



## 98TH GENERAL ASSEMBLY

### State of Illinois

2013 and 2014

SB1273

Introduced 1/31/2013, by Sen. Antonio Muñoz

#### SYNOPSIS AS INTRODUCED:

New Act  
5 ILCS 140/7.5

Creates the Exclusive Provider Benefit Plan Act. Provides that an exclusive provider benefit plan that meets the requirements of the Act shall be permitted. Provides that to the extent of any conflict between the provision permitting exclusive provider benefit plans and any other statutory provision, the provision permitting exclusive provider benefit plans prevails over the conflicting provision. Provides that 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 the provision concerning the applicability of the Act. Provides that 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 the provision concerning the applicability of the Act. Sets forth provisions concerning the applicability of the Health Carrier External Review Act; the construction of the Exclusive Provider Benefit Plan Act; providing information to enrollees and prospective enrollees; the availability of exclusive providers; notice of nonrenewal or termination; transitions of service and continuity of care; prohibitions; exclusive provider benefit plan's access to specialists; health care services appeals, complaints, and external independent reviews; emergency services prior to stabilization; post-stabilization medical services; quality assessment programs; utilization review; and qualifying examinations of insurers and fees. Amends the Freedom of Information Act to establish an exemption for all identified or deidentified health information due to the Department's administration of the Exclusive Provider Benefit Plan Act. Effective immediately.

LRB098 05575 RPM 35613 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning insurance.

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

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

6 Section 5. For the purposes of this Act:

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

11 "Department" means the Department of Insurance.

12 "Director" means the Director of Insurance.

13 "Emergency medical condition" means a medical condition  
14 manifesting itself by acute symptoms of sufficient severity  
15 (including severe pain) such that a prudent layperson, who  
16 possesses an average knowledge of health and medicine, could  
17 reasonably expect the absence of immediate medical attention to  
18 result in:

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

22 (2) serious impairment to bodily functions; or

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

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

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

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

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

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

25 "Health care services" means any services included in the  
26 furnishing of medical care to any individual, or the

1 hospitalization incident to the furnishing of such care, as  
2 well as the furnishing to any person of any and all other  
3 services for the purpose of preventing, alleviating, curing, or  
4 healing human illness or injury.

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

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

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

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

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

1 stabilization.

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

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

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

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

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

22 Section 15. Applicability of this Act.

23 (a) Except as otherwise specifically provided by this  
24 Section, this Section applies to each individual or group

1 exclusive provider benefit plan in which an insurer provides,  
2 through the insurer's health insurance policy, for the payment  
3 of coverage only for the use of an exclusive provider network,  
4 other than the use of a non-exclusive provider for emergency  
5 care services.

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

8 (c) This Act does not apply to:

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

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

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

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

22 Section 20. Applicability of Health Carrier External  
23 Review Act. The Health Carrier External Review Act shall apply  
24 to an exclusive provider benefit plan, except to the extent  
25 that the Director determines the provision to be inconsistent

1 with the function and purpose of an exclusive provider benefit  
2 plan.

3 Section 25. Construction of Act.

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

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

12 Section 30. Provision of information.

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

18 (1) the service area;

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

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

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

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

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

4 (7) the enrollee's financial responsibility for  
5 copayments, deductibles, premiums, and any other  
6 out-of-pocket expenses;

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

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

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

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

25 (b) Upon written request, an exclusive provider benefit  
26 plan shall provide to enrollees a description of the financial



1 relationships between the exclusive provider benefit plan and  
2 any health care provider and, if requested, the percentage of  
3 copayments, deductibles, and total premiums spent on  
4 healthcare related expenses and the percentage of copayments,  
5 deductibles, and total premiums spent on other expenses,  
6 including administrative expenses, except that no exclusive  
7 provider benefit plan shall be required to disclose specific  
8 provider reimbursement.

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

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

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

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

22 (d) An exclusive provider benefit plan shall provide the  
23 information required to be disclosed under this Act upon  
24 enrollment and annually thereafter in a legible and  
25 understandable format. The Department of Insurance shall adopt  
26 rules to establish the format based, to the extent practical,

1 on the standards developed for supplemental insurance coverage  
2 under Title XVIII of the federal Social Security Act as a  
3 guide, so that a person can compare the attributes of the  
4 various health care plans.

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

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

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

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

16 Section 35. Availability of exclusive providers.

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

21 (b) If services are not available through an exclusive  
22 provider within a designated service area under an exclusive  
23 provider benefit plan, an insurer shall reimburse a physician  
24 or health care provider who is a non-exclusive provider at the  
25 same percentage level of benefit as an exclusive provider would

1 have been reimbursed had the insured been treated by an  
2 exclusive provider.

3 Section 40. Notice of nonrenewal or termination. An  
4 exclusive provider benefit plan must give at least 60 days  
5 notice of nonrenewal or termination of an exclusive provider to  
6 the exclusive provider and to the enrollees served by the  
7 exclusive provider. The notice shall include a name and address  
8 to which an enrollee or exclusive provider may direct comments  
9 and concerns regarding the nonrenewal or termination.  
10 Immediate written notice may be provided without 60 days notice  
11 when a health care provider's license has been disciplined by a  
12 state licensing board.

13 Section 45. Transition of service.

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

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

1 period:

2 (A) of 90 days after the date of the notice of the  
3 physician's termination from the health care plan to  
4 the enrollee of the physician's disaffiliation from  
5 the health care plan if the enrollee has an ongoing  
6 course of treatment; or

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

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

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

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

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

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

3 (1) If a new enrollee whose physician is not a member  
4 of the exclusive provider benefit plan's provider network,  
5 but is within the exclusive provider benefit plan's service  
6 area, enrolls in the exclusive provider benefit plan, the  
7 exclusive provider benefit plan shall permit the enrollee  
8 to continue an ongoing course of treatment with the  
9 enrollee's current physician during a transitional period:

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

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

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

22 (A) to accept reimbursement from the exclusive  
23 provider benefit plan at rates established by the  
24 exclusive provider benefit plan; such rates shall be  
25 the level of reimbursement applicable to similar  
26 physicians within the exclusive provider benefit plan

1 for such services;

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

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

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

15 Section 50. Prohibitions.

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

23 (b) No exclusive provider benefit plan by contract, written  
24 policy, or procedure may permit or allow an individual or  
25 entity to dispense a different drug in place of the drug or

1 brand of drug ordered or prescribed without the express  
2 permission of the person ordering or prescribing the drug,  
3 except as provided under Section 3.14 of the Illinois Food,  
4 Drug and Cosmetic Act.

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

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

22 (b) If an exclusive provider benefit plan denies an  
23 enrollee's request for a specialist physician or other health  
24 care provider that is not represented in the exclusive provider  
25 benefit plan's network, an enrollee may appeal the decision

1 through the exclusive provider benefit plan's external  
2 independent review process as provided by the Health Carrier  
3 External Review Act.

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

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

11 (b) When an appeal concerns a decision or action by an  
12 exclusive provider benefit plan, its employees, or its  
13 subcontractors that relates to (i) health care services,  
14 including, but not limited to, procedures or treatments, for an  
15 enrollee with an ongoing course of treatment ordered by a  
16 health care provider, the denial of which could significantly  
17 increase the risk to an enrollee's health or (ii) a treatment  
18 referral, service, procedure, or other health care service, the  
19 denial of which could significantly increase the risk to an  
20 enrollee's health, the exclusive provider benefit plan must  
21 allow for the filing of an appeal either orally or in writing.  
22 Upon submission of the appeal, an exclusive provider benefit  
23 plan must notify the party filing the appeal as soon as  
24 possible, but in no event more than 24 hours after the  
25 submission of the appeal, of all information that the exclusive



1 provider benefit plan requires to evaluate the appeal. The  
2 exclusive provider benefit plan shall render a decision on the  
3 appeal within 24 hours after receipt of the required  
4 information. The exclusive provider benefit plan shall notify  
5 the party filing the appeal and the enrollee and any health  
6 care provider who recommended the health care service involved  
7 in the appeal of its decision orally, followed up by a written  
8 notice of the determination.

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

24 (d) An appeal under subsections (b) or (c) of this Section  
25 may be filed by the enrollee, the enrollee's designee or  
26 guardian, or the enrollee's health care provider. An exclusive

1 provider benefit plan shall designate a clinical peer to review  
2 appeals, because these appeals pertain to medical or clinical  
3 matters and such an appeal must be reviewed by an appropriate  
4 health care professional. No one reviewing an appeal may have  
5 had any involvement in the initial determination that is the  
6 subject of the appeal. The written notice of determination  
7 required under subsections (b) and (c) shall include (i) clear  
8 and detailed reasons for the determination, (ii) the medical or  
9 clinical criteria for the determination, which shall be based  
10 upon sound clinical evidence and reviewed on a periodic basis,  
11 and (iii) in the case of an adverse determination, the  
12 procedures for requesting an external independent review as  
13 provided by the Health Carrier External Review Act.

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

22 (f) Future contractual or employment action by the  
23 exclusive provider benefit plan regarding the patient's  
24 physician or other health care provider shall not be based  
25 solely on the physician's or other health care provider's  
26 participation in health care services appeals, complaints, or

1 external independent reviews under the Health Carrier External  
2 Review Act.

3 (g) Nothing in this Section shall be construed to require  
4 an exclusive provider benefit plan to pay for a health care  
5 service not covered under the enrollee's certificate of  
6 coverage or policy.

7 Section 65. Emergency services prior to stabilization.

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

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

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

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

23 (2) upon timely determination that the emergency  
24 evaluation and treatment were rendered to an enrollee who  
25 sought emergency services and whose circumstance did not

1 meet the definition of emergency medical condition;

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

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

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

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

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

1           (f) The medical director's or his or her designee's  
2 determination of whether the enrollee meets the standard of an  
3 emergency medical condition shall be based solely upon the  
4 presenting symptoms documented in the medical record at the  
5 time care was sought. Only a clinical peer may make an adverse  
6 determination.

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

9           Section 70. Post-stabilization medical services.

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

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

22           (c) The treating physician licensed to practice medicine in  
23 all its branches or health care provider shall document in the  
24 enrollee's medical record the enrollee's presenting symptoms;  
25 emergency medical condition; and time, phone number dialed, and

1 result of the communication for request for authorization of  
2 post-stabilization medical services. The exclusive provider  
3 benefit plan shall provide reimbursement for covered  
4 post-stabilization medical services if:

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

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

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

22 (d) After rendering any post-stabilization medical  
23 services, the treating physician licensed to practice medicine  
24 in all its branches or health care provider shall continue to  
25 make every reasonable effort to contact the exclusive provider  
26 benefit plan or its delegated health care provider regarding

1 authorization, denial, or arrangements for an alternate plan of  
2 treatment or transfer of the enrollee until the treating health  
3 care provider receives instructions from the exclusive  
4 provider benefit plan or delegated health care provider for  
5 continued care or the care is transferred to another health  
6 care provider or the patient is discharged.

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

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

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

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

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

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

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

1 (f) Nothing in this Section prohibits an exclusive provider  
2 benefit plan from delegating tasks associated with the  
3 responsibilities enumerated in this Section to the exclusive  
4 provider benefit plan's contracted health care providers or  
5 another entity. Only a clinical peer may make an adverse  
6 determination. However, the ultimate responsibility for  
7 coverage and payment decisions may not be delegated.

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

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

13 Section 75. Quality assessment program.

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

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

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

25 (A) the accessibility to health care providers;



1 (B) appropriateness of utilization;

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

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

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

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

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

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

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

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

26 (1) the National Commission on Quality Assurance

1 (NCQA);

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

4 (3) the Joint Commission on Accreditation of  
5 Healthcare Organizations (JCAHO); or

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

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

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

20 Section 85. Examinations and fees. The Director may examine  
21 an insurer to determine the quality and adequacy of a network  
22 used by an exclusive provider benefit plan offered by the  
23 insurer under this Act. An insurer is subject to a qualifying  
24 examination of the insurer's exclusive provider benefit plans

1 and subsequent quality of care examinations by the Director at  
2 least once every 5 years. Documentation provided to the  
3 Director during an examination conducted under this Section is  
4 confidential and is not subject to disclosure as public  
5 information under the Freedom of Information Act.

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

8 (5 ILCS 140/7.5)

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

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

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

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

22 (d) Information and records held by the Department of  
23 Public Health and its authorized representatives relating to  
24 known or suspected cases of sexually transmissible disease or

1 any information the disclosure of which is restricted under the  
2 Illinois Sexually Transmissible Disease Control Act.

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

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

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

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

15 (i) Information contained in a local emergency energy plan  
16 submitted to a municipality in accordance with a local  
17 emergency energy plan ordinance that is adopted under Section  
18 11-21.5-5 of the Illinois Municipal Code.

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

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

26 (l) Records and information provided to a residential

1 health care facility resident sexual assault and death review  
2 team or the Executive Council under the Abuse Prevention Review  
3 Team Act.

4 (m) Information provided to the predatory lending database  
5 created pursuant to Article 3 of the Residential Real Property  
6 Disclosure Act, except to the extent authorized under that  
7 Article.

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

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

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

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

26 (r) Information prohibited from being disclosed by the

1 Illinois School Student Records Act.

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

4 (t) All identified or deidentified health information in  
5 the form of health data or medical records contained in, stored  
6 in, submitted to, transferred by, or released from the Illinois  
7 Health Information Exchange, and identified or deidentified  
8 health information in the form of health data and medical  
9 records of the Illinois Health Information Exchange in the  
10 possession of the Illinois Health Information Exchange  
11 Authority due to its administration of the Illinois Health  
12 Information Exchange. The terms "identified" and  
13 "deidentified" shall be given the same meaning as in the Health  
14 Insurance Accountability and Portability Act of 1996, Public  
15 Law 104-191, or any subsequent amendments thereto, and any  
16 regulations promulgated thereunder.

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

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

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

25 (x) Information which is exempted from disclosure under  
26 Section 5-1014.3 of the Counties Code or Section 8-11-21 of the

1 Illinois Municipal Code.

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

6 (Source: P.A. 96-542, eff. 1-1-10; 96-1235, eff. 1-1-11;  
7 96-1331, eff. 7-27-10; 97-80, eff. 7-5-11; 97-333, eff.  
8 8-12-11; 97-342, eff. 8-12-11; 97-813, eff. 7-13-12; 97-976,  
9 eff. 1-1-13.)

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