

HB1918



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB1918

Introduced 1/29/2025, by Rep. Anthony DeLuca

SYNOPSIS AS INTRODUCED:

215 ILCS 134/10

Amends the Managed Care Reform and Patient Rights Act. Provides that any intergovernmental joint self-insurance pool providing health benefits under a specified provision of the Intergovernmental Cooperation Act shall not be included under the definition of "health care plan". Effective immediately.

LRB104 06023 BAB 16056 b

A BILL FOR

1 AN ACT concerning regulation.

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

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

6 (215 ILCS 134/10)

7 Sec. 10. Definitions. In this Act:

8 For a health care plan under Section 45 or for a
9 utilization review program under Section 85, "adverse
10 determination" has the meaning given to that term in Section
11 10 of the Health Carrier External Review Act.

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

16 "Department" means the Department of Insurance.

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

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

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

3 (2) serious impairment to bodily functions;

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

5 (4) inadequately controlled pain; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 dependents; ~~and~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 "Step therapy requirement" does not include:

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

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

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

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

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

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

11 "Utilization review" includes either of the following:

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

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

26 "Utilization review criteria" means criteria, standards,

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

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

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

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