

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 Illinois Insurance Code is amended by  
5 changing Sections 143.31, 155.36, 315.6, and 370s as follows:

6 (215 ILCS 5/143.31)

7 Sec. 143.31. Uniform medical claim and billing forms.

8 (a) The Director shall prescribe by rule, after  
9 consultation with providers of health care or treatment,  
10 insurers, hospital, medical, and dental service corporations,  
11 and other prepayment organizations, insurance claim and  
12 billing forms that the Director determines will provide for  
13 uniformity and simplicity in insurance claims handling. The  
14 claim forms shall include, but need not be limited to,  
15 information regarding the medical diagnosis, treatment, and  
16 prognosis of the patient, together with the details of charges  
17 incident to the providing of care, treatment, or services,  
18 sufficient for the purpose of meeting the proof requirements  
19 of an insurance policy or a hospital, medical, or dental  
20 service contract.

21 (b) An insurer or a provider of health care treatment may  
22 not refuse to accept a claim or bill submitted on duly  
23 promulgated uniform claim and billing forms. An insurer,

1 however, may accept claims and bills submitted on any other  
2 form.

3 (c) After receipt and adjudication or readjudication of  
4 any claim or bill with all required documentation from an  
5 insured or provider, or a notification under 42 U.S.C.  
6 300gg-136, an accident ~~Accident~~ and health insurer shall send  
7 explanation of benefits paid statements or claims summary  
8 statements ~~sent~~ to an insured ~~by the accident and health~~  
9 ~~insurer shall be~~ in a format and written in a manner that  
10 promotes understanding by the insured by setting forth all of  
11 the following:

12 (1) The total dollar amount submitted to the insurer  
13 for payment.

14 (2) Any reduction in the amount paid due to the  
15 application of any co-payment, coinsurance, or deductible,  
16 along with an explanation of the amount of the co-payment,  
17 coinsurance, or deductible applied under the insured's  
18 policy.

19 (3) Any reduction in the amount paid due to the  
20 application of any other policy limitation, penalty, or  
21 exclusion set forth in the insured's policy, along with an  
22 explanation thereof.

23 (4) The total dollar amount paid.

24 (5) The total dollar amount remaining unpaid.

25 (6) If applicable under 42 U.S.C. 300gg-111 or 42  
26 U.S.C. 300gg-115, other information required for any

1 explanation of benefits described in either of those  
2 Sections.

3 (d) The Director may issue an order directing an accident  
4 and health insurer to comply with subsection (c).

5 (e) An accident and health insurer does not violate  
6 subsection (c) by using a document that the accident and  
7 health insurer is required to use by the federal government or  
8 the State.

9 (f) The adoption of uniform claim forms and uniform  
10 billing forms by the Director under this Section does not  
11 preclude an insurer, hospital, medical, or dental service  
12 corporation, or other prepayment organization from obtaining  
13 any necessary additional information regarding a claim from  
14 the claimant, provider of health care or treatment, or  
15 certifier of coverage, as may be required.

16 (g) On and after January 1, 1996 when billing insurers or  
17 otherwise filing insurance claims with insurers subject to  
18 this Section, providers of health care or treatment, medical  
19 services, dental services, pharmaceutical services, or medical  
20 equipment must use the uniform claim and billing forms adopted  
21 by the Director under this Section.

22 (Source: P.A. 91-357, eff. 7-29-99.)

23 (215 ILCS 5/155.36)

24 Sec. 155.36. Managed Care Reform and Patient Rights Act.  
25 Insurance companies that transact the kinds of insurance

1 authorized under Class 1(b) or Class 2(a) of Section 4 of this  
2 Code shall comply with Sections 25, 45, 45.1, 45.2, 45.3, 65,  
3 70, and 85, subsection (d) of Section 30, and the definition of  
4 the term "emergency medical condition" in Section 10 of the  
5 Managed Care Reform and Patient Rights Act. Except as provided  
6 by Section 85 of the Managed Care Reform and Patient Rights  
7 Act, no law or rule shall be construed to exempt any  
8 utilization review program from the requirements of Section 85  
9 of the Managed Care Reform and Patient Rights Act with respect  
10 to any insurance described in this Section.

11 (Source: P.A. 102-409, eff. 1-1-22; 103-426, eff. 8-4-23.)

12 (215 ILCS 5/315.6) (from Ch. 73, par. 927.6)

13 (Section scheduled to be repealed on January 1, 2027)

14 Sec. 315.6. Application of other Code provisions. Unless  
15 otherwise provided in this amendatory Act, every fraternal  
16 benefit society shall be governed by this amendatory Act and  
17 shall be exempt from all other provisions of the insurance  
18 laws of this State not only in governmental relations with the  
19 State but for every other purpose, except for those provisions  
20 specified in this amendatory Act and except as follows:

21 (a) Sections 1, 2, 2.1, 3.1, 117, 118, 132, 132.1,  
22 132.2, 132.3, 132.4, 132.5, 132.6, 132.7, 133, 134, 136,  
23 138, 139, 140, 141, 141.01, 141.1, 141.2, 141.3, 143,  
24 143.31, 143c, 144.1, 147, 148, 149, 150, 151, 152, 153,  
25 154.5, 154.6, 154.7, 154.8, 155, 155.04, 155.05, 155.06,

1 155.07, 155.08 and 408 of this Code; and

2 (b) Articles VIII 1/2, XII, XII 1/2, XIII, XXIV, and  
3 XXVIII of this Code.

4 (Source: P.A. 98-814, eff. 1-1-15.)

5 (215 ILCS 5/370s)

6 Sec. 370s. Managed Care Reform and Patient Rights Act. All  
7 administrators shall comply with Sections 55 and 85 of the  
8 Managed Care Reform and Patient Rights Act. Except as provided  
9 by Section 85 of the Managed Care Reform and Patient Rights  
10 Act, no law or rule shall be construed to exempt any  
11 utilization review program from the requirements of Section 85  
12 of the Managed Care Reform and Patient Rights Act with respect  
13 to any insured or beneficiary described in this Article.

14 (Source: P.A. 91-617, eff. 1-1-00.)

15 Section 10. The Dental Service Plan Act is amended by  
16 changing Section 25 as follows:

17 (215 ILCS 110/25) (from Ch. 32, par. 690.25)

18 Sec. 25. Application of Insurance Code provisions. Dental  
19 service plan corporations and all persons interested therein  
20 or dealing therewith shall be subject to the provisions of  
21 Articles IIA, XI, and XII 1/2 and Sections 3.1, 133, 136, 139,  
22 140, 143, 143.31, 143c, 149, 155.49, 355.2, 355.3, 367.2, 401,  
23 401.1, 402, 403, 403A, 408, 408.2, and 412, and subsection

1 (15) of Section 367 of the Illinois Insurance Code.

2 (Source: P.A. 103-426, eff. 8-4-23.)

3 Section 15. The Network Adequacy and Transparency Act is  
4 amended by changing Section 10 as follows:

5 (215 ILCS 124/10)

6 Sec. 10. Network adequacy.

7 (a) An insurer providing a network plan shall file a  
8 description of all of the following with the Director:

9 (1) The written policies and procedures for adding  
10 providers to meet patient needs based on increases in the  
11 number of beneficiaries, changes in the  
12 patient-to-provider ratio, changes in medical and health  
13 care capabilities, and increased demand for services.

14 (2) The written policies and procedures for making  
15 referrals within and outside the network.

16 (3) The written policies and procedures on how the  
17 network plan will provide 24-hour, 7-day per week access  
18 to network-affiliated primary care, emergency services,  
19 and women's principal health care providers.

20 An insurer shall not prohibit a preferred provider from  
21 discussing any specific or all treatment options with  
22 beneficiaries irrespective of the insurer's position on those  
23 treatment options or from advocating on behalf of  
24 beneficiaries within the utilization review, grievance, or

1 appeals processes established by the insurer in accordance  
2 with any rights or remedies available under applicable State  
3 or federal law.

4 (b) Insurers must file for review a description of the  
5 services to be offered through a network plan. The description  
6 shall include all of the following:

7 (1) A geographic map of the area proposed to be served  
8 by the plan by county service area and zip code, including  
9 marked locations for preferred providers.

10 (2) As deemed necessary by the Department, the names,  
11 addresses, phone numbers, and specialties of the providers  
12 who have entered into preferred provider agreements under  
13 the network plan.

14 (3) The number of beneficiaries anticipated to be  
15 covered by the network plan.

16 (4) An Internet website and toll-free telephone number  
17 for beneficiaries and prospective beneficiaries to access  
18 current and accurate lists of preferred providers,  
19 additional information about the plan, as well as any  
20 other information required by Department rule.

21 (5) A description of how health care services to be  
22 rendered under the network plan are reasonably accessible  
23 and available to beneficiaries. The description shall  
24 address all of the following:

25 (A) the type of health care services to be  
26 provided by the network plan;

1           (B) the ratio of physicians and other providers to  
2 beneficiaries, by specialty and including primary care  
3 physicians and facility-based physicians when  
4 applicable under the contract, necessary to meet the  
5 health care needs and service demands of the currently  
6 enrolled population;

7           (C) the travel and distance standards for plan  
8 beneficiaries in county service areas; and

9           (D) a description of how the use of telemedicine,  
10 telehealth, or mobile care services may be used to  
11 partially meet the network adequacy standards, if  
12 applicable.

13           (6) A provision ensuring that whenever a beneficiary  
14 has made a good faith effort, as evidenced by accessing  
15 the provider directory, calling the network plan, and  
16 calling the provider, to utilize preferred providers for a  
17 covered service and it is determined the insurer does not  
18 have the appropriate preferred providers due to  
19 insufficient number, type, unreasonable travel distance or  
20 delay, or preferred providers refusing to provide a  
21 covered service because it is contrary to the conscience  
22 of the preferred providers, as protected by the Health  
23 Care Right of Conscience Act, the insurer shall ensure,  
24 directly or indirectly, by terms contained in the payer  
25 contract, that the beneficiary will be provided the  
26 covered service at no greater cost to the beneficiary than



1 if the service had been provided by a preferred provider.  
2 This paragraph (6) does not apply to: (A) a beneficiary  
3 who willfully chooses to access a non-preferred provider  
4 for health care services available through the panel of  
5 preferred providers, or (B) a beneficiary enrolled in a  
6 health maintenance organization. In these circumstances,  
7 the contractual requirements for non-preferred provider  
8 reimbursements shall apply unless Section 356z.3a of the  
9 Illinois Insurance Code requires otherwise. In no event  
10 shall a beneficiary who receives care at a participating  
11 health care facility be required to search for  
12 participating providers under the circumstances described  
13 in subsection (b) or (b-5) of Section 356z.3a of the  
14 Illinois Insurance Code except under the circumstances  
15 described in paragraph (2) of subsection (b-5).

16 (7) A provision that the beneficiary shall receive  
17 emergency care coverage such that payment for this  
18 coverage is not dependent upon whether the emergency  
19 services are performed by a preferred or non-preferred  
20 provider and the coverage shall be at the same benefit  
21 level as if the service or treatment had been rendered by a  
22 preferred provider. For purposes of this paragraph (7),  
23 "the same benefit level" means that the beneficiary is  
24 provided the covered service at no greater cost to the  
25 beneficiary than if the service had been provided by a  
26 preferred provider. This provision shall be consistent

1 with Section 356z.3a of the Illinois Insurance Code.

2 (8) A limitation that complies with subsections (d)  
3 and (e) of Section 55 of the Prior Authorization Reform  
4 Act, ~~if the plan provides that the beneficiary will incur~~  
5 ~~a penalty for failing to pre certify inpatient hospital~~  
6 ~~treatment, the penalty may not exceed \$1,000 per~~  
7 ~~occurrence in addition to the plan cost sharing~~  
8 ~~provisions.~~

9 (c) The network plan shall demonstrate to the Director a  
10 minimum ratio of providers to plan beneficiaries as required  
11 by the Department.

12 (1) The ratio of physicians or other providers to plan  
13 beneficiaries shall be established annually by the  
14 Department in consultation with the Department of Public  
15 Health based upon the guidance from the federal Centers  
16 for Medicare and Medicaid Services. The Department shall  
17 not establish ratios for vision or dental providers who  
18 provide services under dental-specific or vision-specific  
19 benefits. The Department shall consider establishing  
20 ratios for the following physicians or other providers:

21 (A) Primary Care;

22 (B) Pediatrics;

23 (C) Cardiology;

24 (D) Gastroenterology;

25 (E) General Surgery;

26 (F) Neurology;

- 1 (G) OB/GYN;
- 2 (H) Oncology/Radiation;
- 3 (I) Ophthalmology;
- 4 (J) Urology;
- 5 (K) Behavioral Health;
- 6 (L) Allergy/Immunology;
- 7 (M) Chiropractic;
- 8 (N) Dermatology;
- 9 (O) Endocrinology;
- 10 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
- 11 (Q) Infectious Disease;
- 12 (R) Nephrology;
- 13 (S) Neurosurgery;
- 14 (T) Orthopedic Surgery;
- 15 (U) Physiatry/Rehabilitative;
- 16 (V) Plastic Surgery;
- 17 (W) Pulmonary;
- 18 (X) Rheumatology;
- 19 (Y) Anesthesiology;
- 20 (Z) Pain Medicine;
- 21 (AA) Pediatric Specialty Services;
- 22 (BB) Outpatient Dialysis; and
- 23 (CC) HIV.

24 (2) The Director shall establish a process for the  
25 review of the adequacy of these standards, along with an  
26 assessment of additional specialties to be included in the

1 list under this subsection (c).

2 (d) The network plan shall demonstrate to the Director  
3 maximum travel and distance standards for plan beneficiaries,  
4 which shall be established annually by the Department in  
5 consultation with the Department of Public Health based upon  
6 the guidance from the federal Centers for Medicare and  
7 Medicaid Services. These standards shall consist of the  
8 maximum minutes or miles to be traveled by a plan beneficiary  
9 for each county type, such as large counties, metro counties,  
10 or rural counties as defined by Department rule.

11 The maximum travel time and distance standards must  
12 include standards for each physician and other provider  
13 category listed for which ratios have been established.

14 The Director shall establish a process for the review of  
15 the adequacy of these standards along with an assessment of  
16 additional specialties to be included in the list under this  
17 subsection (d).

18 (d-5)(1) Every insurer shall ensure that beneficiaries  
19 have timely and proximate access to treatment for mental,  
20 emotional, nervous, or substance use disorders or conditions  
21 in accordance with the provisions of paragraph (4) of  
22 subsection (a) of Section 370c of the Illinois Insurance Code.  
23 Insurers shall use a comparable process, strategy, evidentiary  
24 standard, and other factors in the development and application  
25 of the network adequacy standards for timely and proximate  
26 access to treatment for mental, emotional, nervous, or

1 substance use disorders or conditions and those for the access  
2 to treatment for medical and surgical conditions. As such, the  
3 network adequacy standards for timely and proximate access  
4 shall equally be applied to treatment facilities and providers  
5 for mental, emotional, nervous, or substance use disorders or  
6 conditions and specialists providing medical or surgical  
7 benefits pursuant to the parity requirements of Section 370c.1  
8 of the Illinois Insurance Code and the federal Paul Wellstone  
9 and Pete Domenici Mental Health Parity and Addiction Equity  
10 Act of 2008. Notwithstanding the foregoing, the network  
11 adequacy standards for timely and proximate access to  
12 treatment for mental, emotional, nervous, or substance use  
13 disorders or conditions shall, at a minimum, satisfy the  
14 following requirements:

15 (A) For beneficiaries residing in the metropolitan  
16 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,  
17 network adequacy standards for timely and proximate access  
18 to treatment for mental, emotional, nervous, or substance  
19 use disorders or conditions means a beneficiary shall not  
20 have to travel longer than 30 minutes or 30 miles from the  
21 beneficiary's residence to receive outpatient treatment  
22 for mental, emotional, nervous, or substance use disorders  
23 or conditions. Beneficiaries shall not be required to wait  
24 longer than 10 business days between requesting an initial  
25 appointment and being seen by the facility or provider of  
26 mental, emotional, nervous, or substance use disorders or

1 conditions for outpatient treatment or to wait longer than  
2 20 business days between requesting a repeat or follow-up  
3 appointment and being seen by the facility or provider of  
4 mental, emotional, nervous, or substance use disorders or  
5 conditions for outpatient treatment; however, subject to  
6 the protections of paragraph (3) of this subsection, a  
7 network plan shall not be held responsible if the  
8 beneficiary or provider voluntarily chooses to schedule an  
9 appointment outside of these required time frames.

10 (B) For beneficiaries residing in Illinois counties  
11 other than those counties listed in subparagraph (A) of  
12 this paragraph, network adequacy standards for timely and  
13 proximate access to treatment for mental, emotional,  
14 nervous, or substance use disorders or conditions means a  
15 beneficiary shall not have to travel longer than 60  
16 minutes or 60 miles from the beneficiary's residence to  
17 receive outpatient treatment for mental, emotional,  
18 nervous, or substance use disorders or conditions.  
19 Beneficiaries shall not be required to wait longer than 10  
20 business days between requesting an initial appointment  
21 and being seen by the facility or provider of mental,  
22 emotional, nervous, or substance use disorders or  
23 conditions for outpatient treatment or to wait longer than  
24 20 business days between requesting a repeat or follow-up  
25 appointment and being seen by the facility or provider of  
26 mental, emotional, nervous, or substance use disorders or

1 conditions for outpatient treatment; however, subject to  
2 the protections of paragraph (3) of this subsection, a  
3 network plan shall not be held responsible if the  
4 beneficiary or provider voluntarily chooses to schedule an  
5 appointment outside of these required time frames.

6 (2) For beneficiaries residing in all Illinois counties,  
7 network adequacy standards for timely and proximate access to  
8 treatment for mental, emotional, nervous, or substance use  
9 disorders or conditions means a beneficiary shall not have to  
10 travel longer than 60 minutes or 60 miles from the  
11 beneficiary's residence to receive inpatient or residential  
12 treatment for mental, emotional, nervous, or substance use  
13 disorders or conditions.

14 (3) If there is no in-network facility or provider  
15 available for a beneficiary to receive timely and proximate  
16 access to treatment for mental, emotional, nervous, or  
17 substance use disorders or conditions in accordance with the  
18 network adequacy standards outlined in this subsection, the  
19 insurer shall provide necessary exceptions to its network to  
20 ensure admission and treatment with a provider or at a  
21 treatment facility in accordance with the network adequacy  
22 standards in this subsection.

23 (e) Except for network plans solely offered as a group  
24 health plan, these ratio and time and distance standards apply  
25 to the lowest cost-sharing tier of any tiered network.

26 (f) The network plan may consider use of other health care

1 service delivery options, such as telemedicine or telehealth,  
2 mobile clinics, and centers of excellence, or other ways of  
3 delivering care to partially meet the requirements set under  
4 this Section.

5 (g) Except for the requirements set forth in subsection  
6 (d-5), insurers who are not able to comply with the provider  
7 ratios and time and distance standards established by the  
8 Department may request an exception to these requirements from  
9 the Department. The Department may grant an exception in the  
10 following circumstances:

11 (1) if no providers or facilities meet the specific  
12 time and distance standard in a specific service area and  
13 the insurer (i) discloses information on the distance and  
14 travel time points that beneficiaries would have to travel  
15 beyond the required criterion to reach the next closest  
16 contracted provider outside of the service area and (ii)  
17 provides contact information, including names, addresses,  
18 and phone numbers for the next closest contracted provider  
19 or facility;

20 (2) if patterns of care in the service area do not  
21 support the need for the requested number of provider or  
22 facility type and the insurer provides data on local  
23 patterns of care, such as claims data, referral patterns,  
24 or local provider interviews, indicating where the  
25 beneficiaries currently seek this type of care or where  
26 the physicians currently refer beneficiaries, or both; or



1 (3) other circumstances deemed appropriate by the  
2 Department consistent with the requirements of this Act.

3 (h) Insurers are required to report to the Director any  
4 material change to an approved network plan within 15 days  
5 after the change occurs and any change that would result in  
6 failure to meet the requirements of this Act. Upon notice from  
7 the insurer, the Director shall reevaluate the network plan's  
8 compliance with the network adequacy and transparency  
9 standards of this Act.

10 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;  
11 102-1117, eff. 1-13-23.)

12 Section 20. The Health Maintenance Organization Act is  
13 amended by changing Section 5-3 as follows:

14 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

15 Sec. 5-3. Insurance Code provisions.

16 (a) Health Maintenance Organizations shall be subject to  
17 the provisions of Sections 133, 134, 136, 137, 139, 140,  
18 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,  
19 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,  
20 155.49, 355.2, 355.3, 355b, 355c, 356f, 356g.5-1, 356m, 356q,  
21 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5,  
22 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,  
23 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21,  
24 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29,

1 356z.30, 356z.30a, 356z.31, 356z.32, 356z.33, 356z.34,  
2 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.41,  
3 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50,  
4 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58,  
5 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.65, 356z.67,  
6 356z.68, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b,  
7 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A,  
8 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of  
9 subsection (2) of Section 367, and Articles IIA, VIII 1/2,  
10 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the  
11 Illinois Insurance Code.

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

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

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

20 (3) a corporation organized under the laws of another  
21 state, 30% or more of the enrollees of which are residents  
22 of this State, except a corporation subject to  
23 substantially the same requirements in its state of  
24 organization as is a "domestic company" under Article VIII  
25 1/2 of the Illinois Insurance Code.

26 (c) In considering the merger, consolidation, or other

1 acquisition of control of a Health Maintenance Organization  
2 pursuant to Article VIII 1/2 of the Illinois Insurance Code,

3 (1) the Director shall give primary consideration to  
4 the continuation of benefits to enrollees and the  
5 financial conditions of the acquired Health Maintenance  
6 Organization after the merger, consolidation, or other  
7 acquisition of control takes effect;

8 (2) (i) the criteria specified in subsection (1) (b) of  
9 Section 131.8 of the Illinois Insurance Code shall not  
10 apply and (ii) the Director, in making his determination  
11 with respect to the merger, consolidation, or other  
12 acquisition of control, need not take into account the  
13 effect on competition of the merger, consolidation, or  
14 other acquisition of control;

15 (3) the Director shall have the power to require the  
16 following information:

17 (A) certification by an independent actuary of the  
18 adequacy of the reserves of the Health Maintenance  
19 Organization sought to be acquired;

20 (B) pro forma financial statements reflecting the  
21 combined balance sheets of the acquiring company and  
22 the Health Maintenance Organization sought to be  
23 acquired as of the end of the preceding year and as of  
24 a date 90 days prior to the acquisition, as well as pro  
25 forma financial statements reflecting projected  
26 combined operation for a period of 2 years;

1           (C) a pro forma business plan detailing an  
2           acquiring party's plans with respect to the operation  
3           of the Health Maintenance Organization sought to be  
4           acquired for a period of not less than 3 years; and

5           (D) such other information as the Director shall  
6           require.

7           (d) The provisions of Article VIII 1/2 of the Illinois  
8           Insurance Code and this Section 5-3 shall apply to the sale by  
9           any health maintenance organization of greater than 10% of its  
10          enrollee population (including, without limitation, the health  
11          maintenance organization's right, title, and interest in and  
12          to its health care certificates).

13          (e) In considering any management contract or service  
14          agreement subject to Section 141.1 of the Illinois Insurance  
15          Code, the Director (i) shall, in addition to the criteria  
16          specified in Section 141.2 of the Illinois Insurance Code,  
17          take into account the effect of the management contract or  
18          service agreement on the continuation of benefits to enrollees  
19          and the financial condition of the health maintenance  
20          organization to be managed or serviced, and (ii) need not take  
21          into account the effect of the management contract or service  
22          agreement on competition.

23          (f) Except for small employer groups as defined in the  
24          Small Employer Rating, Renewability and Portability Health  
25          Insurance Act and except for medicare supplement policies as  
26          defined in Section 363 of the Illinois Insurance Code, a

1 Health Maintenance Organization may by contract agree with a  
2 group or other enrollment unit to effect refunds or charge  
3 additional premiums under the following terms and conditions:

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

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

25 The Health Maintenance Organization shall include a  
26 statement in the evidence of coverage issued to each enrollee

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

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

15 (g) Rulemaking authority to implement Public Act 95-1045,  
16 if any, is conditioned on the rules being adopted in  
17 accordance with all provisions of the Illinois Administrative  
18 Procedure Act and all rules and procedures of the Joint  
19 Committee on Administrative Rules; any purported rule not so  
20 adopted, for whatever reason, is unauthorized.

21 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;  
22 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.  
23 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,  
24 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;  
25 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.  
26 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,

1 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;  
2 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.  
3 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,  
4 eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

5 Section 25. The Limited Health Service Organization Act is  
6 amended by changing Section 4003 as follows:

7 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

8 Sec. 4003. Illinois Insurance Code provisions. Limited  
9 health service organizations shall be subject to the  
10 provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,  
11 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151, 152, 153,  
12 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49,  
13 355.2, 355.3, 355b, 356q, 356v, 356z.4, 356z.4a, 356z.10,  
14 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a,  
15 356z.32, 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53,  
16 356z.54, 356z.57, 356z.59, 356z.61, 356z.64, 356z.67, 356z.68,  
17 364.3, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412,  
18 444, and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII,  
19 XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.  
20 Nothing in this Section shall require a limited health care  
21 plan to cover any service that is not a limited health service.  
22 For purposes of the Illinois Insurance Code, except for  
23 Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited  
24 health service organizations in the following categories are

1 deemed to be domestic companies:

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

3 (2) a corporation organized under the laws of another  
4 state, 30% or more of the enrollees of which are residents  
5 of this State, except a corporation subject to  
6 substantially the same requirements in its state of  
7 organization as is a domestic company under Article VIII  
8 1/2 of the Illinois Insurance Code.

9 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;  
10 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff.  
11 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816,  
12 eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23;  
13 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff.  
14 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,  
15 eff. 1-1-24; revised 8-29-23.)

16 Section 30. The Managed Care Reform and Patient Rights Act  
17 is amended by changing Sections 10, 45, and 85 as follows:

18 (215 ILCS 134/10)

19 Sec. 10. Definitions. In this Act:

20 For a health care plan under Section 45 or for a  
21 utilization review program under Section 85, "adverse  
22 determination" has the meaning given to that term in Section  
23 10 of the Health Carrier External Review Act ~~"Adverse~~  
24 ~~determination" means a determination by a health care plan~~



1 ~~under Section 45 or by a utilization review program under~~  
2 ~~Section 85 that a health care service is not medically~~  
3 ~~necessary.~~

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

8 "Department" means the Department of Insurance.

9 "Emergency medical condition" means a medical condition  
10 manifesting itself by acute symptoms of sufficient severity,  
11 regardless of the final diagnosis given, such that a prudent  
12 layperson, who possesses an average knowledge of health and  
13 medicine, could reasonably expect the absence of immediate  
14 medical attention to result in:

15 (1) placing the health of the individual (or, with  
16 respect to a pregnant woman, the health of the woman or her  
17 unborn child) in serious jeopardy;

18 (2) serious impairment to bodily functions;

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

20 (4) inadequately controlled pain; or

21 (5) with respect to a pregnant woman who is having  
22 contractions:

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

25 (B) a transfer to another hospital may pose a  
26 threat to the health or safety of the woman or unborn

1 child.

2 "Emergency medical screening examination" means a medical  
3 screening examination and evaluation by a physician licensed  
4 to practice medicine in all its branches, or to the extent  
5 permitted by applicable laws, by other appropriately licensed  
6 personnel under the supervision of or in collaboration with a  
7 physician licensed to practice medicine in all its branches to  
8 determine whether the need for emergency services exists.

9 "Emergency services" means, with respect to an enrollee of  
10 a health care plan, transportation services, including but not  
11 limited to ambulance services, and covered inpatient and  
12 outpatient hospital services furnished by a provider qualified  
13 to furnish those services that are needed to evaluate or  
14 stabilize an emergency medical condition. "Emergency services"  
15 does not refer to post-stabilization medical services.

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

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

1 whom the plan has the ultimate obligation to arrange for the  
2 provision of or payment for services through organizational  
3 arrangements for ongoing quality assurance, utilization review  
4 programs, or dispute resolution. Nothing in this definition  
5 shall be construed to mean that an independent practice  
6 association or a physician hospital organization that  
7 subcontracts with a health care plan is, for purposes of that  
8 subcontract, a health care plan.

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

11 (1) indemnity health insurance policies including  
12 those using a contracted provider network;

13 (2) health care plans that offer only dental or only  
14 vision coverage;

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

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

20 (5) health care provided pursuant to the Workers'  
21 Compensation Act or the Workers' Occupational Diseases  
22 Act; and

23 (6) except with respect to subsections (a) and (b) of  
24 Section 65 and subsection (a-5) of Section 70,  
25 not-for-profit voluntary health services plans with health  
26 maintenance organization authority in existence as of

1           January 1, 1999 that are affiliated with a union and that  
2           only extend coverage to union members and their  
3           dependents.

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

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

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

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

26          "Person" means a corporation, association, partnership,

1 limited liability company, sole proprietorship, or any other  
2 legal entity.

3 "Physician" means a person licensed under the Medical  
4 Practice Act of 1987.

5 "Post-stabilization medical services" means health care  
6 services provided to an enrollee that are furnished in a  
7 licensed hospital by a provider that is qualified to furnish  
8 such services, and determined to be medically necessary and  
9 directly related to the emergency medical condition following  
10 stabilization.

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

16 "Utilization review" means the evaluation, including any  
17 evaluation based on an algorithmic automated process, of the  
18 medical necessity, appropriateness, and efficiency of the use  
19 of health care services, procedures, and facilities.

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

22 (Source: P.A. 102-409, eff. 1-1-22; 103-426, eff. 8-4-23.)

23 (215 ILCS 134/45)

24 Sec. 45. Health care services appeals, complaints, and  
25 external independent reviews.

1           (a) A health care plan shall establish and maintain an  
2 appeals procedure as outlined in this Act. Compliance with  
3 this Act's appeals procedures shall satisfy a health care  
4 plan's obligation to provide appeal procedures under any other  
5 State law or rules. All appeals of a health care plan's  
6 administrative determinations and complaints regarding its  
7 administrative decisions shall be handled as required under  
8 Section 50.

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

1 primary care physician, and any health care provider who  
2 recommended the health care service involved in the appeal of  
3 its decision orally followed-up by a written notice of the  
4 determination.

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

20 (d) An appeal under subsection (b) or (c) may be filed by  
21 the enrollee, the enrollee's designee or guardian, the  
22 enrollee's primary care physician, or the enrollee's health  
23 care provider. A health care plan shall designate a clinical  
24 peer to review appeals, because these appeals pertain to  
25 medical or clinical matters and such an appeal must be  
26 reviewed by an appropriate health care professional. No one

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

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

19 (f) Until July 1, 2013, if an external independent review  
20 decision made pursuant to the Illinois Health Carrier External  
21 Review Act upholds a determination adverse to the covered  
22 person, the covered person has the right to appeal the final  
23 decision to the Department; if the external review decision is  
24 found by the Director to have been arbitrary and capricious,  
25 then the Director, with consultation from a licensed medical  
26 professional, may overturn the external review decision and



1 require the health carrier to pay for the health care service  
2 or treatment; such decision, if any, shall be made solely on  
3 the legal or medical merits of the claim. If an external review  
4 decision is overturned by the Director pursuant to this  
5 Section and the health carrier so requests, then the Director  
6 shall assign a new independent review organization to  
7 reconsider the overturned decision. The new independent review  
8 organization shall follow subsection (d) of Section 40 of the  
9 Health Carrier External Review Act in rendering a decision.

10 (g) Future contractual or employment action by the health  
11 care plan regarding the patient's physician or other health  
12 care provider shall not be based solely on the physician's or  
13 other health care provider's participation in health care  
14 services appeals, complaints, or external independent reviews  
15 under the Illinois Health Carrier External Review Act.

16 (h) Nothing in this Section shall be construed to require  
17 a health care plan to pay for a health care service not covered  
18 under the enrollee's certificate of coverage or policy.

19 (i) Even if a health care plan or other utilization review  
20 program uses an algorithmic automated process in the course of  
21 utilization review for medical necessity, the health care plan  
22 or other utilization review program shall ensure that only a  
23 clinical peer makes any adverse determination based on medical  
24 necessity and that any subsequent appeal is processed as  
25 required by this Section, including the restriction that only  
26 a clinical peer may review an appeal. A health care plan or

1 other utilization review program using an automated process  
2 shall have the accreditation and the policies and procedures  
3 required by subsection (b-10) of Section 85 of this Act.

4 (Source: P.A. 96-857, eff. 7-1-10.)

5 (215 ILCS 134/85)

6 Sec. 85. Utilization review program registration.

7 (a) No person may conduct a utilization review program in  
8 this State unless once every 2 years the person registers the  
9 utilization review program with the Department and provides  
10 proof of current accreditation for itself and its  
11 subcontractors ~~certifies compliance~~ with the Health  
12 Utilization Management Standards of the Utilization Review  
13 Accreditation Commission, the National Committee for Quality  
14 Assurance, or another accreditation entity authorized under  
15 this Section ~~Health Utilization Management Standards of the~~  
16 ~~American Accreditation Healthcare Commission (URAC) sufficient~~  
17 ~~to achieve American Accreditation Healthcare Commission (URAC)~~  
18 ~~accreditation or submits evidence of accreditation by the~~  
19 ~~American Accreditation Healthcare Commission (URAC) for its~~  
20 ~~Health Utilization Management Standards. Nothing in this Act~~  
21 ~~shall be construed to require a health care plan or its~~  
22 ~~subcontractors to become American Accreditation Healthcare~~  
23 ~~Commission (URAC) accredited.~~

24 (b) In addition, the Director of the Department, in  
25 consultation with the Director of the Department of Public

1 Health, may certify alternative utilization review standards  
2 of national accreditation organizations or entities in order  
3 for plans to comply with this Section. Any alternative  
4 utilization review standards shall meet or exceed those  
5 standards required under subsection (a).

6 (b-5) The Department shall recognize the Accreditation  
7 Association for Ambulatory Health Care among the list of  
8 accreditors from which utilization organizations may receive  
9 accreditation and qualify for reduced registration and renewal  
10 fees.

11 (b-10) Utilization review programs that use algorithmic  
12 automated processes to decide whether to render adverse  
13 determinations based on medical necessity in the course of  
14 utilization review shall use objective, evidence-based  
15 criteria compliant with the accreditation requirements of the  
16 Health Utilization Management Standards of the Utilization  
17 Review Accreditation Commission or the National Committee for  
18 Quality Assurance (NCQA) and shall provide proof of such  
19 compliance to the Department with the registration required  
20 under subsection (a), including any renewal registrations.  
21 Nothing in this subsection supersedes paragraph (2) of  
22 subsection (e). The utilization review program shall include,  
23 with its registration materials, attachments that contain  
24 policies and procedures:

25 (1) to ensure that licensed physicians with relevant  
26 board certifications establish all criteria that the

1 algorithmic automated process uses for utilization review;

2 and

3 (2) for a program integrity system that, both before  
4 new or revised criteria are used for utilization review  
5 and when implementation errors in the algorithmic  
6 automated process are identified after new or revised  
7 criteria go into effect, requires licensed physicians with  
8 relevant board certifications to verify that the  
9 algorithmic automated process and corrections to it yield  
10 results consistent with the criteria for their certified  
11 field.

12 (c) The provisions of this Section do not apply to:

13 (1) persons providing utilization review program  
14 services only to the federal government;

15 (2) self-insured health plans under the federal  
16 Employee Retirement Income Security Act of 1974, however,  
17 this Section does apply to persons conducting a  
18 utilization review program on behalf of these health  
19 plans;

20 (3) hospitals and medical groups performing  
21 utilization review activities for internal purposes unless  
22 the utilization review program is conducted for another  
23 person.

24 Nothing in this Act prohibits a health care plan or other  
25 entity from contractually requiring an entity designated in  
26 item (3) of this subsection to adhere to the utilization

1 review program requirements of this Act.

2 (d) This registration shall include submission of all of  
3 the following information regarding utilization review program  
4 activities:

5 (1) The name, address, and telephone number of the  
6 utilization review programs.

7 (2) The organization and governing structure of the  
8 utilization review programs.

9 (3) The number of lives for which utilization review  
10 is conducted by each utilization review program.

11 (4) Hours of operation of each utilization review  
12 program.

13 (5) Description of the grievance process for each  
14 utilization review program.

15 (6) Number of covered lives for which utilization  
16 review was conducted for the previous calendar year for  
17 each utilization review program.

18 (7) Written policies and procedures for protecting  
19 confidential information according to applicable State and  
20 federal laws for each utilization review program.

21 (e) (1) A utilization review program shall have written  
22 procedures for assuring that patient-specific information  
23 obtained during the process of utilization review will be:

24 (A) kept confidential in accordance with applicable  
25 State and federal laws; and

26 (B) shared only with the enrollee, the enrollee's

1           designee, the enrollee's health care provider, and those  
2           who are authorized by law to receive the information.

3           Summary data shall not be considered confidential if it  
4           does not provide information to allow identification of  
5           individual patients or health care providers.

6           (2) Only a clinical peer ~~health care professional~~ may  
7           make adverse determinations regarding the medical  
8           necessity of health care services during the course of  
9           utilization review. Either a health care professional or  
10          an accredited algorithmic automated process, or both in  
11          combination, may certify the medical necessity of a health  
12          care service in accordance with accreditation standards.  
13          Nothing in this subsection prohibits an accredited  
14          algorithmic automated process from being used to refer a  
15          case to a clinical peer for a potential adverse  
16          determination.

17          (3) When making retrospective reviews, utilization  
18          review programs shall base reviews solely on the medical  
19          information available to the attending physician or  
20          ordering provider at the time the health care services  
21          were provided. This paragraph includes billing records and  
22          diagnosis or procedure codes that substantively contain  
23          the same medical information to an equal or lesser degree  
24          of specificity as the records the attending physician or  
25          ordering provider directly consulted at the time health  
26          care services were provided.

1           (4) When making prospective, concurrent, and  
2 retrospective determinations, utilization review programs  
3 shall collect only information that is necessary to make  
4 the determination and shall not routinely require health  
5 care providers to numerically code diagnoses or procedures  
6 to be considered for certification, unless required under  
7 State or federal Medicare or Medicaid rules or  
8 regulations, but may request such code if available, or  
9 routinely request copies of medical records of all  
10 enrollees reviewed. During prospective or concurrent  
11 review, copies of medical records shall only be required  
12 when necessary to verify that the health care services  
13 subject to review are medically necessary. In these cases,  
14 only the necessary or relevant sections of the medical  
15 record shall be required.

16           (f) If the Department finds that a utilization review  
17 program is not in compliance with this Section, the Department  
18 shall issue a corrective action plan and allow a reasonable  
19 amount of time for compliance with the plan. If the  
20 utilization review program does not come into compliance, the  
21 Department may issue a cease and desist order. Before issuing  
22 a cease and desist order under this Section, the Department  
23 shall provide the utilization review program with a written  
24 notice of the reasons for the order and allow a reasonable  
25 amount of time to supply additional information demonstrating  
26 compliance with requirements of this Section and to request a

1 hearing. The hearing notice shall be sent by certified mail,  
2 return receipt requested, and the hearing shall be conducted  
3 in accordance with the Illinois Administrative Procedure Act.

4 (g) A utilization review program subject to a corrective  
5 action may continue to conduct business until a final decision  
6 has been issued by the Department.

7 (h) Any adverse determination made by a health care plan  
8 or its subcontractors may be appealed in accordance with  
9 subsection (f) of Section 45.

10 (i) The Director may by rule establish a registration fee  
11 for each person conducting a utilization review program. All  
12 fees paid to and collected by the Director under this Section  
13 shall be deposited into the Insurance Producer Administration  
14 Fund.

15 (Source: P.A. 99-111, eff. 1-1-16.)

16 Section 35. The Voluntary Health Services Plans Act is  
17 amended by changing Section 10 as follows:

18 (215 ILCS 165/10) (from Ch. 32, par. 604)

19 Sec. 10. Application of Insurance Code provisions. Health  
20 services plan corporations and all persons interested therein  
21 or dealing therewith shall be subject to the provisions of  
22 Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140,  
23 143, 143.31, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3,  
24 355b, 356g, 356g.5, 356g.5-1, 356q, 356r, 356t, 356u, 356v,



1 356w, 356x, 356y, 356z.1, 356z.2, 356z.3a, 356z.4, 356z.4a,  
2 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12,  
3 356z.13, 356z.14, 356z.15, 356z.18, 356z.19, 356z.21, 356z.22,  
4 356z.25, 356z.26, 356z.29, 356z.30, 356z.30a, 356z.32,  
5 356z.33, 356z.40, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53,  
6 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62,  
7 356z.64, 356z.67, 356z.68, 364.01, 364.3, 367.2, 368a, 401,  
8 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7)  
9 and (15) of Section 367 of the Illinois Insurance Code.

10 Rulemaking authority to implement Public Act 95-1045, if  
11 any, is conditioned on the rules being adopted in accordance  
12 with all provisions of the Illinois Administrative Procedure  
13 Act and all rules and procedures of the Joint Committee on  
14 Administrative Rules; any purported rule not so adopted, for  
15 whatever reason, is unauthorized.

16 (Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;  
17 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff.  
18 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804,  
19 eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23;  
20 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff.  
21 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91,  
22 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;  
23 103-551, eff. 8-11-23; revised 8-29-23.)

24 Section 40. The Health Carrier External Review Act is  
25 amended by changing Section 10 as follows:

1 (215 ILCS 180/10)

2 Sec. 10. Definitions. For the purposes of this Act:

3 "Adverse determination" means:

4 (1) a determination by a health carrier or its  
5 designee utilization review organization that, based upon  
6 the health information provided for a covered person, a  
7 request for a benefit, including any quantity, frequency,  
8 duration, or other measurement of a benefit, under the  
9 health carrier's health benefit plan upon application of  
10 any utilization review technique does not meet the health  
11 carrier's requirements for medical necessity,  
12 appropriateness, health care setting, level of care, or  
13 effectiveness or is determined to be experimental or  
14 investigational and the requested benefit is therefore  
15 denied, reduced, or terminated or payment is not provided  
16 or made, in whole or in part, for the benefit;

17 (2) the denial, reduction, or termination of or  
18 failure to provide or make payment, in whole or in part,  
19 for a benefit based on a determination by a health carrier  
20 or its designee utilization review organization that a  
21 preexisting condition was present before the effective  
22 date of coverage; or

23 (3) a rescission of coverage determination, which does  
24 not include a cancellation or discontinuance of coverage  
25 that is attributable to a failure to timely pay required

1 premiums or contributions towards the cost of coverage.

2 "Adverse determination" includes unilateral  
3 determinations that replace the requested health care service  
4 with an approval of an alternative health care service without  
5 the agreement of the covered person or the covered person's  
6 attending provider for the requested health care service, or  
7 that condition approval of the requested service on first  
8 trying an alternative health care service, either if the  
9 request was made under a medical exceptions procedure, or if  
10 all of the following are true: (1) the requested service was  
11 not excluded by name, description, or service category under  
12 the written terms of coverage, (2) the alternative health care  
13 service poses no greater risk to the patient based on  
14 generally accepted standards of care, and (3) the alternative  
15 health care service is at least as likely to produce the same  
16 or better effect on the covered person's health as the  
17 requested service based on generally accepted standards of  
18 care. "Adverse determination" includes determinations made  
19 based on any source of health information pertaining to the  
20 covered person that is used to deny, reduce, replace,  
21 condition, or terminate the benefit or payment. "Adverse  
22 determination" includes determinations made in response to a  
23 request for authorization when the request was submitted by  
24 the health care provider regardless of whether the provider  
25 gave notice to or obtained the consent of the covered person or  
26 authorized representative to file the request. "Adverse

1 determination" does not include substitutions performed under  
2 Section 19.5 or 25 of the Pharmacy Practice Act.

3 "Authorized representative" means:

4 (1) a person to whom a covered person has given  
5 express written consent to represent the covered person  
6 for purposes of this Law;

7 (2) a person authorized by law to provide substituted  
8 consent for a covered person;

9 (3) a family member of the covered person or the  
10 covered person's treating health care professional when  
11 the covered person is unable to provide consent;

12 (4) a health care provider when the covered person's  
13 health benefit plan requires that a request for a benefit  
14 under the plan be initiated by the health care provider;  
15 or

16 (5) in the case of an urgent care request, a health  
17 care provider with knowledge of the covered person's  
18 medical condition.

19 "Best evidence" means evidence based on:

20 (1) randomized clinical trials;

21 (2) if randomized clinical trials are not available,  
22 then cohort studies or case-control studies;

23 (3) if items (1) and (2) are not available, then  
24 case-series; or

25 (4) if items (1), (2), and (3) are not available, then  
26 expert opinion.

1 "Case-series" means an evaluation of a series of patients  
2 with a particular outcome, without the use of a control group.

3 "Clinical review criteria" means the written screening  
4 procedures, decision abstracts, clinical protocols, and  
5 practice guidelines used by a health carrier to determine the  
6 necessity and appropriateness of health care services.

7 "Cohort study" means a prospective evaluation of 2 groups  
8 of patients with only one group of patients receiving specific  
9 intervention.

10 "Concurrent review" means a review conducted during a  
11 patient's stay or course of treatment in a facility, the  
12 office of a health care professional, or other inpatient or  
13 outpatient health care setting.

14 "Covered benefits" or "benefits" means those health care  
15 services to which a covered person is entitled under the terms  
16 of a health benefit plan.

17 "Covered person" means a policyholder, subscriber,  
18 enrollee, or other individual participating in a health  
19 benefit plan.

20 "Director" means the Director of the Department of  
21 Insurance.

22 "Emergency medical condition" means a medical condition  
23 manifesting itself by acute symptoms of sufficient severity,  
24 including, but not limited to, severe pain, such that a  
25 prudent layperson who possesses an average knowledge of health  
26 and medicine could reasonably expect the absence of immediate

1 medical attention to result in:

2 (1) placing the health of the individual or, with  
3 respect to a pregnant woman, the health of the woman or her  
4 unborn child, in serious jeopardy;

5 (2) serious impairment to bodily functions; or

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

7 "Emergency services" means health care items and services  
8 furnished or required to evaluate and treat an emergency  
9 medical condition.

10 "Evidence-based standard" means the conscientious,  
11 explicit, and judicious use of the current best evidence based  
12 on an overall systematic review of the research in making  
13 decisions about the care of individual patients.

14 "Expert opinion" means a belief or an interpretation by  
15 specialists with experience in a specific area about the  
16 scientific evidence pertaining to a particular service,  
17 intervention, or therapy.

18 "Facility" means an institution providing health care  
19 services or a health care setting.

20 "Final adverse determination" means an adverse  
21 determination involving a covered benefit that has been upheld  
22 by a health carrier, or its designee utilization review  
23 organization, at the completion of the health carrier's  
24 internal grievance process procedures as set forth by the  
25 Managed Care Reform and Patient Rights Act or as set forth for  
26 any additional authorization or internal appeal process

1 provided by contract between the health carrier and the  
2 provider. "Final adverse determination" includes  
3 determinations made in an appeal of a denial of prior  
4 authorization when the appeal was submitted by the health care  
5 provider regardless of whether the provider gave notice to or  
6 obtained the consent of the covered person or authorized  
7 representative to file an internal appeal.

8 "Health benefit plan" means a policy, contract,  
9 certificate, plan, or agreement offered or issued by a health  
10 carrier to provide, deliver, arrange for, pay for, or  
11 reimburse any of the costs of health care services.

12 "Health care provider" or "provider" means a physician,  
13 hospital facility, or other health care practitioner licensed,  
14 accredited, or certified to perform specified health care  
15 services consistent with State law, responsible for  
16 recommending health care services on behalf of a covered  
17 person.

18 "Health care services" means services for the diagnosis,  
19 prevention, treatment, cure, or relief of a health condition,  
20 illness, injury, or disease.

21 "Health carrier" means an entity subject to the insurance  
22 laws and regulations of this State, or subject to the  
23 jurisdiction of the Director, that contracts or offers to  
24 contract to provide, deliver, arrange for, pay for, or  
25 reimburse any of the costs of health care services, including  
26 a sickness and accident insurance company, a health

1 maintenance organization, or any other entity providing a plan  
2 of health insurance, health benefits, or health care services.  
3 "Health carrier" also means Limited Health Service  
4 Organizations (LHSO) and Voluntary Health Service Plans.

5 "Health information" means information or data, whether  
6 oral or recorded in any form or medium, and personal facts or  
7 information about events or relationships that relate to:

8 (1) the past, present, or future physical, mental, or  
9 behavioral health or condition of an individual or a  
10 member of the individual's family;

11 (2) the provision of health care services to an  
12 individual; or

13 (3) payment for the provision of health care services  
14 to an individual.

15 "Independent review organization" means an entity that  
16 conducts independent external reviews of adverse  
17 determinations and final adverse determinations.

18 "Medical or scientific evidence" means evidence found in  
19 the following sources:

20 (1) peer-reviewed scientific studies published in or  
21 accepted for publication by medical journals that meet  
22 nationally recognized requirements for scientific  
23 manuscripts and that submit most of their published  
24 articles for review by experts who are not part of the  
25 editorial staff;

26 (2) peer-reviewed medical literature, including



1 literature relating to therapies reviewed and approved by  
2 a qualified institutional review board, biomedical  
3 compendia, and other medical literature that meet the  
4 criteria of the National Institutes of Health's Library of  
5 Medicine for indexing in Index Medicus (Medline) and  
6 Elsevier Science Ltd. for indexing in Excerpta Medicus  
7 (EMBASE);

8 (3) medical journals recognized by the Secretary of  
9 Health and Human Services under Section 1861(t)(2) of the  
10 federal Social Security Act;

11 (4) the following standard reference compendia:

12 (a) The American Hospital Formulary Service-Drug  
13 Information;

14 (b) Drug Facts and Comparisons;

15 (c) The American Dental Association Accepted  
16 Dental Therapeutics; and

17 (d) The United States Pharmacopoeia-Drug  
18 Information;

19 (5) findings, studies, or research conducted by or  
20 under the auspices of federal government agencies and  
21 nationally recognized federal research institutes,  
22 including:

23 (a) the federal Agency for Healthcare Research and  
24 Quality;

25 (b) the National Institutes of Health;

26 (c) the National Cancer Institute;

- 1 (d) the National Academy of Sciences;
- 2 (e) the Centers for Medicare & Medicaid Services;
- 3 (f) the federal Food and Drug Administration; and
- 4 (g) any national board recognized by the National
- 5 Institutes of Health for the purpose of evaluating the
- 6 medical value of health care services; or
- 7 (6) any other medical or scientific evidence that is
- 8 comparable to the sources listed in items (1) through (5).

9 "Person" means an individual, a corporation, a

10 partnership, an association, a joint venture, a joint stock

11 company, a trust, an unincorporated organization, any similar

12 entity, or any combination of the foregoing.

13 "Prospective review" means a review conducted prior to an

14 admission or the provision of a health care service or a course

15 of treatment in accordance with a health carrier's requirement

16 that the health care service or course of treatment, in whole

17 or in part, be approved prior to its provision.

18 "Protected health information" means health information

19 (i) that identifies an individual who is the subject of the

20 information; or (ii) with respect to which there is a

21 reasonable basis to believe that the information could be used

22 to identify an individual.

23 "Randomized clinical trial" means a controlled prospective

24 study of patients that have been randomized into an

25 experimental group and a control group at the beginning of the

26 study with only the experimental group of patients receiving a

1 specific intervention, which includes study of the groups for  
2 variables and anticipated outcomes over time.

3 "Retrospective review" means any review of a request for a  
4 benefit that is not a concurrent or prospective review  
5 request. "Retrospective review" does not include the review of  
6 a claim that is limited to veracity of documentation or  
7 accuracy of coding.

8 "Utilization review" has the meaning provided by the  
9 Managed Care Reform and Patient Rights Act.

10 "Utilization review organization" means a utilization  
11 review program as defined in the Managed Care Reform and  
12 Patient Rights Act.

13 (Source: P.A. 97-574, eff. 8-26-11; 97-813, eff. 7-13-12;  
14 98-756, eff. 7-16-14.)

15 Section 45. The Prior Authorization Reform Act is amended  
16 by changing Section 55 as follows:

17 (215 ILCS 200/55)

18 Sec. 55. Denial or penalty.

19 (a) The health insurance issuer or its contracted  
20 utilization review organization may not revoke or further  
21 limit, condition, or restrict a previously issued prior  
22 authorization approval while it remains valid under this Act.

23 (b) Notwithstanding any other provision of law, if a claim  
24 is properly coded and submitted timely to a health insurance

1 issuer, the health insurance issuer shall make payment  
2 according to the terms of coverage on claims for health care  
3 services for which prior authorization was required and  
4 approval received before the rendering of health care  
5 services, unless one of the following occurs:

6 (1) it is timely determined that the enrollee's health  
7 care professional or health care provider knowingly  
8 provided health care services that required prior  
9 authorization from the health insurance issuer or its  
10 contracted utilization review organization without first  
11 obtaining prior authorization for those health care  
12 services;

13 (2) it is timely determined that the health care  
14 services claimed were not performed;

15 (3) it is timely determined that the health care  
16 services rendered were contrary to the instructions of the  
17 health insurance issuer or its contracted utilization  
18 review organization or delegated reviewer if contact was  
19 made between those parties before the service being  
20 rendered;

21 (4) it is timely determined that the enrollee  
22 receiving such health care services was not an enrollee of  
23 the health care plan; or

24 (5) the approval was based upon a material  
25 misrepresentation by the enrollee, health care  
26 professional, or health care provider; as used in this

1 paragraph (5), "material" means a fact or situation that  
2 is not merely technical in nature and results or could  
3 result in a substantial change in the situation.

4 (c) Nothing in this Section shall preclude a utilization  
5 review organization or a health insurance issuer from  
6 performing post-service reviews of health care claims for  
7 purposes of payment integrity or for the prevention of fraud,  
8 waste, or abuse.

9 (d) If a health insurance issuer imposes a monetary  
10 penalty on the enrollee for the enrollee's, health care  
11 professional's, or health care provider's failure to obtain  
12 any form of prior authorization for a health care service, the  
13 penalty may not exceed the lesser of:

14 (1) the actual cost of the health care service; or

15 (2) \$1,000 per occurrence in addition to the plan  
16 cost-sharing provisions.

17 (e) A health insurance issuer may not require both the  
18 enrollee and the health care professional or health care  
19 provider to obtain any form of prior authorization for the  
20 same instance of a health care service, nor otherwise require  
21 more than one prior authorization for the same instance of a  
22 health care service.

23 (Source: P.A. 102-409, eff. 1-1-22.)

24 Section 99. Effective date. This Act takes effect January  
25 1, 2025.