

ARTICLE XX-1/2 HEALTH CARE REIMBURSEMENT

(215 ILCS 5/370f)

Sec. 370f. Short Title. This Article may be cited as the "Health Care Reimbursement Reform Act of 1985".

(Source: P.A. 84-618.)

(215 ILCS 5/370g) Sec. 370g. Definitions. As used in this Article, the following definitions apply:

- (a) "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization. The term includes, but is not limited to, hospital, medical, surgical, dental, vision and pharmaceutical services or products.
- (b) "Insurer" means an insurance company or a health service corporation authorized in this State to issue policies or subscriber contracts which reimburse for expenses of health care services.
- (c) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.
- (d) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services.
- (e) "Noninstitutional provider" means any person licensed under the Medical Practice Act of 1987, as now or hereafter amended.
- (f) "Beneficiary" means an individual entitled to reimbursement for expenses of or the discount of provider fees for health care services under a program where the beneficiary has an incentive to utilize the services of a provider which has entered into an agreement or arrangement with an administrator.
- (g) "Administrator" means any person, partnership or corporation, other than an insurer or health maintenance organization holding a certificate of authority under the "Health Maintenance Organization Act", as now or hereafter amended, that arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider.
- (h) "Emergency" means an accidental bodily injury or emergency medical condition which reasonably requires the beneficiary or insured to seek immediate medical care under circumstances or at locations which reasonably preclude the beneficiary or insured from obtaining needed medical care from a preferred provider.

(Source: P.A. 88-400.)

(215 ILCS 5/370h)

Sec. 370h. NonInstitutional Providers. Before entering into any agreement under this Article an insurer or administrator shall establish terms and conditions that must be met by noninstitutional providers wishing to enter into an agreement with the insurer or administrator. These terms and conditions may not discriminate unreasonably against or among noninstitutional providers. Neither difference in prices among noninstitutional providers produced by a process of individual negotiation nor price differences among other noninstitutional providers in different geographical areas or different specialties constitutes unreasonable discrimination.

An insurer or administrator shall not refuse to contract with any noninstitutional provider who meets the terms and conditions established by the insurer or administrator.

(Source: P.A. 84-618.)

(215 ILCS 5/370i)

Sec. 370i. Policies, agreements or arrangements with incentives or limits on reimbursement authorized.

(a) Policies, agreements or arrangements issued under this Article may not contain terms or conditions that would operate unreasonably to restrict the access and availability of health care services for the insured.

(b) An insurer or administrator may:

(1) enter into agreements with certain providers of its choice relating to health care services which may be rendered to insureds or beneficiaries of the insurer or administrator, including agreements relating to the amounts to be charged the insureds or beneficiaries for services rendered;

(2) issue or administer programs, policies or subscriber contracts in this State that include incentives for the insured or beneficiary to utilize the services of a provider which has entered into an agreement with the insurer or administrator pursuant to paragraph (1) above.

(Source: P.A. 84-618.)

(215 ILCS 5/370j)

Sec. 370j. Requirements not applicable to insurers. Except as otherwise provided, no insurer authorized to do business in this State shall be subject to any of the requirements of this Article that are applicable to administrators.

Requirements not applicable to self-insured employers, employee benefit trust funds, other ERISA exempt organizations or the State of Illinois. Such organizations are not subject to any provisions of this Article even though they may contract with administrators for administration of health insurance claims subject to contractual arrangements of the administrator's preferred provider program.

(Source: P.A. 84-1431.)

(215 ILCS 5/370k)

Sec. 370k. Registration. All administrators of a preferred provider program subject to this Article shall register with the Department of Insurance, which shall by rule establish criteria for such registration including minimum solvency requirements and an annual registration fee for each administrator.

The Department of Insurance shall compile and maintain a listing updated at least annually of administrators and insurers offering agreements authorized under this Article.

(Source: P.A. 84-618.)

(215 ILCS 5/370l)

Sec. 370l. Fiduciary and bonding requirements. Each administrator who handles money for purposes of payment for providers services subject to this Article shall (1) establish and maintain a fiduciary account, separate and apart from any and all other accounts, for the receipt and disbursement of funds for reimbursement for programs covered under this Article, or (2) post or cause to be posted, a bond of indemnity in an amount equal to not less than 10% of the total estimated annual reimbursements under such programs.

If a bond of indemnity is posted, it shall be held by the Director of Insurance for the benefit and indemnification of the beneficiaries and payors of services under the programs subject to this Article.

An administrator who operates more than one such program may establish and maintain a separate fiduciary account or bond of indemnity for each such program, or may operate and maintain a consolidated fiduciary account or bond of indemnity for all such programs.

(Source: P.A. 84-618.)

(215 ILCS 5/370m)

Sec. 370m. Program Requirements. Each administrator shall provide to each beneficiary of any program subject to this Article a document which (1) sets forth those providers with which agreements or arrangements have been made to provide health care services to such beneficiary, a source for the beneficiary to contact regarding changes in such providers and a clear description of any incentives for the beneficiary to utilize such providers, (2) discloses the extent of coverage as well as any limitations or exclusions of health care services under the

program, (3) clearly sets out the circumstances under which reimbursement will be made to a beneficiary unable to utilize the services of a provider with which an arrangement or agreement has been made, (4) a description of the process for addressing a beneficiary complaint under the program, and (5) discloses deductible and coinsurance amounts charged to any person receiving health care services from such a provider.

(Source: P.A. 84-618.)

(215 ILCS 5/370n)

Sec. 370n. Utilization Review Requirements: Any preferred provider organization providing hospital, medical or dental services must include a program of utilization review.

This Section applies to insurers and administrators.

(Source: P.A. 84-1431.)

(215 ILCS 5/370o)

Sec. 370o. Emergency Care. Any preferred provider contract, subject to this Article shall provide the beneficiary or insured emergency care coverage such that payment for this coverage is not dependent upon whether such services are performed by a preferred or nonpreferred provider and such coverage shall be at the same benefit level as if the service or treatment had been rendered by a plan provider.

(Source: P.A. 85-476.)

(215 ILCS 5/370p)

Sec. 370p. Failure to register. Any administrator subject to this Article who fails to register or pay the fee required by this Article shall be construed to be an unauthorized insurer as defined in Article VII of the "Illinois Insurance Code", as now or hereafter amended, and shall be subject to the penalties contained therein.

(Source: P.A. 84-618.)

(215 ILCS 5/370q)

Sec. 370q. To the extent of any conflict between this Article and any other statutory provision, this Article prevails over the conflicting provision. Agreements may be entered into under this Article notwithstanding any policy provision to the contrary.

(Source: P.A. 84-618.)

(215 ILCS 5/370r)

Sec. 370r. Prescription drugs; cancer treatment. No group policy of accident or health insurance that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must be recognized for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

- (a) the American Medical Association Drug Evaluations;
- (b) the American Hospital Formulary Service Drug Information; or
- (c) the United States Pharmacopeia Drug Information; or

if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.

Any coverage required by this Section shall also include those medically necessary services associated with the administration of a drug.

Despite the provisions of this Section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed. This Section shall apply only to cancer drugs. Nothing in this Section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

(Source: P.A. 87-980.)