is determined by a licensed clinical peer that the service or treatment of the specific condition is medically necessary and such services or treatments are not available through the exclusive provider benefit plan network. Coverage for all services performed in accordance with this Section shall be at the same benefit level as if the service or treatment had been rendered by an exclusive provider.

(b) If an exclusive provider benefit plan denies an enrollee's request for a specialist physician or other health care provider that is not represented in the exclusive provider benefit plan's network, an enrollee may appeal the decision through the exclusive provider benefit plan's external independent review process as provided by the Health Carrier External Review Act.

Section 60. Health care services appeals, complaints, and external independent reviews.

(a) An exclusive provider benefit plan shall establish and maintain an appeals procedure as outlined in this Act. Compliance with this Act's appeals procedures shall satisfy an exclusive provider benefit plan's obligation to provide appeal procedures under any other State law or rules.

(b) When an appeal concerns a decision or action by an exclusive provider benefit plan, its employees, or its subcontractors that relates to (i) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health or (ii) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, the exclusive provider benefit plan must allow for the filing of an appeal either orally or in writing. Upon submission of the appeal, an exclusive provider benefit plan must notify the party filing the appeal as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the exclusive provider benefit plan requires to evaluate the appeal. The exclusive provider benefit plan shall render a decision on the appeal within 24 hours after receipt of the required information. The exclusive provider benefit plan shall notify

the party filing the appeal and the enrollee and any health care provider who recommended the health care service involved in the appeal of its decision orally, followed up by a written notice of the determination.

(c) For all appeals related to health care services, including, but not limited to, procedures or treatments for an enrollee, not covered by subsection (b) of this Section, the exclusive provider benefit plan shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection (c), an exclusive provider benefit plan must notify the party filing an appeal, within 3 business days after the submission, of all information that the plan requires to evaluate the appeal. The exclusive provider benefit plan shall render a decision on the appeal within 15 business days after receipt of the required information. The health care plan shall notify the party filing the appeal, the enrollee, and any health care provider who recommended the health care service involved in the appeal orally of its decision, followed up by a written notice of the determination.

(d) An appeal under subsections (b) or (c) of this Section may be filed by the enrollee, the enrollee's designee or guardian, or the enrollee's health care provider. An exclusive provider benefit plan shall designate a clinical peer to review appeals, because these appeals pertain to medical or clinical matters and such an appeal must be reviewed by an appropriate health care professional. No one reviewing an appeal may have

had any involvement in the initial determination that is the subject of the appeal. The written notice of determination required under subsections (b) and (c) shall include (i) clear and detailed reasons for the determination, (ii) the medical or clinical criteria for the determination, which shall be based upon sound clinical evidence and reviewed on a periodic basis, and (iii) in the case of an adverse determination, the procedures for requesting an external independent review as provided by the Health Carrier External Review Act.

(e) If an appeal filed under subsections (b) or (c) is denied for a reason, including, but not limited to, the service, procedure, or treatment is not viewed as medically necessary, denial of specific tests or procedures, denial of referral to specialist physicians or denial of hospitalization requests or length of stay requests, any involved party may request an external independent review as provided by the Health Carrier External Review Act.

(f) Future contractual or employment action by the exclusive provider benefit plan regarding the patient's physician or other health care provider shall not be based solely on the physician's or other health care provider's participation in health care services appeals, complaints, or external independent reviews under the Health Carrier External Review Act.

(g) Nothing in this Section shall be construed to require an exclusive provider benefit plan to pay for a health care

service not covered under the enrollee's certificate of coverage or policy.

Section 65. Emergency services prior to stabilization.

(a) An exclusive provider benefit plan that provides or that is required by law to provide coverage for emergency services shall provide coverage such that payment under this coverage is not dependent upon whether the services are performed by a plan or non-plan health care provider and without regard to prior authorization. This coverage shall be at the same benefit level as if the services or treatment had been rendered by the health care plan physician licensed to practice medicine in all its branches or health care provider.

(b) Prior authorization or approval by the plan shall not be required for emergency services.

(c) Coverage and payment shall only be retrospectively denied under the following circumstances:

(1) upon reasonable determination that the emergency services claimed were never performed;

(2) upon timely determination that the emergency evaluation and treatment were rendered to an enrollee who sought emergency services and whose circumstance did not meet the definition of emergency medical condition;

(3) upon determination that the patient receiving such services was not an enrollee of the health care plan; or

(4) upon material misrepresentation by the enrollee or

health care provider.

For the purposes of this subsection (c), "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

(d) When an enrollee presents to a hospital seeking emergency services, the determination as to whether the need for those services exists shall be made for purposes of treatment by a physician licensed to practice medicine in all its branches or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches. The physician or other appropriate personnel shall indicate in the patient's chart the results of the emergency medical screening examination.

(e) The appropriate use of the 9-1-1 emergency telephone system or its local equivalent shall not be discouraged or penalized by the exclusive provider benefit plan when an emergency medical condition exists. This provision shall not imply that the use of the 9-1-1 emergency telephone system or its local equivalent is a factor in determining the existence of an emergency medical condition.

(f) The medical director's or his or her designee's determination of whether the enrollee meets the standard of an emergency medical condition shall be based solely upon the presenting symptoms documented in the medical record at the

time care was sought. Only a clinical peer may make an adverse determination.

(g) Nothing in this Section shall prohibit the imposition of deductibles, copayments, and co-insurance.

Section 70. Post-stabilization medical services.

(a) If prior authorization for covered post-stabilization services is required by the exclusive provider benefit plan, the plan shall provide access 24 hours a day, 7 days a week to persons designated by the plan to make such determinations, provided that any determination made under this Section must be made by a health care professional.

(b) The treating physician licensed to practice medicine in all its branches or health care provider shall contact the exclusive provider benefit plan or delegated health care provider as designated on the enrollee's health insurance card to obtain authorization, denial, or arrangements for an alternate plan of treatment or transfer of the enrollee.

(c) The treating physician licensed to practice medicine in all its branches or health care provider shall document in the enrollee's medical record the enrollee's presenting symptoms; emergency medical condition; and time, phone number dialed, and result of the communication for request for authorization of post-stabilization medical services. The exclusive provider benefit plan shall provide reimbursement for covered post-stabilization medical services if:

(1) authorization to render them is received from the exclusive provider benefit plan or its delegated health care provider; or

(2) after 2 documented good faith efforts, the treating health care provider has attempted to contact the enrollee's exclusive provider benefit plan or its delegated health care provider, as designated on the enrollee's health insurance card, for prior authorization of post-stabilization medical services and neither the plan nor designated persons were accessible or the authorization was not denied within 60 minutes of the request.

For the purposes of this subsection (c), "2 documented good faith efforts" means the health care provider has called the telephone number on the enrollee's health insurance card or other available number either 2 times or one time and an additional call to any referral number provided.

(d) After rendering any post-stabilization medical services, the treating physician licensed to practice medicine in all its branches or health care provider shall continue to make every reasonable effort to contact the exclusive provider benefit plan or its delegated health care provider regarding authorization, denial, or arrangements for an alternate plan of treatment or transfer of the enrollee until the treating health care provider receives instructions from the exclusive provider benefit plan or delegated health care provider for

continued care or the care is transferred to another health care provider or the patient is discharged.

(e) Payment for covered post-stabilization services may be denied:

(1) if the treating health care provider does not meet the conditions outlined in subsection (c) of this Section;

(2) upon determination that the post-stabilization services claimed were not performed;

(3) upon timely determination that the post-stabilization services rendered were contrary to the instructions of the exclusive provider benefit plan or its delegated health care provider if contact was made between those parties prior to the service being rendered;

(4) upon determination that the patient receiving such services was not an enrollee of the exclusive provider benefit plan; or

(5) upon material misrepresentation by the enrollee or health care provider.

For the purposes of this subsection (e), "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

(f) Nothing in this Section prohibits an exclusive provider benefit plan from delegating tasks associated with the responsibilities enumerated in this Section to the exclusive provider benefit plan's contracted health care providers or

another entity. Only a clinical peer may make an adverse determination. However, the ultimate responsibility for coverage and payment decisions may not be delegated.

(g) Coverage and payment for post-stabilization medical services for which prior authorization or deemed approval is received shall not be retrospectively denied.

(h) Nothing in this Section shall prohibit the imposition of deductibles, copayments, and co-insurance.

Section 75. Quality assessment program.

(a) An exclusive provider benefit plan shall develop and implement a quality assessment and improvement strategy designed to identify and evaluate accessibility, continuity, and quality of care. The exclusive provider benefit plan shall have:

(1) an ongoing, written, internal quality assessment program;

(2) specific written guidelines for monitoring and evaluating the quality and appropriateness of care and services provided to enrollees requiring the exclusive provider benefit plan to assess:

(A) the accessibility to health care providers;

(B) appropriateness of utilization;

(C) concerns identified by the exclusive provider benefit plan's medical or administrative staff and enrollees; and

(D) other aspects of care and service directly related to the improvement of quality of care;

(3) a procedure for remedial action to correct quality problems that have been verified in accordance with the written plan's methodology and criteria, including written procedures for taking appropriate corrective action; and

(4) follow-up measures implemented to evaluate the effectiveness of the action plan.

(b) The exclusive provider benefit plan shall establish a committee that oversees the quality assessment and improvement strategy that includes physician and enrollee participation.

(c) Reports on quality assessment and improvement activities shall be made to the governing body of the exclusive provider benefit plan not less than quarterly.

(d) The exclusive provider benefit plan shall make available its written description of the quality assessment program to the Department of Public Health.

(e) With the exception of subsection (d), the Department of Public Health shall accept evidence of accreditation with regard to the health care network quality management and performance improvement standards of:

(1) the National Commission on Quality Assurance (NCQA);

(2) the American Accreditation Healthcare Commission (URAC);

(3) the Joint Commission on Accreditation of

Healthcare Organizations (JCAHO); or

(4) any other entity that the Director of Public Health deems has substantially similar or more stringent standards than provided for in this Section.

(f) If the Department of Public Health determines that an exclusive provider benefit plan is not in compliance with the terms of this Section, it shall certify the finding to the Department of Insurance. The Department of Insurance may subject the exclusive provider benefit plan to penalties, as provided in this Act, for such non-compliance.

Section 80. Utilization review. If an exclusive provider benefit plan conducts a utilization review program in this State, then the exclusive provider benefit plan shall do so in accordance with Section 85 of the Managed Care Reform and Patient Rights Act.

Section 85. Examinations and fees. The Director may examine an insurer to determine the quality and adequacy of a network used by an exclusive provider benefit plan offered by the insurer under this Act. An insurer is subject to a qualifying examination of the insurer's exclusive provider benefit plans and subsequent quality of care examinations by the Director at least once every 5 years. Documentation provided to the Director during an examination conducted under this Section is confidential and is not subject to disclosure as public

information under the Freedom of Information Act.

Section 900. The Freedom of Information Act is amended by changing Section 7.5 as follows:

(5 ILCS 140/7.5)

Sec. 7.5. Statutory Exemptions. To the extent provided for by the statutes referenced below, the following shall be exempt from inspection and copying:

(a) All information determined to be confidential under Section 4002 of the Technology Advancement and Development Act.

(b) Library circulation and order records identifying library users with specific materials under the Library Records Confidentiality Act.

(c) Applications, related documents, and medical records received by the Experimental Organ Transplantation Procedures Board and any and all documents or other records prepared by the Experimental Organ Transplantation Procedures Board or its staff relating to applications it has received.

(d) Information and records held by the Department of Public Health and its authorized representatives relating to known or suspected cases of sexually transmissible disease or any information the disclosure of which is restricted under the Illinois Sexually Transmissible Disease Control Act.

(e) Information the disclosure of which is exempted under Section 30 of the Radon Industry Licensing Act.

(f) Firm performance evaluations under Section 55 of the Architectural, Engineering, and Land Surveying Qualifications Based Selection Act.

(g) Information the disclosure of which is restricted and exempted under Section 50 of the Illinois Prepaid Tuition Act.

(h) Information the disclosure of which is exempted under the State Officials and Employees Ethics Act, and records of any lawfully created State or local inspector general's office that would be exempt if created or obtained by an Executive Inspector General's office under that Act.

(i) Information contained in a local emergency energy plan submitted to a municipality in accordance with a local emergency energy plan ordinance that is adopted under Section 11-21.5-5 of the Illinois Municipal Code.

(j) Information and data concerning the distribution of surcharge moneys collected and remitted by wireless carriers under the Wireless Emergency Telephone Safety Act.

(k) Law enforcement officer identification information or driver identification information compiled by a law enforcement agency or the Department of Transportation under Section 11-212 of the Illinois Vehicle Code.

(l) Records and information provided to a residential health care facility resident sexual assault and death review team or the Executive Council under the Abuse Prevention Review Team Act.

(m) Information provided to the predatory lending database

created pursuant to Article 3 of the Residential Real Property Disclosure Act, except to the extent authorized under that Article.

(n) Defense budgets and petitions for certification of compensation and expenses for court appointed trial counsel as provided under Sections 10 and 15 of the Capital Crimes Litigation Act. This subsection (n) shall apply until the conclusion of the trial of the case, even if the prosecution chooses not to pursue the death penalty prior to trial or sentencing.

(o) Information that is prohibited from being disclosed under Section 4 of the Illinois Health and Hazardous Substances Registry Act.

(p) Security portions of system safety program plans, investigation reports, surveys, schedules, lists, data, or information compiled, collected, or prepared by or for the Regional Transportation Authority under Section 2.11 of the Regional Transportation Authority Act or the St. Clair County Transit District under the Bi-State Transit Safety Act.

(q) Information prohibited from being disclosed by the Personnel Records Review Act.

(r) Information prohibited from being disclosed by the Illinois School Student Records Act.

(s) Information the disclosure of which is restricted under Section 5-108 of the Public Utilities Act.

(t) All identified or deidentified health information in

the form of health data or medical records contained in, stored in, submitted to, transferred by, or released from the Illinois Health Information Exchange, and identified or deidentified health information in the form of health data and medical records of the Illinois Health Information Exchange in the possession of the Illinois Health Information Exchange Authority due to its administration of the Illinois Health Information Exchange. The terms "identified" and "deidentified" shall be given the same meaning as in the Health Insurance Accountability and Portability Act of 1996, Public Law 104-191, or any subsequent amendments thereto, and any regulations promulgated thereunder.

(u) Records and information provided to an independent team of experts under Brian's Law.

(v) Names and information of people who have applied for or received Firearm Owner's Identification Cards under the Firearm Owners Identification Card Act.

(w) ~~(v)~~ Personally identifiable information which is exempted from disclosure under subsection (g) of Section 19.1 of the Toll Highway Act.

(x) All identified or deidentified health information in the form of health data or medical records in possession of the Department of Insurance due to the Department's administration of the Exclusive Provider Benefit Plan Act.

(Source: P.A. 96-542, eff. 1-1-10; 96-1235, eff. 1-1-11; 96-1331, eff. 7-27-10; 97-80, eff. 7-5-11; 97-333, eff.

8-12-11; 97-342, eff. 8-12-11; revised 9-2-11.)

Section 999. Effective date. This Act takes effect upon becoming law.".