

SURVEY OF ILLINOIS LAW: HEALTH CARE LAW

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I. INTRODUCTION TO HEALTH CARE LAW

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Health care remains among the most active and diverse fields in law. This year's Survey reviews significant issues in state and federal health care law with respect to Illinois statutory and regulatory health care professional practice changes, the proposed Illinois Physician Orders for Life-Sustaining Treatment (POLST) Registry, the multiple Illinois COVID-19 Executive Orders, the Illinois Biometric Information Privacy Act and recent lawsuit-related issues and the opioid epidemic in the presence of the COVID-19 pandemic. Senior Illinois health care attorneys, most of whom are current or former members of the Illinois State Bar Association's Health Care Section Council, researched and drafted the various articles to inform Illinois lawyers of significant developments in this dynamic practice area.

II. STATUTORY AND REGULATOR HEALTH CARE PROFESSIONAL PRACTICE CHANGES

Sherri DeVito

As set forth by the Department of Professional Regulation law, “[t]he practice of the regulated professions, trades, and occupations in Illinois . . . affect[s] the public health, safety, and welfare of the [citizens] of [the] [s]tate and in the public interest [they are] subject to regulation and control by the [Illinois] Department of Financial and Professional Regulation” (IDFPR).¹

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This section will examine a variety of practice changes concerning certain regulated health care professionals, including physicians, advanced practice

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- ¹ 20 ILL. COMP. STAT. 2105/2105-10 (2020).

registered nurses, pharmacists, physical therapists, physician assistants, and prescribing psychologists.

A. Physicians

The Medical Practice Act of 1987 and its implementing rules provide for the licensure and regulation of physicians in Illinois.² Section 22.2 of the Act provides a prohibition against fee-splitting, and in 2019 that language was updated to provide that “[a] violation of [] the provisions of [that] [s]ection constitutes an unlawful practice under the Consumer Fraud and Deceptive Business Practices Act.”³ Additionally, in 2019, Section 36 of the Act was modified to remove language stating that,

Where a physician has been found, upon complaint and investigation of the [IDFPR], and after hearing, to have performed an abortion procedure in a willful and wanton manner upon a woman who was not pregnant at the time such abortion was performed, the [IDFPR] shall automatically revoke the license of such physician to practice medicine in Illinois.⁴

In 2018, Section 49.5 addressing telemedicine was updated to clarify that:

‘[T]elemedicine’ means the performance of any of the activities listed in Section 49, including, but not limited to, rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois by a person in a different location than the patient as a result of transmission of individual patient data by telephonic, electronic, or other means of communication.⁵

Previously, this section required that such "person" must be located outside of Illinois.⁶ Additionally, language was added clarifying that “[t]elemedicine does not include . . . health care services provided to an existing patient while the person licensed under the Act or patient is traveling.”⁷

² 225 ILL. COMP. STAT. 60 (2020).

³ Act of Jan. 1, 2019, Pub. Act 100-1058 (codified as amended at 225 ILL. COMP. STAT. 60/22.2(g) (2019)).

⁴ Reproductive Health Act, Pub. Act 101-13, effective June 12, 2019.

⁵ Telehealth Act, Pub. Act 100-317, effective Jan. 1, 2018 (codified as amended at 225 ILL. COMP. STAT. 60/49.5(c)).

⁶ Telehealth Act, Pub. Act 100-317, effective Jan. 1, 2018 (codified as amended at 225 ILL. COMP. STAT. 60/49.5).

⁷ Telehealth Act, Pub. Act 100-317, effective Jan. 1, 2018 (codified as amended at 225 ILL. COMP. STAT. 60/49.5(c)(4)).

B. Advanced Practice Registered Nurses

In 2018, the Nurse Practice Act was overhauled to provide full-practice authority for certain advanced practice registered nurses (APRNs).⁸ “Full-practice authority” advanced practice registered nurses (FPA-APRNs) are required to have a written collaborative agreement with a physician unless they receive substantial post-graduate training under the direct supervision of a physician—4,000 hours of clinical training and 250 hours in additional educational and training components.⁹ The physician must then sign a written attestation confirming that the training was completed.¹⁰ Prescription orders issued by FPA-APRNs must indicate that they have “full-practice authority.”¹¹ If the FPA-APRN wishes to prescribe Schedule II narcotics, such as opioids, and benzodiazepines, the FPA-APRN must maintain a formalized consultation relationship with a physician that must be noted in the state's Prescription Monitoring Program; it does not need to be filed with the IDFPR.¹² “[T]he specific Schedule II narcotic drug must be identified by . . . name,” and the “[FPA-APRN] and physician must discuss the condition of any patients for whom [such medication] is prescribed” at least monthly.¹³ FPA-APRNs are prohibited from administering such medications via injection, nor can they perform operative surgery.¹⁴ FPA-APRNs providing services in a hospital, hospital affiliate, or ambulatory surgical treatment center may also be privileged to complete discharge orders and prescriptions in their name.¹⁵

This same legislation modified Section 65-50 of the Act addressing titles nurses may use.¹⁶ APRNs are now specifically prohibited from using the title “doctor” or “physician” in paid or approved advertising.¹⁷ Furthermore, “[i]f an [APRN] has a doctorate degree, when identifying himself or herself as ‘doctor’ in a clinical setting, the [APRN] must clearly state that [their] educational preparation is not in medicine and that [they] are not a medical doctor or physician.”¹⁸ The intent of this new language is to improve patient safety and prevent fraud and deception.

⁸ Act of Sept. 20, 2017, Pub. Act 100-513 (codified at 225 ILL. COMP. STAT. 65/65-43) (2020)). This Act also updated the licensure category from “advanced practice nurse” to “advanced practice registered nurse”.

⁹ *Id.*

¹⁰ *Id.*

¹¹ 45 Ill. Reg. 228 (Jan. 4, 2021) (codified at ILL. ADMIN. CODE tit. 68, § 1300.466(d) (2021)).

¹² Act of Sept. 20, 2017, Pub. Act 100-513 (codified at 225 ILL. COMP. STAT. 65/65-43) (2020)).

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Act of Sept. 20, 2017, Pub. Act 100-513 (codified at 225 ILL. COMP. STAT. 65/65-45) (2020)).

¹⁶ Act of Sept. 20, 2017, Pub. Act 100-513 (codified at 225 ILL. COMP. STAT. 65/65-50) (2020)).

¹⁷ *Id.*

¹⁸ *Id.*

C. Pharmacists

Pharmacists in Illinois are licensed under the Pharmacy Practice Act and its corresponding rules.¹⁹ Beginning on January 1, 2020, the practice of pharmacy now includes the administration of injections of “long-acting or extended-release form opioid antagonists for the treatment of substance use disorder” following the initial administration by a licensed physician.²⁰ A valid prescription from a licensed physician is required, as is “the completion of appropriate training [that] includ[es] how to address contraindications and adverse reactions.”²¹ The requirements of such training must be set forth by rule, which has not been published as of the date of writing.²² Additionally, notification must be given to the patient's physician, and record retention is required.²³

Pharmacists may also administer injections of long-term antipsychotic medications pursuant to a prescription from a licensed physician after completion of training.²⁴ Such training must be conducted by an Accreditation Council of Pharmaceutical Education accredited provider, and it must “includ[e] how to address contraindications and adverse reactions.”²⁵ Similar to the opioid antagonist rules, the IDFPR has not yet issued rules for the administration of antipsychotic medications as of the date of this writing. Notification to the patient's physician and appropriate record retention is also required.²⁶

D. Prescribing Psychologists

The Clinical Psychologist Licensing Act and its corresponding regulations provide for the licensing of prescribing psychologists, a separate category of license from a traditional clinical psychologist that was established in 2014.²⁷ Licensed prescribing psychologists must, beginning in 2019, include their name and signature on all prescriptions they write, and the prescribing psychologist must sign their own name.²⁸ In that same year, their clinical training requirements were updated to require 14 months' supervising clinical training instead of 36 credit hours.²⁹ Additionally,

¹⁹ 225 ILL. COMP. STAT. 85 (2020); ILL. ADMIN. CODE PART tit. 68, § 1330 (2020).

²⁰ Act of Jan. 1, 2020, Pub. Act 101-349 (codified at 225 ILL. COMP. STAT. 85/3(d) (2020)).

²¹ *Id.*

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ Act of June 25, 2014, Pub. Act 98-668 (codified at 225 ILL. COMP. STAT. 15/4.2 (2014)).

²⁸ Act of July 19, 2019, Pub. Act 101-84 (codified at 225 ILL. COMP. STAT. 85/3(e) (2019)).

²⁹ Act of June 25, 2014, Pub. Act 98-668 (codified at 225 ILL. COMP. STAT. 15/4.2 (2014)).

prescribing psychologists have been added to the Telehealth Act as a category of health care professionals who may provide telehealth services.³⁰

E. Physical Therapists

Beginning in 2017, the Illinois Physical Therapy Act was updated to allow physical therapists to include dry needling as part of their defined scope of practice.³¹ Dry needling is “also known as intramuscular therapy, [and it involves] an advanced needling skill [] limited to the treatment of myofascial pain [while] using a single-use, single insertion, sterile filiform needle . . . to stimulate trigger points.”³² In order to provide such service, the licensed physical therapist must complete “a total of [fifty] hours of instruction in . . . the musculoskeletal and neuromuscular system; the anatomical basis of pain mechanisms, chronic pain, and referred pain; myofascial trigger point theory, and universal precautions.”³³ Physical therapists must also complete at least thirty hours of didactic course work specific to intramuscular manual therapy and at least fifty-four practicum hours of intramuscular manual therapy course work covering certain areas.³⁴ In addition, physical therapists must complete “at least 200 patient treatment sessions under general supervision recognized by the American Physical Therapy Association” and successfully complete a competency exam approved by the IDFPR.³⁵

Physical therapists are able, as of 2018, to “provide physical therapy services to a patient with or without a referral from a health care professional.”³⁶ “[P]hysical therapist[s] providing services without a referral from a health care professional must notify the patient's treating health care professional within 5 business days after the patient's first visit that [they are] receiving physical therapy.”³⁷ However, a physical therapist must refer a patient to their treating health care professional or:

[T]o a health care professional of the patient's choice[] if the patient does not demonstrate measurable or functional improvement after [ten] visits or [fifteen] business days, whichever occurs first, and continued improvement thereafter; the patient returns for services for the same or similar condition after [thirty] calendar days of being discharged by the physical therapist; or

³⁰ Act of July 19, 2019, Pub. Act 101-84 (codified at 225 ILL. COMP. STAT. 150/5 (2019)).

³¹ Act of Aug. 25, 2017, Pub. Act 100-418 (codified at 225 ILL. COMP. STAT. 90/1(1) (2017)).

³² Act of Aug. 25, 2017, Pub. Act 100-418 (codified at 225 ILL. COMP. STAT. 90/1.5 (2017)).

³³ 42 Ill. Reg. 14185 (July 11, 2018) (codified at ILL. ADMIN. CODE tit. 68, § 1340.75 (2018)).

³⁴ *Id.*

³⁵ *Id.*

³⁶ Act of Aug. 16, 2018, Pub. Act 100-897 (codified at 225 ILL. COMP. STAT. 90/1.2(a) (2018)).

³⁷ Act of Aug. 16, 2018, Pub. Act 100-897 (codified at 225 ILL. COMP. STAT. 90/1.2(b) (2018)).

the patient's condition, at the time of evaluation, is determined to be beyond the scope of the physical therapist.³⁸

F. Physician Assistants

Physician assistants providing services in the state of Illinois are regulated by the Physician Assistant Practice Act of 1987 and its corresponding rules.³⁹ In 2017, the Act was amended to replace the written supervisory agreement under which physician assistants need to practice with a written collaborative agreement with a collaborating physician.⁴⁰ Additionally, Public Act 100-453 amended the Act to clarify that physician assistants are “not allowed to personally bill patients or in any way charge for services.”⁴¹ The following year, the Act was again updated to allow collaborating physicians to collaborate with a maximum of seven full-time equivalent physician assistants; this number was previously limited to five.⁴² Physicians are able to “collaborate with more than seven physician assistants when the services are provided in a federal primary care health professional shortage area with a Health Professional Shortage Area score greater than or equal to twelve.”⁴³ Section 21 of the Act, which addresses grounds for disciplinary action, was similarly updated to provide “that entering into an excessive number of written collaborative agreements with physicians resulting in the inability to adequately collaborate, or the failure to adequately collaborate,” may subject licensees to discipline.⁴⁴

G. Mandatory Training for Health Care Professionals

While the specific continuing education courses a health care professional must take for licensure and/or license renewal are generally left to the prerogative of the health care professional, the General Assembly has newly mandated trainings that health care professionals must take. Beginning in 2020:

Medical personnel . . . who work with children in their professional or official capacity must complete mandated reporter training at least every [six] years . . . [and] attest at each time of licensure renewal . . . that they understand they are a mandated reporter . . . , that they are aware of the process for making a report, that they know how to respond to a child in a

³⁸ Act of Aug. 16, 2018, Pub. Act 100-897 (codified at 225 ILL. COMP. STAT. 90/1.2(c) (2018)).

³⁹ 225 ILL. COMP. STAT. 90/1(1) (2020); ILL. ADMIN. CODE tit. 68 § 1350 (2020).

⁴⁰ Act of Aug. 25, 2017, Pub. Act 100-453 (codified at 225 ILL. COMP. STAT. 95/5.5 (2020)).

⁴¹ *Id.*

⁴² Act of Jan. 1, 2019, Pub. Act 100-605 (codified at 225 ILL. COMP. STAT. 95/7(a) (2019)).

⁴³ Act of Jan. 1, 2019, Pub. Act 100-605 (codified at 225 ILL. COMP. STAT. 60/54.5 (2019)).

⁴⁴ Act of Jan. 1, 2019, Pub. Act 100-605 (codified at 225 ILL. COMP. STAT. 95/21 (2019)).

trauma-informed manner, and that they are aware of the role of child protective services and the role of a reporter after a call has been made.⁴⁵

Medical personnel who do not work with children in their professional or official capacity must make the same attestation but are not required to undergo repeated training.⁴⁶

In addition, for license renewals occurring on or after January 1, 2020, health care professionals must complete at least one hour of sexual harassment training as part of their continuing education requirements.⁴⁷ The training must include, “at a minimum, what is sexual harassment, including its forms and types; what one should do if one experiences or witnesses unwelcome sexual contact; reporting sexual harassment within one’s place of employment and to outside entities, such as the Illinois Department of Human Rights; and whistleblower protections.”⁴⁸

The field of health care remains ever-changing, with the varied professions often seeking scope expansions. For those attorneys providing services to health care clients, a regular review of the Illinois Register and the Illinois General Assembly’s website is recommended.⁴⁹

III. PA 101-0163 AND THE CREATION OF AN ILLINOIS ADVANCE DIRECTIVES AND UNIFORM POLST FORM REGISTRY

Keith Emmons and Leonard Nelson,
with the assistance of Connor Mallon

A. Introduction

Illinois Public Act 101-0163, which became effective on January 1, 2020, requires the Illinois Department of Public Health (“IDPH” or “Department”) to study the feasibility of creating a statewide registry (“Registry”) for advance directives and the state’s uniform Practitioner Orders for Life Sustaining Treatment (POLST) form, and to file the Department’s feasibility study (“Feasibility Study”) with the Illinois General Assembly not later than January 1, 2021.⁵⁰ The Registry concept originated with and was promoted by members of the Illinois State Bar Association

⁴⁵ Act of Jan. 1, 2020, Pub. Act 101-564 (codified at 325 ILL. COMP. STAT. 5/4(k) (2020)).

⁴⁶ *Id.*

⁴⁷ Act of Jan. 1, 2019, Pub. Act 100-762 (codified at 20 ILL. COMP. STAT. 2105/2105-15.5 (2020)).

⁴⁸ 43 Ill. Reg. 5297 (May 10, 2019) (codified at ILL. ADMIN. CODE tit. 68 § 1130.400 (2019)).

⁴⁹ ILLINOIS REGISTER, CYBERDRIVEILLINOIS, <https://www.cyberdriveillinois.com/departments/index/register/home.html> (last visited Jan. 15, 2021); ILLINOIS GENERAL ASSEMBLY, ILGA, <https://ilga.gov/default.asp> (last visited Jan. 15, 2021).

⁵⁰ 20 ILL COMP. STAT. 2310/2310-600 (2020).

("ISBA") Health Care Section Council and was supported by ISBA Standing Committee on Legislation as a bar association legislative initiative.⁵¹

To enhance the functionality of the proposed Registry, Public Act 101-0163 for the first-time permitted Illinois advance directives to be created, executed, revoked, and stored in both hard copy and electronic format.⁵² The broad public policy goals of the Public Act were as follows:

- (1) To enable an individual to easily document and share the individual's advance care planning wishes.
- (2) To facilitate electronic capture, transmission, and storage of an individual's advance care planning wishes by means of a reliable electronic solution.
- (3) To facilitate and promote the sharing of an individual's advance care planning wishes among care providers by eliminating barriers resulting from paper documents containing these wishes that are not easily transferred and accessed, thus promoting the opportunity for the patient's wishes to be known in all of the health care settings the patient may encounter.⁵³

The Illinois General Assembly specifically described the Registry's public policy basis as follows: "The registry would allow residents of this State to submit the forms (for advance directives and the Uniform POLST form) and for the forms to be made available to health care providers and professionals in a timely manner for the provision of care or services."⁵⁴

Additionally, as to the Registry, the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois was amended by adding a provision to permit the Uniform Illinois POLST form to exist in hard copy and electronic format or to be executed or revoked by electronic signature; and, more importantly for the purposes of this article, by creating an IDPH stake holder advisory committee ("Advisory Committee") to report to the Illinois General Assembly on the feasibility of creating a statewide advance directive and POLST form registry.⁵⁵

The other relevant Illinois statutes affected by the passage of PA 101-0163 include the following:

⁵¹ Ill. State Bar Ass'n, Legislative Proposal 100-10.

⁵² Act of July 29, 2019, Pub. L. No. 101-0163, § 1 (codified as amended in scattered sections of 755 ILL. COMP. STAT.).

⁵³ Act of July 29, 2019, Pub. L. No. 101-0163, § 1 (codified as amended in scattered sections of 755 ILL. COMP. STAT.; 20 ILL. COMP. STAT.; 5 ILL. COMP. STAT.).

⁵⁴ *Id.* (amending act of July 26, 2019, Public Act 101-0163 (codified as amended at 20 ILL. COMP. STAT. 2310/2310-600 (2020)).

⁵⁵ 20 ILL. COMP. STAT. 2310/2310-6010(b-5) (2021).

- The Illinois Electronic Commerce Security Act was amended by deleting references to living wills or health care powers of attorney from a list of documents that were prohibited from being created in an electronic format or from being executed or revoked by electronic signature. The effect of the amendment was to permit such advance directives to be executed or revoked electronically.⁵⁶
- The Illinois Living Will Act,⁵⁷ the Illinois Health Care Surrogate Act,⁵⁸ the Illinois Mental Health Treatment Preference Act,⁵⁹ and the Illinois Powers of Attorney for Health Care Law⁶⁰ were all amended to permit the advance directives to be in either hard copy or electronic format; permit an advance directive's or uniform DNR/POLST form's written revocation to be in either hard copy or electronic format; by proscribing the mechanism for an electronic revocation; and, by permitting all documents, writings, forms and copies under the referenced Acts to be in either hard copy or electronic format.⁶¹

It should be noted that the Mental Health Treatment Preference advance directive was not ultimately considered by the Advisory Committee for placement in the proposed Registry and, accordingly, will not be further discussed in this article.⁶² All other statutory advance directives and the uniform POLST forms (also considered an advance directive by the authors of this article) as referenced in the Illinois Health Care Surrogate Act would be potential candidates for placement in any future Registry authorized by the Illinois General Assembly.

B. IDPH Advance Directive Responsibilities

The IDPH is required by Illinois law and by the Federal Patient Self-Determination Act⁶³ (PSDA) to publish a summary of Illinois advance directive laws and to make available related advance directive forms to the public on the Department's website.⁶⁴ As discussed above, each of the

⁵⁶ 5 ILL. COMP. STAT. 175/1-101 (2020).

⁵⁷ 755 ILL. COMP. STAT. 35/1 (2020).

⁵⁸ 755 ILL. COMP. STAT. 40/1 (2020).

⁵⁹ 755 ILL. COMP. STAT. 43/1 (2020).

⁶⁰ 755 ILL. COMP. STAT. 45/4 (2020).

⁶¹ See 755 ILL. COMP. STAT. 35/1 (2020); 755 ILL. COMP. STAT. 40/1 (2020); 755 ILL. COMP. STAT. 43/1 (2020); 755 ILL. COMP. STAT. 45/4 (2020).

⁶² See Act of July 29, 2019, Pub. L. No. 101-0163, § 30.

⁶³ 42 U.S.C. § 1395cc(f)(1) (2018).

⁶⁴ 20 ILL. COMP. STAT. 2310/2310-600 (2020).

advance directives and the Uniform POLST forms may be executed, revoked, and maintained in either hardcopy or electronic format.⁶⁵

C. The Illinois Living Will Act

Among the characteristics of the Illinois living will discussed on the IDPH website are the following:

- The Illinois living will only applies if the person who executed that advance directive has a terminal condition and is unable to communicate his/her treatment preferences to health care providers;⁶⁶
- A terminal condition is defined as “an incurable and irreversible condition such that death is imminent, and the application of any death delaying procedures would only serve to prolong the dying process;”⁶⁷
- A living will informs health care professionals as to whether the person who executed that advance directive prefers to receive or prefers to decline death-delaying procedures;⁶⁸
- Unlike a power of attorney for health care, a living will does not permit health care providers to withdraw nutrition and hydration from a patient if the withdrawal of food and water would be the only cause of a patients' death.⁶⁹

D. The Illinois Health Care Power of Attorney Law

Among the characteristics of the Illinois Health Care Power of Attorney (HCPOA) discussed on the IDPH website are the following:

- An HCPOA permits persons who executes that advance directive to choose another person to make health care decisions for them in the future if the person executing the HCPOA is no longer able to make such decisions for themselves;⁷⁰
- Persons who execute an HCPOA are referred to as health care principals, and the person the health care principal

⁶⁵ Act of July 29, 2019, Pub. L. No. 101-0163, § 1 (codified as amended in scattered sections of 755 ILL. COMP. STAT.; 20 ILL. COMP. STAT; 5 ILL. COMP. STAT).

⁶⁶ *Advance Directives*, ILL. DEP'T OF PUBLIC HEALTH, <https://www.dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives> (last visited Jan. 12, 2021).

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Advance Directives*, *supra* note 66, at 7.

chooses to make health care decisions for them is referred to as a health care agent,⁷¹

- The HCPOA provides the health care agent with specific directions from the health care principal about the health care the principal does or does not wish in the event the health care principal cannot make decisions for himself/herself.⁷²

E. The Illinois Health Care Surrogate Act

The IDPH website also contains an explanation of the Illinois Health Care Surrogate Act, which is important for at least two reasons. First, the Act contains authority and direction for the Illinois Department of Public Health Uniform POLST form for use as another Illinois health care advance directive.⁷³ Second, the Act also provides authorization for surrogate health care decision-making by a rank-ordered list of potential surrogates for persons who lack decisional capacity and who do not possess either a living will or health care power of attorney.⁷⁴

Among the characteristics of the Illinois Health Care Surrogate Act discussed on the IDPH website are the following:

- If a person cannot make health care decisions for himself/herself, a health care "surrogate" may be chosen for him/her pursuant to the Act;⁷⁵
- Two doctors would be required by the Act to certify that a person could not make health care decisions for himself/herself before a health care surrogate could be appointed;⁷⁶
- A health care surrogate could be selected from a rank-ordered list including one of the following persons (in order of priority): "guardian of the person, spouse, any adult child(ren), either parent, any adult brother or sister, any adult grandchild(ren), a close friend, or guardian of the estate";⁷⁷
- "[A] health care surrogate [could not advise a] health care professional to withdraw or withhold life-sustaining treatment unless a person had a 'qualifying condition'" defined as:

⁷¹ *Id.*

⁷² *Id.*

⁷³ 755 ILL. COMP. STAT. ANN. 40/65 (2020).

⁷⁴ 755 ILL. COMP. STAT. ANN. 40/25 (2020).

⁷⁵ *Advance Directives*, *supra* note 66, at 7.

⁷⁶ *Id.*

⁷⁷ *Id.*

(1) a "terminal condition" (an incurable or irreversible injury for which there is no reasonable prospect of cure or recovery, death is imminent, and life-sustaining treatment will only prolong the dying process); (2) "permanent unconsciousness" (a condition that, to a high degree of medical certainty, will last permanently, without improvement; there is no thought, purposeful social interaction or sensory awareness present; and providing life-sustaining treatment will only have minimal medical benefit), or (3) an "incurable or irreversible condition" (an illness or injury for which there is no reasonable prospect for cure or recovery, that ultimately will cause the patient's death, that imposes severe pain or an inhumane burden on the patient, and for which life-sustaining treatment will have minimal medical benefit) as certified by two doctors.⁷⁸

F. IDPH Uniform Do-Not-Resuscitate/Practitioner Orders for Life-Sustaining Treatment Forms Synopsis

Among the characteristics of the Illinois Uniform do-not-resuscitate (DNR)/practitioner orders for life-sustaining treatment (POLST) forms discussed on the IDPH website are the following:

- A person may consult with a health care professional about having a DNR/POLST Order entered;⁷⁹
- A DNR/POLST Order is an advanced directive that provides that cardiopulmonary resuscitation (CPR) will not be performed if the person subject to the order experiences heart and/or breathing stoppage;⁸⁰
- A DNR/POLST Order form contains a provision that permits the person subject to the order to record their preferences for receiving or withholding life-sustaining medical care and treatment, including nutrition and hydration;⁸¹
- A Uniform DNR/POLST Order is available for download at the IDPH webpage;
- The IDPH webpage also provides "a link to guidance for individuals, health care professionals and health care providers concerning the IDPH Uniform DNR/POLST Order;"⁸²

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ ILL. DEP'T OF PUBLIC HEALTH, IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM 1 (2017).

⁸² *Advance Directives, supra* note 66, at 7.

- Instructions for the Uniform DNR/POLST Order also permit the person subject to the order to advise whether that person also has executed a Living Will or HCPOA;⁸³
- The Uniform DNR/POLST Order requires the signature of the person subject to the order or that person's authorized legal representative (legal guardian, health care power of attorney, or health care surrogate), as well as the signature of the person's attending practitioner and a witness who is 18 years of age or older;⁸⁴
- A DNR/POLST Order can be entered into a person's medical record only if it contains all of the required signatures above;⁸⁵
- The person subject to a DNR/POLST Order is encouraged to ask their health care practitioner to work with them to prepare the Uniform DNR/POLST Order.⁸⁶

G. The IDPH Feasibility Study Report to The Illinois General Assembly

The Advisory Committee—comprised of representatives of professional groups such as the Illinois State Bar Association, the Illinois State Medical Society, the Illinois Hospital and Health Association, as well as professional associations for nurses, physician assistants, emergency medical systems, nursing homes, organ and tissue procurement, POLST education and elder and disability law—was charged by PA 101-0163⁸⁷ with filing the Feasibility Study with the Illinois General Assembly on or before January 1, 2021.⁸⁸ The Advisory Committee met by video conference calls on November 23 and December 16, 2020, to provide comments and edits for a Feasibility Study to be drafted by IDPH staff. The Feasibility Study titled “Statewide Registry of Advance Directives and Practitioner Orders for Life-Sustaining Treatment (POLST) Forms—Report to the Illinois General Assembly” was finalized by IDPH staff and filed by the IDPH Director, Dr. Ngozi Ezike, on December 31, 2020.⁸⁹

⁸³ ILLINOIS DEPARTMENT OF PUBLIC HEALTH, IDPH UNIFORM PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) FORM: GUIDANCE FOR INDIVIDUALS 1, 5 (n.d.), <https://www.dph.illinois.gov/sites/default/files/publications/uniform-polst-form-guidancefor-individuals-5-2016-050616.pdf> (last visited Mar. 3, 2021).

⁸⁴ *Advance Directives*, *supra* note 66, at 7.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ Act of July 26, 2019, Public Act 101-0163 (codified as amended at 20 ILL. COMP. STAT. 2310/2310-600 (2020)).

⁸⁸ *Id.*

⁸⁹ NGOZI O. EZIKE, STATEWIDE REGISTRY OF ADVANCE DIRECTIVES AND PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) FORMS: REPORT TO THE ILLINOIS GENERAL ASSEMBLY 1 (2020).

H. The Feasibility Study Introductory Summary

Dr. Ezike's cover letter to the report provides in relevant part:

In consultation with the POLST Registry Advisory Committee, the Illinois Department of Public Health concludes that proposed statewide registry for POLST forms is a feasible endeavor for Illinois if the state (1) initially limits registry capabilities and content to solely POLST forms and (2) pursues a public-private partnership to fund the registry using existing technology procured from a third-party vendor.⁹⁰ While an ideal registry would include broad user and public education and an expansion to include advance directives as well as POLST forms, such optimization is not feasible at this time.⁹¹

I. Registry Content

Public Act 101-0163 contemplated studying the feasibility of a statewide Registry containing all Illinois advance directives accessible by Illinois residents for the submission of such documents and accessible by health care providers and professionals for the provision of health care and treatment.⁹²

Nonetheless, the Advisory Committee concluded very early in its discussions that a proposed Registry should be limited to POLST forms to simplify the Registry's implementation process.⁹³ The IDPH staff representative and a majority of the Advisory Committee favored initiating a Registry limited to POLST forms to vet the utility of the Registry concept as something of a pilot study but agreed that future consideration of Registry utilization for living wills and powers of attorney for health care should be part of the Committee's final recommendations.⁹⁴

Generally, the Advisory Committee believed that the Uniform POLST form would provide a more streamlined document that was already available on the IDPH website and which conceivably could be more easily completed, executed, loaded into the proposed Registry, and successfully accessed by health care providers.⁹⁵ The Committee believed the POLST only Registry

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² Act of July 26, 2019, Pub. L. No. 101-0163 (codified as amended at 20 ILL. COMP. STAT. 2310/2310-600 (2020)).

⁹³ NGOZI O. EZIKE, STATEWIDE REGISTRY OF ADVANCE DIRECTIVES AND PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) FORMS: REPORT TO THE ILLINOIS GENERAL ASSEMBLY, 1 (2020).

⁹⁴ *Id.* at 15.

⁹⁵ *Id.* at 1.

format provided the best opportunity for the Registry to successfully launch and operate.⁹⁶

The nature of the POLST form and its utilization was important to that judgment.⁹⁷ The Uniform POLST form permits a person to obtain a physician order to accept or decline Cardio-Pulmonary Resuscitation (CPR) in the event the patient is found not breathing or without normal heart function.⁹⁸ The immediate treatment decision to initiate CPR is straightforward and time-sensitive but is better informed by knowing the patient's treatment wishes with respect to CPR.⁹⁹ The Advisory Committee recognized that, while some patients would prefer not to be resuscitated given their overall condition of health, CPR would typically be administered by health care providers to a non-responsive patient in the absence of patient direction.¹⁰⁰ For those patients wishing to decline resuscitation, the Advisory Committee felt that a time-bound emergency treatment decision could be informed by first responder and emergency health care provider access to an electronic Registry containing a simple form demonstrating the patient's CPR treatment preference.¹⁰¹ Once the Registry was effectively operating, the Committee believed it would be more capable of adding in more sophisticated advance directive forms such as the living will and the HCPOA, which could direct more sophisticated and less emergent health care decision making.¹⁰²

J. Advisory Committee Final Recommendations

Lastly, and more specifically, the Feasibility Study contained the following Advisory Committee recommendations for Illinois General Assembly consideration:

1. Direct IDPH to narrow contents for a statewide registry to only POLST forms. Consider adding advance directives, such as HCPOA forms and living wills, after Illinois has established a robust POLST registry.
2. Direct IDPH to collect information on statewide use of POLST forms. There is a lack of data about whether and how the POLST form is being used. The state should consider collaborating with trade organizations and other groups (e.g., POLST Illinois) that can convene stakeholders and other interested parties in order to find this information.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 4.

¹⁰¹ *Id.*

¹⁰² *Id.*

3. Direct IDPH to explore public-private partnerships for sustainable operation of a limited registry as proposed. After obtaining rough capital and operating cost estimates for the registry as proposed, the state should prioritize a public-private partnership model that leverages 90/10 funding from the Centers for Medicare & Medicaid Services and emphasizes financial support for the registry from stakeholders most likely to benefit from its operation, especially health systems and health plans.

4. Direct IDPH to procure services from a third-party vendor to operate the technology for the statewide registry of POLST forms. Consider using the registry design and functions proposed by the Advisory Committee to develop a request for proposal. The state and its private partner(s) will need to further define the registry at this point to properly procure a technology solution.

5. Consider legislation to establish a statewide registry as proposed in this report. A legislative mandate can accelerate the development of the registry and secure cooperation from necessary partners to address operational issues. The General Assembly should also consider any necessary legal adjustments to ensure the use of the statewide POLST registry is consistent with related statutes (e.g., practitioner liability).

6. Direct IDPH to conduct an evaluation once the registry reaches a critical mass of completed POLST forms. Continued spending on the proposed statewide registry should depend on the results of an evaluation demonstrating the effect of POLST forms on processes and outcomes of end-of-life care in Illinois as compared to a suitable control group.¹⁰³

K. Conclusion

Ideally, the public policy goals of P.A. 101-0163 (listed at the beginning of this article) can be best met by a registry for all types of advance directives and POLST forms. However, the complexity and expense of this expansive type of registry might, in practice, prove daunting. For now, the Advisory Committee has recommended that the registry be limited to POLST forms.¹⁰⁴ This is an important first step; if the POLST registry proves practicable, it could ultimately be broadened. For now, the POLST registry should significantly facilitate the advance care planning wishes of Illinois residents.

¹⁰³ *Id.* (citations omitted).

¹⁰⁴ *Id.*

IV. ILLINOIS COVID-19 EXECUTIVE ORDERS: TEMPORARY SUSPENSION OF CERTAIN STATUTES AND REGULATIONS RELATED TO THE PRACTICE OF MEDICINE

Allison de Corral

The COVID-19 pandemic has significantly affected the health care community and its ability to provide health care services during the COVID-19 pandemic. In order to facilitate the provision of health care during the COVID-19 pandemic, states, through State Disaster Proclamations and State Executive Orders, have eased statutes and regulations relating to health care and the practice of medicine. In Illinois, pursuant to the Illinois Emergency Management Agency Act (IEMAA), “[in] the event of a disaster . . . the Governor may . . . declare that a disaster exists.”¹⁰⁵ And as such, “the Governor may exercise . . . [his/her] emergency powers.”¹⁰⁶ In the event that the Governor declares a disaster exists, the Governor may:

[S]uspend the provisions of any regulatory statute prescribing procedures for the conduct of State business, or the orders, rules and regulations of any State agency, if strict compliance with the provisions of any statute, order, rule, or regulation would in any way prevent, hinder or delay necessary action, including emergency purchases, by the Illinois Emergency Management Agency, in coping with the disaster.¹⁰⁷

On March 9, 2020, the Governor of Illinois declared that the COVID-19 pandemic and its surrounding circumstances amounted to a public health emergency as defined in Section 4 of the Illinois Emergency Management Agency Act.¹⁰⁸ As a result, the Governor, through his emergency powers,

¹⁰⁵ 20 ILL. COMP. STAT. 3305/7 (2020) (Emergency powers provided to the Governor may not exceed 30 days) (The lapse of emergency powers, provided to the Governor, “shall not, as regards any act or acts occurring or committed within the 30-day period, deprive any person, firm, corporation, political subdivision, or body politic of any right or rights to compensation or reimbursement which he, she, it, or they may have under the provisions of this Act.”).

¹⁰⁶ *Id.*

¹⁰⁷ 20 ILL. COMP. STAT. 3305/7(1) (2020).

¹⁰⁸ 20 ILL. COMP. STAT. 3305/4 (2020) (Public health emergency means an occurrence or imminent threat of an illness or health condition that: (a) is believed to be caused by any of the following: (i) bioterrorism; (ii) the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin; (iii) a natural disaster; (iv) a chemical attack or accidental release; or (v) a nuclear attack or accident; and (b) poses a high probability of any of the following harms: (i) a large number of deaths in the affected population; (ii) a large number of serious or long-term disabilities in the affected population; or (iii) widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.).

suspended certain statutes and regulations that pertain to the provision of health care and the practice of medicine in the State of Illinois.¹⁰⁹

A. Immunity from Civil Liability

Under the Illinois Good Samaritan Act:

[P]erson[s] licensed under the Medical Practice Act of 1987 . . . who, in good faith, provide[] emergency care without a fee to a person, shall not, as a result of [their] acts or omissions, except willful or wanton misconduct on [their] part, in providing care, be liable for civil damages.¹¹⁰

As a result of the COVID-19 pandemic and the Gubernatorial Disaster Proclamation, and pursuant to the Good Samaritan Act, health care professionals and health care facilities were directed to provide assistance in support of the State's efforts to mitigate the effects of the COVID-19

¹⁰⁹ See Ill. Exec. Order No. 2020-09 (Mar. 19, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-09.pdf>; Ill. Exec. Order No. 2020-12 (Mar. 24, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-12.pdf>; Ill. Exec. Order No. 2020-19 (Apr. 1, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-19.pdf>; Ill. Exec. Order No. 2020-22 (Apr. 7, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-22.pdf>; Ill. Exec. Order No. 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-26.pdf>; Ill. Exec. Order No. 2020-33 (May 6, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-33.pdf>; Ill. Exec. Order No. 2020-37 (May 13, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-37.pdf>; Ill. Exec. Order No. 2020-39 (May 29, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-39.pdf>; Ill. Exec. Order No. 2020-44 (Jun. 26, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-44.pdf>; Ill. Exec. Order No. 2020-48 (Jul. 24, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-48.pdf>; Ill. Exec. Order No. 2020-52 (Aug. 21, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-52.pdf>; Ill. Exec. Order No. 2020-55 (Sep. 18, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-55.pdf>; Ill. Exec. Order No. 2020-59 (Oct. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-59.pdf>; Ill. Exec. Order No. 2020-71 (Nov. 13, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-71.pdf>; Ill. Exec. Order No. 2020-74 (Dec. 11, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-74.pdf>; Ill. Exec. Order 2021-01 (Jan. 8, 2021), <https://www2.illinois.gov/Documents/ExecOrders/2021/ExecutiveOrder-2021-01.pdf>.

¹¹⁰ 745 ILL. COMP. STAT. 49/25 (2020) (Similarly, a person licensed under the Medical Practice Act of 1987, or a health care professional, including but not limited to an advanced practice registered nurse, physician assistant, nurse, pharmacist, physical therapist, or podiatric physician, licensed in this State or any other state or territory of the United States, who in good faith “provides medical treatment, diagnosis, or advice as a part of the services of an established free medical clinic providing care to medically indigent patients which is limited to care that does not require the services of a licensed hospital or ambulatory surgical treatment center and who receives no fee or compensation from that source shall not be liable for civil damages as a result of his or her acts or omissions in providing that medical treatment, except for willful or wanton misconduct.”); 745 ILL. COMP. STAT. 49/30 (2020).

pandemic.¹¹¹ Executive Order 2020-19 established that, for the duration of the Governor's Disaster Proclamation, health care professionals would “be immune from civil liability for any injury or death alleged to have been caused by any act or omission by such health care professional.”¹¹² For civil immunity to apply, such health care professionals must have been engaged in the course of providing assistance to the State by rendering health care services in response to the COVID-19 pandemic.¹¹³ Any civil immunity provided to health care professionals would not apply in instances where the injury or death was caused by gross negligence or willful misconduct.¹¹⁴ Similarly, health care facilities would “be immune from civil liability for any injury or death alleged to have been caused by any act or omission by such health care facility.”¹¹⁵ For such civil immunity to apply, the injury or death must have occurred at a time when such health care facility was engaged in the course of providing assistance to the State by rendering health care services in response to the COVID-19 pandemic.¹¹⁶ The civil immunity provided to health care facilities would not apply when the injury or death was caused by gross negligence or willful misconduct by such health care facility.¹¹⁷

Subsequent Executive Orders, amended Executive Order 2020-19 granting immunity from civil liability to health care facilities and health care

¹¹¹ Ill. Exec. Order No. 2020-19 (Apr. 1, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-19.pdf>.

¹¹² Ill. Exec. Order No. 2020-19 (Apr. 1, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-19.pdf> (“‘Health [c]are [p]rofessional’ is defined as all licensed or certified health care or emergency medical services workers who (i) are providing health care services at a Health Care Facility in response to the COVID-19 outbreak and are authorized to do so; or (ii) are working under the direction of the Illinois Emergency Management Agency (IEMA) or DPH in response to the Gubernatorial Disaster Proclamations.”).

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ Ill. Exec. Order No. 2020-19 (Apr. 1, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-19.pdf>. (“‘Health Care Facilities’ means: (i) Facilities licensed, certified, or approved by any State agency and covered by the following: 77 Ill. Admin. Section 1130.215(a)-(f); University of Illinois Hospital Act, 110 ILCS 330; Alternative Health Care Delivery Act, 210 ILCS 3/35(2)-(4); Emergency Medical Services (EMS) Systems Act, 210 ILCS 50; or Department of Veterans’ Affairs Act, 20 ILCS 2805; (ii) State-operated Developmental Centers certified by the federal Centers for Medicare and Medicaid Services and licensed State-operated Mental Health Centers created pursuant to the Mental Health and Developmental Disabilities Administrative Act, 20 ILCS 1705/4; (iii) Licensed community-integrated living arrangements as defined by the Community-Integrated Living Arrangements Licensing and Certification Act, 210 ILCS 135/2; (iv) Licensed Community Mental Health Centers as defined in the Community Services Act, 405 ILCS 30; (v) Federally qualified health centers under the Social Security Act, 42 U.S.C. § 1396d(1)(2)(B); and (vi) Any government-operated site providing health care services established for the purpose of responding to the COVID-19 outbreak.”).

¹¹⁶ *Id.*

¹¹⁷ *Id.*

professionals.¹¹⁸ Executive Order 2020-33 expanded the definition of health care facilities to include supportive living facilities, assisted living establishments, and shared housing establishments.¹¹⁹ It also clarified that "rendering assistance" by hospitals in support of the State's response to the Disaster Proclamation included accepting a transfer of a COVID-19 patient from another hospital that does not have the required room and capability to render treatment to COVID-19 patients.¹²⁰ Similarly, Executive Order 2020-37, which superseded Executive Order 2020-19, clarified and further delineated what conduct by hospitals, health care facilities, and health care professionals would warrant civil immunity during the COVID-19 pandemic.¹²¹ Hospitals, which continue to postpone or cancel all elective surgeries or procedures in order to respond to the COVID-19 pandemic, would be immune from civil liability for any injury or death presumed to be caused by an act of omission by such a hospital.¹²² Health care professionals rendering services in such hospitals would also be immune from civil liability for any injury or death presumed to be caused by an act of omission by such health care professionals.¹²³ Hospitals that perform elective procedures or surgeries on or after May 11, 2020, or health care professionals who render services in such hospital, would also be immune from civil liability for any injury or death which relates to the diagnosis, treatment, or transmission of COVID-19 supposed to have been caused by any act or omission by the health care professional or hospital.¹²⁴ Health care facilities, as well as health care professionals providing services in health care facilities, would also be immune from civil liability for any injury or death related to the transmission, treatment, or diagnosis of COVID-19 assumed to be caused by an act or

¹¹⁸ Ill. Exec. Order No. 2020-33 (May 6, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-33.pdf>.

¹¹⁹ *Id.* (The Executive Order further defines "Health Care Facilities" to include: "(vii) Supportive living facilities certified by the Illinois Department of Healthcare and Family Services pursuant to the Illinois Public Aid Code, 305 ILCS 5/5-5.01(a); and (viii) Assisted living establishments and shared housing establishments licensed by the DPH pursuant to the Assisted Living and Shared Housing Act, 210 ILCS 9.").

¹²⁰ *Id.* ("The receiving hospital shall accept such transfer of a COVID-19 patient if it has sufficient capacity and capability necessary to provide treatment for the COVID-19 patient. In determining whether a hospital has sufficient capacity and capability necessary to provide treatment for a COVID-19 patient, the hospital shall consider, at a minimum, its ability to provide safe and effective treatment consistent with current public health recommendations and available supplies, staffing, and medical bed capacity.").

¹²¹ Ill. Exec. Order No. 2020-37 (May 13, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-37.pdf>.

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Id.* (For civil immunity to apply, the hospital or health care professional must have been "rendering assistance to the State in response to the COVID-19 outbreak by providing health care services consistent with current guidelines issued by IDPH.").

omission by such health care professional or health care facility.¹²⁵ Such immunity from civil liability, described above, would not include any injury or death by any hospital or health care professional, which was caused by gross negligence or willful misconduct.¹²⁶ On June 27, 2020, Executive Order 2020-37 expired and has not been reissued, by subsequent Executive Orders, by the Governor.¹²⁷

B. Telehealth Services

Pursuant to the Illinois Telehealth Act, a health care professional may engage in the practice of Telehealth Services to the extent of their scope of practice consistent with the standards of care for in-person services.¹²⁸ Such health care professionals using Telehealth Services to provide treatment to a patient located in the State of Illinois must be licensed or authorized to practice in Illinois.¹²⁹ Under the Telehealth Act, telehealth is defined as "the evaluation, diagnosis, or interpretation of electronically transmitted patient-specific data between a remote location and a licensed health care professional that generates interaction or treatment recommendations."¹³⁰ "Telehealth" also includes telemedicine and the [provision] of health care services provided by way of an interactive telecommunications system."¹³¹ The Telehealth Act does not alter the scope of practice of any health care professional, nor does it permit the delivery of health care services in a setting or in a manner not authorized by the laws of the State of Illinois.¹³²

On March 19, 2020, the Governor issued Executive Order 2020-09, which expanded Telehealth Services in the State of Illinois.¹³³ The Executive

¹²⁵ Ill. Exec. Order No. 2020-37 (May 13, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-37.pdf>. (For civil immunity to apply, the injury or death must have "occurred at the time when a Health Care Facility or the Health Care Professional was rendering assistance to the State in response to the COVID-19 outbreak by providing health care services consistent with current guidance by IDPH.")

¹²⁶ *Id.*

¹²⁷ See Ill. Exec. Order No. 2020-37 (May 13, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-37.pdf>. and Ill. Exec. Order No. 2020-44 (Jun. 26, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-44.pdf>.

¹²⁸ 225 ILL. COMP. STAT. 150/15 (2020).

¹²⁹ 225 ILL. COMP. STAT. 150/10 (2020).

¹³⁰ 225 ILL. COMP. STAT. 150/5 (2020).

¹³¹ *Id.* (Interactive telecommunications system is defined as "an audio and video system permitting 2-way, live interactive communication between the patient and the distant site health care provider."); 215 ILL. COMP. STAT. 5/356z.22 (2020).

¹³² 225 ILL. COMP. STAT. 150/15 (2020).

¹³³ Ill. Exec. Order No. 2020-09 (Mar. 19, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-09.pdf>.

Order broadened the definition of Telehealth Services under Section 356z.22 of the Illinois Insurance Code.¹³⁴ Telehealth Services shall now include:

[T]he provision of health care, psychiatry, mental health treatment, substance use disorder treatment, and related services to a patient, regardless of their location, through electronic or telephonic methods, such as telephone (landline or cellular), video technology commonly available on smart phones and other devices such as FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, and videoconferencing, as well as any method within the meaning of "telehealth services" under Section 356z.22 of the Illinois Insurance Code, 215 ILCS 5.¹³⁵

Telehealth Services, subject to Executive Order 2020-09's coverage requirements, may now 'be provided by any in-network physicians, physician assistants, advanced practice registered nurses, optometrists, dentists, clinical psychologists, and prescribing psychologists, as long as such provider of Telehealth Services is licensed, registered, certified, or authorized to practice in the State of Illinois."¹³⁶ The in-network provider does not need to have been established, prior to the COVID-19 pandemic, in a designated telehealth network, in order to provide Telehealth Services.¹³⁷

For the duration of the Gubernatorial Disaster Proclamation, a covered entity and/or a covered health care provider subject to the Mental Health and Developmental Disabilities Confidentiality Act, and who "uses audio or video communication technology to provide Telehealth Services to [developmental disability and mental health] patients may be able to use any non-public facing remote communication product."¹³⁸ Providers and covered entities are urged to inform patients that third-party applications may probably increase privacy risks.¹³⁹ As such, providers and covered entities

¹³⁴ *Id.* (Telehealth services "means the delivery of covered health care services by way of an interactive telecommunications system."); 215 ILL. COMP. STAT. 5/356z.22(a) (2020).

¹³⁵ Ill. Exec. Order No. 2020-09 (Mar. 19, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-09.pdf>.

¹³⁶ Ill. Exec. Order No. 2020-09 (Mar. 19, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-09.pdf>. (Section 5, Telehealth Services, subject to Executive Order 2020-09's coverage requirements, also includes any in-network occupational therapists, occupational therapists, pharmacists, physical therapists, clinical social workers, speech-language pathologists, audiologists, hearing instrument dispensers, other mental health providers, and other substance use disorder treatment providers).

¹³⁷ *Id.*

¹³⁸ Ill. Exec. Order No. 2020-09 (Mar. 19, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-09.pdf>. (Section 9, The use of any non-public facing remote communication product must be in accordance with Section 1 of Executive Order 2020-09) ("This exercise of discretion applies to Telehealth Service providers or covered entities for any reason, regardless of whether the Telehealth Service concerns the diagnosis and treatment of health conditions related to COVID-19.").

¹³⁹ *Id.*

are encouraged to use all encryption and privacy modes when using such third-party applications.¹⁴⁰

For the duration of the Gubernatorial Disaster Proclamation, "health insurance issuers, regulated by the Department of Insurance, shall cover the costs of all Telehealth Services" provided by in-network providers who deliver "clinically appropriate, medically necessary covered services and treatments."¹⁴¹ Health insurance issuers may not "impose upon telehealth services utilization review requirements that are unnecessary, duplicative, or unwarranted, nor impose any treatment limitations that are more stringent than the requirements applicable to the same health care service when rendered in-person."¹⁴² Health insurance issuers may also not impose prior authorization requirements for any Telehealth Services related to COVID-19, which are provided by an in-network provider.¹⁴³

C. Health Care Worker Background Checks

Executive Order 2020-12 and Executive Order 2021-04 suspended, for the duration of the Gubernatorial Disaster Proclamation, several provisions of the Health Care Worker Background Check Act.¹⁴⁴ The provision prohibiting the hiring of a certified nursing assistant with an inactive license on the Health Care Worker Registry was suspended so long as the certified nursing assistant had an inactive status of no more than five years, at the time the license became inactive the certified nursing assistant was in good standing, and the certified nursing assistant completes and submits any required forms to the Department of Public Health.¹⁴⁵ The provision, which limits the conditional employment of certified nursing assistants to three months until the results of a fingerprint-based criminal history record check, was also suspended.¹⁴⁶ Such conditional employment may not exceed six months without obtaining the results of a fingerprint-based criminal history

¹⁴⁰ *Id.*

¹⁴¹ Ill. Exec. Order No. 2020-09 (Mar. 19, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/execorder-2020-09.pdf>.

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ Ill. Exec. Order No. 2020-12 (Mar. 24, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-12.pdf>; Ill. Exec. Order No. 2021-04 (Feb. 5, 2021), <https://www2.illinois.gov/Documents/ExecOrders/2021/ExecutiveOrder-2021-04.pdf>. *See also* 225 ILL. COMP. STAT. 46/33(g) (2020); 225 ILL. COMP. STAT. 46/33(1) (2020); 225 ILL. COMP. STAT. 46/33(e) (2020).

¹⁴⁵ Ill. Exec. Order No. 2020-12 (Mar. 24, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-12.pdf>.

¹⁴⁶ Ill. Exec. Order No. 2020-12 (Mar. 24, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-12.pdf>. *See also* 225 ILL. COMP. STAT. 46/33(1) (2020). Section 2 of Executive Order No. 2020-12 was rescinded on July 24, 2020, by Executive Order No. 2020-48. *See* Ill. Exec. Order No. 2020-48 (July 24, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-48.pdf>.

record check.¹⁴⁷ Lastly, the provision requiring applicants, employees, and designated students to have their fingerprints collected electronically and then sent to the Illinois Department of State Police within ten working days is also suspended, for the duration of the Gubernatorial Disaster Proclamation, so long as fingerprints of designated students, applicants, or employees are sent within thirty working days of commencing employment or enlistment in a Certified Nursing Assistant training program.¹⁴⁸

D. Licensing

Executive Order 2020-09 suspends, for the duration of the Gubernatorial Disaster Proclamation, the provision in the Medical Practice Act of 1987 requiring licensees with lapsed licenses or inactive licenses of less than three years to provide proof of completed continuing education requirements for one renewal period and proof of payment of reinstatement fee.¹⁴⁹

E. Hospital Capacity

Executive Order 2020-26 established that the Illinois Department of Public Health (IDPH) would exercise discretion in the enforcement of provisions of the Hospital Licensing Act¹⁵⁰, the Emergency Management Services Act,¹⁵¹ the Department of Public Health Powers and Duties Law,¹⁵² the Illinois Adverse Health Care Events Reporting Law of 2005¹⁵³ and any corresponding regulations in the Illinois Administrative Code.¹⁵⁴ Such discretion, by the IDPH, is for the duration of the Gubernatorial Disaster Proclamation and would allow Illinois hospitals and health care providers to provide accommodations in order to ensure patient safety during the COVID-19 pandemic.¹⁵⁵

¹⁴⁷ Ill. Exec. Order No. 2020-12 (Mar. 24, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-12.pdf>. *See also* 225 ILL. COMP. STAT. 46/33(l) (2020). Section 2 of Executive Order No. 2020-12 was rescinded on July 24, 2020, by Executive Order No. 2020-48. *See* Ill. Exec. Order No. 2020-48 (July 24, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-48.pdf>.

¹⁴⁸ Ill. Exec. Order No. 2021-04 (Feb. 5, 2021), <https://www2.illinois.gov/Documents/ExecOrders/2021/ExecutiveOrder-2021-04.pdf>. *See also* 225 ILL. COMP. STAT. 46/33(e) (2020).

¹⁴⁹ Ill. Exec. Order No. 2020-09 (Mar. 19, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-09.pdf>; *See also* Medical Practice Act of 1987, 225 ILL. COMP. STAT. 60/21 (2020).

¹⁵⁰ *See* 210 ILL. COMP. STAT. 85/1 to 85/16 (2020).

¹⁵¹ *See* 210 ILL. COMP. STAT. 50/1 to 50/33 (2020).

¹⁵² *See* 20 ILL. COMP. STAT. 2310/2310-1 to 2310/2310-700 (2020).

¹⁵³ *See* 410 ILL. COMP. STAT. 522/10-1 to 522/10-50 (2020).

¹⁵⁴ Ill. Exec. Order No. 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-26.pdf>.

¹⁵⁵ *Id.*

The Hospital Licensing Act provisions related to notice of discharge for aged patients and patients with disabilities on Medicare, as well as the provision requiring hospitals to promptly report deaths are suspended.¹⁵⁶ Similarly, the Hospital Licensing Act requirement for hospitals to report drug overdoses to the IDPH is also suspended.¹⁵⁷ The requirement that a hospital arranges for the transportation of a patient by an ambulance service provider is suspended.¹⁵⁸ The provision that the Governor appoint a Hospital Licensing Board and requirements for the Director to create and implement Department rules has also been suspended for the duration of the Gubernatorial Disaster Proclamation.¹⁵⁹ The requirements for the employment of physicians by hospitals and hospital affiliates, as well as the provisions for the staffing of nurses based on patient acuity, are suspended as well.¹⁶⁰ Lastly, the provisions that televisions located in hospitals have activated at all times the closed captioning feature has been suspended.¹⁶¹

The provisions in the Hospital Report Card Act, and any corresponding regulations, are suspended for the duration of the Gubernatorial Disaster Proclamation, except for employee whistleblower protections and employee private right of action provisions.¹⁶² Reporting deadlines pursuant to the Illinois Adverse Health Care Events Reporting Law, and any corresponding regulations, are also suspended.¹⁶³ Such suspension of reporting

¹⁵⁶ Ill. Exec. Order No. 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-26.pdf>; *See also* 210 ILL. COMP. STAT. 85/6.09 (2020); 210 ILL. COMP. STAT. 85/6.09b (2020). The provisions of Executive Order 2020-26, Section 2(a)-(d) and (f)-(h), suspending certain licensing requirements of the Hospital Licensing Act were rescinded on August 22, 2020 and subsequently reissued on December 11, 2020. *See* Ill. Exec. Order 2020-74 (Dec. 11, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-74.pdf>; Ill. Exec. Order 2021-01 (Jan. 8, 2021), <https://www2.illinois.gov/Documents/ExecOrders/2021/ExecutiveOrder-2021-01.pdf>.

¹⁵⁷ Ill. Exec. Order No. 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-26.pdf>; *See also* 210 ILL. COMP. STAT. 85/6.14g (2020).

¹⁵⁸ Ill. Exec. Order No. 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-26.pdf>; *See also* 210 ILL. COMP. STAT. 85/6.22 (2020).

¹⁵⁹ Ill. Exec. Order No. 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-26.pdf>; *See also* 210 ILL. COMP. STAT. 85/10 (2020).

¹⁶⁰ Ill. Exec. Order No. 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-26.pdf>; *See also* 210 ILL. COMP. STAT. 85/10.8 (2020); 210 ILL. COMP. STAT. 85/10.10 (2020).

¹⁶¹ Ill. Exec. Order No. 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-26.pdf>; *See also* 210 ILL. COMP. STAT. 85/11.8 (2020).

¹⁶² Ill. Exec. Order No. 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-26.pdf>; *See also* 210 ILL. COMP. STAT. 86/1 to 86/99 (2020); ILL. ADM. CODE tit. 77, § 255 (2020). The Provision of Executive Order 2020-26 Section 3 was rescinded on August 22, 2020 and subsequently reissued on December 11, 2020. *See* Ill. Exec. Order 2020-74 (Dec. 11, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-74.pdf>; Ill. Exec. Order 2021-01 (Jan. 8, 2021), <https://www2.illinois.gov/Documents/ExecOrders/2021/ExecutiveOrder-2021-01.pdf>.

¹⁶³ Ill. Exec. Order 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-26.pdf>; *See also* 410 ILL. COMP. STAT. 522/10-1 to 522/10-50 (2020);

requirements does not eliminate a Health Care Facility's obligation to report, pursuant to any deadlines, an adverse health care event but allows for such facilities to report adverse health care events after the conclusion of the Gubernatorial Disaster Proclamation.¹⁶⁴

Lastly, Executive Order 2020-26 also provides that hospitals licensed by the IDPH or the State of Illinois may establish Alternate Care Facilities in order to diagnose, treat, nurse, or provide room and board to COVID-19 patients as well as non-COVID-19 patients.¹⁶⁵ Such Alternate Care Facilities shall allow for increased hospital capacity for COVID-19 patients.¹⁶⁶ For the duration of the Gubernatorial Disaster Proclamation, all of the provisions of the Hospital Licensing Act as well as any regulations in the Illinois Administrative Code, as they apply to Alternate Care Facilities, are suspended as long as the Alternate Care Facility is compliant with the standards in the IDPH emergency rules.¹⁶⁷

In conclusion, recent statutory and regulatory suspensions have allowed health care professionals, hospitals, and health care facilities to continue to provide care during the COVID-19 pandemic and ensure that patients do not face further hardships in access to general health care as well as diagnostic testing and treatment services for COVID-19. These statutory and regulatory suspensions, pursuant to Illinois Executive Orders, shall be in force, unless rescinded, for the duration of the Gubernatorial Disaster Proclamation, which was extended, on January 8, 2021, for another thirty days.¹⁶⁸

V. "FIRST, DO NO HARM": THE ILLINOIS BIOMETRIC INFORMATION PRIVACY ACT AND THE SEARCH FOR BUSINESS PROTECTION AGAINST NO-INJURY LAWSUITS

Nicholas Kurk, Jacob D. Radecki, and Rick Hindmand

ILL. ADM. CODE tit. 77, § 235. The provision of Executive Order 2020-26 (COVID-19 Executive Order No. 24), Section 5 was rescinded on August 22, 2020 and subsequently reissued on December 11, 2020. *See* Ill. Exec. Order 2020-74 (Dec. 11, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-74.pdf>; Ill. Exec. Order 2021-01 (Jan. 8, 2021), <https://www2.illinois.gov/Documents/ExecOrders/2021/ExecutiveOrder-2021-01.pdf>.

¹⁶⁴ Ill. Exec. Order 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-26.pdf>; *See also* 410 ILL. COMP. STAT. 522/10-1 to 522/10-50 (2020); ILL. ADM. CODE tit. 77, § 235. The provision of Executive Order 2020-26 (COVID-19 Executive Order No. 24), Section 5 was rescinded on August 22, 2020 and subsequently reissued on December 11, 2020. *See* Ill. Exec. Order 2020-74 (Dec. 11, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-74.pdf>; Ill. Exec. Order 2021-01 (Jan. 8, 2021), <https://www2.illinois.gov/Documents/ExecOrders/2021/ExecutiveOrder-2021-01.pdf>.

¹⁶⁵ Ill. Exec. Order 2020-26 (Apr. 16, 2020), <https://www2.illinois.gov/Documents/ExecOrders/2020/ExecutiveOrder-2020-26.pdf>.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*; *See also* 210 ILL. COMP. STAT. 85/1 to 85/16 (2020); ILL. ADM. CODE tit. 77, § 250.

¹⁶⁸ Ill. Proclamation No. 2021-1 (Jan. 8, 2021), <https://www2.illinois.gov/sites/gov/Documents/CoronavirusDisasterProc-01-08-2021.pdf>.

Since the Illinois Biometric Information Privacy Act (“BIPA”)¹⁶⁹ was enacted, the statute has given rise to a tidal wave of expensive class-action lawsuits against all manner of businesses throughout the country – and all this despite the fact that, in nearly every case, the “aggrieved” party has suffered no injury beyond a mere technical violation of the statute.¹⁷⁰ The health care industry is no exception – plaintiffs seeking to make quick cash off of unsuspecting businesses have increasingly targeted health care entities.¹⁷¹ With the Illinois Supreme Court's 2019 pronouncement that actual harm is not necessary to state a BIPA claim, lawsuits against Illinois businesses – including health care entities – have proliferated.¹⁷² As we discuss below, lawsuits often take issue with health care companies' use of employee biometric information for timekeeping purposes and to secure sensitive information, such as medical records or products, such as prescription drugs.¹⁷³ In summary, BIPA's strict technical requirements and draconian liquidated damages provisions demand the attention of in-house counsel and administrators to take preventative action and ward off expensive and preventable litigation.¹⁷⁴

This section proceeds in three parts. We first describe BIPA's background and key case developments, then discuss the worrying trend of recent cases specifically targeting entities in the health care industry. Finally, we close with suggestions of how health care entities can protect themselves against this troubling trend.

A. BIPA Background

The Illinois legislature enacted BIPA in 2008 based on concerns that consumers' biometric data – including, commonly, fingerprints – were being gathered, stored, and possibly sold.¹⁷⁵ BIPA's “Legislative findings; intent” section contends that, when BIPA was being enacted, businesses were using locations in Illinois “as pilot testing sites for new applications of biometric-facilitated financial transactions, including finger-scan technologies at grocery stores, gas stations, and school cafeterias.”¹⁷⁶ In trying to reduce the risk that Illinois residents' biometric information could be compromised by

¹⁶⁹ 740 ILL. COMP. STAT. 14/1 to 14/99 (2020).

¹⁷⁰ Monica R. Chmielewski et al., *Biometric Privacy: Illinois Supreme Court Decision Allows Claims to Proceed Without Showing of Actual Harm*, NAT'L L. REV. (Feb. 4, 2019), <https://www.natlawreview.com/article/biometric-privacy-illinois-supreme-court-decision-allows-claims-to-proceed-without>.

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ 740 ILL. COMP. STAT. 14/15 (2020).

¹⁷⁶ 740 ILL. COMP. STAT. 14/5 (2020).

these types of programs, the Illinois legislature quickly drafted and passed BIPA.¹⁷⁷ In doing so, the Illinois legislature created a burdensome set of regulations strictly governing “the collection, use, and storage of biometric data.”¹⁷⁸ Among other things, BIPA requires that companies collecting biometric data inform the subject – typically consumers or employees – that their biometric data is being collected, how it is being used, and when it will be destroyed.¹⁷⁹ Indeed, companies in possession of biometric information must have a publicly available written policy identifying the same.¹⁸⁰ Moreover, companies must also obtain a written release from any individual whose biometric information is collected.¹⁸¹

Illinois is one of only a few states with this type of sweeping legislation related to biometric information.¹⁸² And within that small group, Illinois law is unique: “it provides a private right of action, including liquidated damages, for any ‘person aggrieved’ by a violation of the statute.”¹⁸³ And these liquidated damages are steep – plaintiffs and putative class members are entitled to \$1,000 for each negligent violation and \$5,000 for each willful violation of BIPA.¹⁸⁴

B. *Rosenbach v. Six Flags*: What’s “Harm” Got to Do with It?

After BIPA became “hot” for the plaintiffs’ bar, many businesses and their counsel hoped that BIPA’s “person aggrieved” phrase would be strictly interpreted and require actual harm – i.e., that someone’s biometric information was actually disclosed or misused.¹⁸⁵ Unfortunately for BIPA defendants, the Illinois Supreme Court put to rest any hope of relief from the statute’s plain text in *Rosenbach v. Six Flags Entertainment*.¹⁸⁶ In *Rosenbach*, a plaintiff brought a claim against Six Flags for collecting his fingerprint for a season pass without providing the required written disclosures or obtaining his written consent or release.¹⁸⁷ The plaintiff did not allege an actual injury resulting from this technical violation of BIPA, such as identity theft, nor did

¹⁷⁷ S.B. 2400, 95th Gen. Assemb., Reg. Sess. (Ill. 2008), Biometric Information Privacy Act, Pub. Act. No. 95-0994, 2008 Ill. Laws 3693 (2008) (codified as amended at 740 ILL. COMP. STAT. 14/1 to 14/99).

¹⁷⁸ 740 ILL. COMP. STAT. 14/15 (2020).

¹⁷⁹ 740 ILL. COMP. STAT. 14/15(b) (2020).

¹⁸⁰ 740 ILL. COMP. STAT. 14/15(a) (2020).

¹⁸¹ 740 ILL. COMP. STAT. 14/15(b) (2020).

¹⁸² Chmielewski et al., *supra* note 170.

¹⁸³ 740 ILL. COMP. STAT. 14/20 (2020); *see also* Chmielewski et al., *supra* note 170.

¹⁸⁴ 740 ILL. COMP. STAT. 14/20 (2020).

¹⁸⁵ Brief for Illinois Chamber of Commerce as Amici curiae Supporting Defendants at 8, *Rosenbach v. Six Flags Ent. Corp.*, 129 N.E.3d 1197 (Ill. 2019), 2018 WL 5777926, at *7-8.

¹⁸⁶ *Rosenbach v. Six Flags Ent. Corp.*, 2019 IL 123186.

¹⁸⁷ *Id.* ¶ 11.

he allege that any of his biometric data was even sold, disclosed, or otherwise shared.¹⁸⁸

After Six Flags successfully moved to dismiss the complaint on the basis that the plaintiff had not alleged any “actual injury,” two questions were certified for interlocutory appeal to the Second District.¹⁸⁹ Both questions related to whether the plaintiff was “aggrieved” within the meaning of the statute despite failing to allege actual damages or any negative effects resulting from Six Flags’ collection or use of his biometric data.¹⁹⁰ The Second District sided with Six Flags and held that the plaintiff’s claim was insufficient because he merely alleged that Six Flags violated the statute’s technical requirements, and a plaintiff must allege some actual injury – i.e., recognizable harm – stemming from a BIPA violation.¹⁹¹

However, after an appeal to the Illinois Supreme Court, businesses hoping for a more restrictive interpretation of BIPA’s injury requirements were disappointed.¹⁹² The Illinois Supreme Court reversed the Second District, explaining that according to BIPA’s plain language, the statute enacted an unambiguous and strict right to biometric privacy.¹⁹³ The Illinois Supreme Court further held that BIPA “define[s] the contours of that statutory right.”¹⁹⁴ Based on this interpretation, the Illinois Supreme Court held that a business that failed to strictly comply with the requirements of BIPA – regardless of whether or not that noncompliance led to any actual injury to affected individuals – had harmed potential plaintiffs by violating their right to biometric privacy.¹⁹⁵ Consequently, the Illinois Supreme Court held, even a mere “technical violation” of BIPA results in the loss of biometric privacy, violates plaintiffs’ rights, and means that affected individuals are “aggrieved” and may pursue a private right of action against the offending business.¹⁹⁶

The practical effect of *Rosenbach* was that companies facing BIPA lawsuits were stripped of their primary defense in litigation and their primary bargaining chip in settlement negotiations. Thus, even though several other commonly-raised defenses are currently working their way through the Illinois court systems—including defenses related to the length of the statute of limitations and potential preemption of claims against employers by the Illinois Worker’s Compensation Act—for now, BIPA is essentially operating

¹⁸⁸ *Id.* ¶¶ 8-16.

¹⁸⁹ *Id.* at ¶ 14.

¹⁹⁰ *Id.*

¹⁹¹ *Id.* at ¶ 15.

¹⁹² *Id.* at ¶¶ 37-38.

¹⁹³ *Id.*

¹⁹⁴ *Id.* at ¶ 33.

¹⁹⁵ *Id.* at ¶¶ 33-34.

¹⁹⁶ *Id.* at ¶¶ 34-35.

as a strict liability statute entitling each class member to at least a \$1,000 statutory fine.¹⁹⁷

C. Some Relief for Employers – Seventh Circuit Case Law and Arbitrability of BIPA Claims.

Courts in the Seventh Circuit have held that where an employee has a collective bargaining agreement (CBA”) with an employer, the CBA will govern whether the employee has to arbitrate a claim under BIPA – and whether the employee has a claim at all.¹⁹⁸ In *Miller v. Southwest Airlines Co.*, union employees alleged that Southwest violated BIPA by collecting and storing their biometric information.¹⁹⁹ Southwest asserted that the unions consented to such collection through their CBA.²⁰⁰ The trial court agreed, ruling that the dispute must be decided by an adjustment board.²⁰¹ In a consolidated appeal with a related case, the Seventh Circuit affirmed the trial court’s dismissal, holding that “[h]ow workers clock in and out is a proper subject of negotiation between unions and employers.”²⁰² And in *Crooms v. Southwest Airlines*, a judge in the federal court for the Northern District of Illinois extended the principles expressed by the Seventh Circuit in *Miller*.²⁰³ In discussing the same CBA, the *Crooms* court held that the plaintiffs’ BIPA claims fell within the scope of the parties’ arbitration agreement such that an arbitrator would decide whether the BIPA claims had to proceed in arbitration rather than court.²⁰⁴

D. Recent BIPA Case Law in the Health Care Context

¹⁹⁷ See generally, *Stauffer v. Innovative Heights Fairview Heights, LLC*, 480 F.Supp.3d 888, 904-05 (S.D. Ill. 2020) (finding that, because there is no express statute of limitations in BIPA, plaintiff’s claim was not time barred); *Robertson v. Hostmark Hospitality Group, Inc.*, No. 18-CH-5194, 2019 WL 8640568, at *2-3 (Ill. Cir. Ct. 2019) (finding that plaintiff’s claims under BIPA were not time barred); *McDonald v. Symphony Bronzeville Park LLC*, No. 1-19-2398, 2020 IL App (1st) 192398, at *8 (“[T]he exclusivity provisions of the Compensation Act do not bar a claim for statutory, liquidated damages, where an employer is alleged to have violated an employee’s statutory privacy rights under the Privacy Act.”); *Sherman v. Brandt Industries USA Ltd.*, No. 20-cv-1185, 2020 WL 6685701, at *6-7 (C.D. Ill. Nov. 12, 2020) (finding that plaintiff’s BIPA claims are not preempted by the Illinois Workers’ Compensation Act).

¹⁹⁸ See generally, *Miller v. Southwest Airlines Co.*, 926 F.3d 898 (7th Cir. 2019).

¹⁹⁹ *Miller*, 926 F.3d at 900.

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Crooms v. Southwest Airlines Co.*, 459 F.Supp.3d 1041, 1048-51 (N.D. Ill. 2020).

²⁰⁴ *Id.* at 1058.

There is a growing trend of BIPA lawsuits against Illinois health care providers and related entities.²⁰⁵ These lawsuits have often taken the form of claims by employees against their employers for using employee biometric information in timekeeping or securing sensitive information or even pharmaceuticals.²⁰⁶ And some have recently taken the form of lawsuits by consumers against health care-related entities for privacy violations.²⁰⁷ What follows is a brief discussion of just a few types of BIPA lawsuits faced by Illinois health care entities in recent months:

In *House and Crawley-McCray v. St. Anthony Hospital*, two former employees of St. Anthony Hospital filed a putative class action lawsuit against their former employer, alleging that St. Anthony Hospital employees were required to scan their fingerprints or hands at the beginning and end of their workday as well as the beginning and end of their meal breaks.²⁰⁸ The plaintiffs alleged that St. Anthony violated multiple BIPA provisions, including its notice and consent provisions.²⁰⁹

In *Hicks v. Evergreen Living*, a former employee of the Evergreen Living nursing facility alleged that the facility violated BIPA by requiring employees to use biometric timekeeping devices to clock in and out of work.²¹⁰ The plaintiff alleged that Evergreen violated BIPA in multiple ways and entitled her and the putative class to substantial liquidated damages.²¹¹

In *Jacobs v. Walgreen Co.*, a plaintiff filed his putative class action lawsuit against Walgreens, alleging that Walgreens used facial recognition technology to capture his biometric information when he shopped at a Chicago-area Walgreens location.²¹² Like the *St. Anthony* and *Evergreen Living* plaintiffs, the *Walgreen* plaintiff also alleged that Walgreen violated multiple BIPA provisions.²¹³

²⁰⁵ See Julia Lynch et al., *The Illinois Biometric Information Privacy Act and Health Care*, 36 Health Care Lawyer No. 3 (Mar. 2020).

²⁰⁶ Julia Lynch et al., *The Illinois Biometric Information Privacy Act and Health Care*, 36 Health Care Lawyer No. 3 (Mar. 2020).

²⁰⁷ *Id.*

²⁰⁸ Complaint at 1, *House v. St. Anthony Hospital Inc.*, No. 2020-CH-04788 (Ill. Cir. Ct. dismissed Sept. 28, 2020).

²⁰⁹ *Id.*

²¹⁰ Complaint at 1-2, *Hicks v. Evergreen Living & Rehab Center, et al.*, No. 20-cv-04032 (N.D. Ill. filed July 9, 2020). Hicks was originally filed in the Circuit Court of Cook County and was subsequently removed to the Northern District of Illinois by the defendant. See Notice of Removal, *Hicks v. Evergreen Living & Rehab Center, et al.*, No. 20-cv-04032 (N.D. Ill. filed July 9, 2020).

²¹¹ Complaint at 8-10, *Hicks v. Evergreen Living & Rehab Center, et al.*, No. 20-cv-04032 (N.D. Ill. filed July 9, 2020).

²¹² Complaint at 2, *Leroy Jacobs v. Walgreen Co.*, No. 2020-CH-06118 (Ill. Cir. Ct. filed Oct. 2, 2020).

²¹³ Complaint at 4, *Jacobs v. Walgreen Co.*, No. 2020-CH-06118 (Ill. Cir. Ct. filed Oct. 2, 2020); See also Complaint at 1, *House v. St. Anthony Hospital Inc.*, No. 2020-CH-04788 (Ill. Cir. Ct. dismissed Sept. 28, 2020); Complaint at 1-2, *Hicks v. Evergreen Living & Rehab Center, et al.*, No. 20-cv-04032 (N.D. Ill. filed July 9, 2020).

E. “An Ounce of Prevention”: What Can Health Care Entities Do?

As the case law discussed in this article indicates, health care entities are, unfortunately for them, not immune to BIPA’s reach. As long as BIPA claims remain an ongoing threat to Illinois businesses, we strongly recommend that health care providers and health care entities doing business in Illinois and collecting biometric information take the following precautions:

- Ensure that they have policies clearly identifying a retention schedule and specifying guidelines for destroying biometric data and that those policies are available to the public.
- Draft explicit and easy-to-understand disclosures that are given to individuals (in particular, employees) before the entity collects any biometric information regarding the individual. Those disclosures should inform individuals that their biometric data is being collected and describe the purpose, length of time, and use for any collected information.
- Confirm that they receive and retain explicit written releases permitting them to collect individuals’ biometric information. This may be particularly challenging for health care providers that collect biometric information from patients.
- Review their internal policies and procedures and ensure that the standard of care for storing, transmitting, and protecting biometric data is reasonable in the health care industry.
- HIPAA covered entities and business associates also need to keep in mind that protected health information (PHI) generally includes biometric identifiers created or received by a health care provider or health plan and relating to an individual’s health or health care, or to pay for health care, unless the information is in employment records maintained by the entity as the employer.²¹⁴ Appropriate safeguards, therefore, need to be implemented to protect the privacy, security, and integrity of the biometric PHI as required under the HIPAA regulations.

Illinois health care entities that decide to use biometric timekeeping or security devices should also consider requiring employees to sign arbitration agreements or employment agreements containing class action waivers. Further, if employees are unionized, health care entities should consider negotiating for the inclusion of class action waivers in their collective bargaining agreements. And regardless, health care entities should contact their legal counsel to discuss their options in ensuring compliance with BIPA’s stringent requirements.

²¹⁴ See 45 C.F.R. § 160.103 (2014); 42 U.S.C.A. § 1320d(6) (2010). (defining “individually identifiable health information” and “protected health information”); 45 C.F.R. § 164.514(b)(2)(i)(P) (2013).

VI. THE OPIOID EPIDEMIC AND THE LAW IN THE CONTEXT OF COVID-19

Juliet Sorenson and Alexandra Tarzikhan

A. Introduction: An Extraordinary Surplus of Needless Deaths

The opioid epidemic persists as one of the most pressing public health issues in the United States amidst the COVID-19 pandemic.²¹⁵ “Between the opioid crisis and the COVID-19 pandemic, America now suffers from an extraordinary surplus of needless . . . deaths.” The most recent increase in drug overdose mortality began in 2019 and continued into 2020 and “appears to have accelerated during the COVID-19 pandemic.”²¹⁶ According to preliminary data released by the U.S. Centers for Disease Control and Prevention’s (CDC) National Center for Health Statistics, an estimated 19,416 individuals died of a drug overdose in the U.S. in the first quarter of 2020 compared with 16,682 in the same three-month period in 2019.²¹⁷ Between June 2019 and May 2020, drug overdose deaths increased more than 20% in twenty-five states and the District of Columbia, including Illinois.²¹⁸ According to the CDC, synthetic opioids, namely illicitly manufactured fentanyl and fentanyl analogs, are currently the “primary driver[s]” of drug overdose fatalities. This does not include methadone.²¹⁹ In Illinois, this trend manifests at both the local and state levels.²²⁰ At the end of 2020, there was a record number of 1,599 opioid overdose deaths in Cook County.²²¹ DuPage

²¹⁵ *Issue Brief: Reports of Increases in Opioid – and Other Drug – Related Overdose and other Concerns During COVID Pandemic*, AM. MED. ASS’N (March 3, 2021), www.ama-assn.org/system/files/2020-12/issue-brief-increases-in-opioid-related-overdose.pdf.

²¹⁶ *National Center for Health Statistics*, CTR. FOR DISEASE CONTROL AND PREVENTION (Oct. 14, 2020), https://www.cdc.gov/nchs/data/health_policy/Provisional-Drug-Overdose-Deaths-by-Quarter-Demographic-Characteristics-Q1-2020.pdf.

²¹⁷ *Id.*

²¹⁸ *Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic*, CTR. FOR DISEASE CONTROL AND PREVENTION (Dec. 17, 2020, 8:00 AM ET), <https://emergency.cdc.gov/han/2020/han00438.asp>.

²¹⁹ *Id.*

²²⁰ *Statewide Semiannual Opioid Report*, ILL. DEP’T OF PUB. HEALTH, Sept. 2020, at 13, <https://www.dph.illinois.gov/sites/default/files/publications/semiannual-opioid-overdose-report9292020final.pdf>; Katie Anthony, *Cook County Closes 2020 with Record Highs of 875 Gun-related Homicides, 1,599 Opioid Deaths*, CHICAGO SUN TIMES (Jan. 2, 2021), <https://chicago.suntimes.com/metro-state/2021/1/2/22210281/cook-county-homicide-total-2020-970-opioid-covid>; Press Release, Richard Jorgensen, DuPage County Coroner, *Public Safety Announcement: Surge in Overdose Deaths*, DUPAGE COUNTY, ILLINOIS (May 13, 2020) (on file at https://www.dupageco.org/Coroner/Coroner_News/2020/62840/).

²²¹ Anthony, *supra* note 220.

County also saw a surge in opioid-related deaths.²²² There was a corresponding statewide increase in emergency department visits and emergency administrations of naloxone, an overdose reversal medication, due to opioid overdose.²²³

Simultaneously, 21,171 individuals to date have died due to COVID-19 in Illinois.²²⁴ The latest rise in fatal drug overdoses may be attributable to factors related to the COVID-19 pandemic, including “widespread mitigation measures for COVID-19,” disruptions in health care and social safety nets, and social and economic stressors.²²⁵ A CDC survey of U.S. adults in June 2020 found that 13% of respondents reported having “started or increased substance use to cope with pandemic-related stress or emotions.”²²⁶ “Groups that were more likely to use substances as a coping mechanism were young adults (nearly a quarter of those aged eighteen to twenty-four years), Hispanic (21.9%) and Black (18.4%) respondents, essential workers (24.7%), and unpaid caregivers for adults (32.9%).”²²⁷

B. The Opioid Epidemic is Disproportionately Impacting Minority Groups in Illinois.

In 2019 and 2020, a prominent racial disparity was seen in the number of emergency department visits per 100,000 capita for opioid overdose in Illinois. Black or African-American/Not-Hispanic populations visited the [emergency department] on average 5.5 times more often than White/Not-Hispanic populations and on average [six] times more often than Hispanic populations.²²⁸

The most recent surveillance report published by the CDC finds that the highest rates of opioid overdose fatalities nationally can be found in the 25 to 34-year old non-Hispanic White population.²²⁹ In Cook County, Illinois, however, 63% of the opioid-related deaths in 2020 occurred in Black and

²²² Jorgensen, *supra* note 220.

²²³ *Statewide Semiannual Opioid Report*, *supra* note 220 at 113.

²²⁴ *COVID-19 Statistics*, ILL. DEP’T. OF PUB. HEALTH, <https://www.dph.illinois.gov/covid19/covid19-statistics> (Mar. 25, 2021).

²²⁵ *Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic*, CTR. FOR DISEASE CONTROL AND PREVENTION (Dec. 17, 2020, 8:00 AM ET), <https://emergency.cdc.gov/han/2020/han00438.asp>.

²²⁶ Mark É Czeisler, et al., *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020*, Report from *Morbidity and Mortality Weekly Report (MMWR)*, CTR. FOR DISEASE CONTROL AND PREVENTION (Aug. 14, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>.

²²⁷ *Id.*

²²⁸ *Statewide Semiannual Opioid Report*, *supra* note 220 at 7.

²²⁹ Lawrence Scholl, et al., *Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017*, Report from *Morbidity and Mortality Weekly Report (MMWR)*, CTR. FOR DISEASE CONTROL AND PREVENTION (Jan. 4, 2019), https://www.cdc.gov/mmwr/volumes/67/wr/mm675152e1.htm#T1_down.

Latino communities, even though they accounted for less than half of the county's total population.²³⁰ This disproportionate impact is being seen across the State.²³¹ Thus, the populations at risk for opioid overdose in Illinois differ from the national trends and will require unique and targeted interventions.²³²

In the same vein, COVID-19 has made clear the need to address social determinants of health. In a state that is just 14% Black overall, 30% of all COVID-19 cases in Illinois occur among Black residents.²³³ The share of Black COVID-19 deaths in Illinois is even higher: as many of 41% of those who have died of COVID-19 in the state are Black.²³⁴ The COVID-19 pandemic and opioid epidemic are directly impacted by social determinants of health. These two public health problems will amplify the existing disparities, be it racial/ethnic and socioeconomic, if not addressed.²³⁵

C. A Roundup of Recent Developments Indicates a Convergence Towards a Rights-Based Approach to the Opioid Epidemic in Illinois.

A review of relevant legislative and regulatory developments in the past year indicates a commitment by the state's executive and legislative branches to address the opioid epidemic through a lens of access and equity. Recent caselaw reflects the use of this lens by the courts, as well.

1. *Legislative and Regulatory*

In September 2017, Illinois released its State Opioid Action Plan (SOAP), which identified overarching goals and defined processes for

²³⁰ Alice Yin, *Deadliest Year Ever for Fatal Opioid Overdoses in Cook County. 'These Are Losses that Could and Should be Prevented.'*, CHICAGO TRIB. (Dec. 10, 2020, 5:54 AM), <https://www.chicagotribune.com/news/breaking/ct-opioid-deaths-cook-county-20201209-vepciaddh5aajn3e6ilfpihg3i-story.html>.

²³¹ *Statewide Semiannual Opioid Report*, *supra* note 220 at 1.

²³² Compare Scholl, et al., *supra* note 229 (finding that national opioid-overdose fatalities are most prominent among non-Hispanic White populations), with *Statewide Semiannual Opioid Report*, *supra* note 220 at 1 (finding that opioid-overdose fatalities are most prominent among Black and Latino populations).

²³³ Cecilia Reyes et al., *Chicago's Coronavirus Disparity: Black Chicagoans are Dying at Nearly Six Times the Rate of White Residents, Data Show*, CHI. TRIB. (April 7, 2020), www.chicagotribune.com/coronavirus/ct-coronavirus-chicago-coronavirus-deaths-demographics-lightfoot-20200406-77nlylh.

²³⁴ Amanda Vinicky, *41% of Illinois Residents Dying from COVID-19 are Black*, WINDOW TO THE WORLD (April 5, 2020, 6:47 PM), <https://news.wttw.com/2020/04/05/41-illinois-residents-dying-covid-19-are-black>.

²³⁵ Danielle F. Haley & Richard Saitz, *The Opioid Epidemic During COVID-19 Pandemic*, 324 J. AM. MED. ASS'N. 1615, 1616 (2020), <https://jamanetwork.com/journals/jama/fullarticle/2770985>.

achieving them.²³⁶ One of the main goals of the SOAP was to reduce opioid-related deaths by one-third in three years.²³⁷ To achieve this goal, the SOAP focused on efforts falling into three pillars: prevention, treatment and recovery, and response.²³⁸ “Accomplishments since the release of the SOAP and the May 2018 Implementation Report” are described below.

In accordance with the SOAP, increasing naloxone training and distribution became integrated into some of the nine central strategies to reduce opioid deaths.²³⁹ Under this same trend, Illinois passed several laws just before SOAP “that revolve around authorized dispensing methods; providing civil, criminal, and disciplinary immunity for the prescriber or dispenser; and training, certification, and/or education requirements.”²⁴⁰ One major change was the enactment of the Illinois Naloxone Standing Order.²⁴¹ Standing orders allow prescribing physicians to provide medications to people who meet predetermined criteria.²⁴²

The Naloxone Standardized Procedure summarizes how entities may become authorized to obtain, dispense, and administer naloxone hydrochloride for an opioid overdose and includes educational requirements for obtaining the Illinois Naloxone Standing Order.

The Naloxone Standing Order was created in accordance with the Alcoholism and Other Drug Abuse and Dependency Act (20 ILCS 301/5-23) and Executive Order 17-05. It was issued by the Chief Medical Officer of the Illinois Department of Public Health on September 7, 2017, and is renewed annually. The Naloxone Standing Order authorizes trained, licensed pharmacists and overdose education and naloxone distribution (OEND) programs to provide naloxone to individuals who request it to reverse a potential opioid-related overdose without a direct prescription. Opioid Overdose Education and Naloxone programs include law enforcement agencies, drug treatment programs, local health departments, hospitals, urgent care facilities, or other community-based organizations that do not have access to a standing order through their organization. Pharmacists must complete approved training in order to dispense naloxone as a standing order. Training topics include opioid overdose recognition and prevention, naloxone administration techniques, and the importance of

²³⁶ BRUCE RAUNER, STATE OF ILLINOIS OPIOID ACTION PLAN 9-31 (Sept. 2017), <http://dph.illinois.gov/sites/default/files/publications/Illinois-Opioid-Action-Plan-Sept-6-2017-FINAL.pdf>.

²³⁷ *Id.* at 10.

²³⁸ *Id.* at 9-10.

²³⁹ *Id.* at 10.

²⁴⁰ Michael Gabay, *Increasing Access to Naloxone and Legal Issues*, NAT'L CTR. FOR BIOTECHNOLOGY INFO. (Sept. 2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5030873/>.

²⁴¹ ILL. DEP'T OF FINANCIAL AND PRO. REGUL., ILLINOIS NALOXENE STANDARDIZED PROCEDURE (2017), <http://www.dph.illinois.gov/sites/default/files/Naloxone-SO-Procedures.pdf>.

²⁴² *State Naloxone Access Rules and Resources*, SAFEPROJECT (2021), <https://www.safeproject.us/naloxone-awareness-project/state-rules/>.

calling 911 after naloxone administration. Pharmacists must complete Illinois Department of Public Health (IDPH) approved training modules. Alternatively, applicants may meet requirements by demonstrating an understanding of the Naloxone Standardized Procedures and completing the following training videos (Naloxone Overview and Patient Counseling and Instructional Videos for Administration of Naloxone). Lastly, pharmacies using the standing order to dispense naloxone must report naloxone-dispensing information to the Illinois Prescription Monitoring Program. In addition, many insurance providers, including Medicaid and Medicare, can be billed for naloxone, allowing it to be more affordable and thereby decreasing the cost barrier for access to care.²⁴³

In January 2018, each prescriber with controlled substance licenses had to register for the Illinois Prescription Monitoring Program, an electronic tool that collects information on controlled substance prescriptions, reported on a daily basis by retail pharmacies dispensing in Illinois.²⁴⁴

In January 2019, the Illinois legislature began the process of passing House Bill 122, which will establish an Office of the Ombudsman for Behavioral Health (Office) within the Department of Human Services.²⁴⁵ The bill provided that the Governor designate an Ombudsman for Behavioral Health Access to Care by November 1, 2019, to assist residents of Illinois in accessing behavioral health care, including substance use disorders.²⁴⁶ The Ombudsman's duties would be to

[I]dentify [] and report to the appropriate regulatory or oversight agency concerns, complaints, and potential violations of State or federal rules, regulations, or statutes concerning the availability of . . . benefits for mental health conditions or substance use disorders . . . ; [to] provide appropriate information to help consumers obtain behavioral health care; and [] develop appropriate points of contact for referrals to other State and federal agencies.²⁴⁷

The Ombudsman Office would serve as a neutral and confidential intermediary and provide an informal process to support residents in resolving complaints related to mental health or substance use disorder programs, services, and its certified providers.²⁴⁸ In addition, a liaison from the Director of Insurance and the Secretary of Human Services would need to be appointed “to receive reports of concerns, complaints, and potential

²⁴³ *Naloxone*, ILL. DEP'T. OF PUB. HEALTH, <https://www.dph.illinois.gov/naloxone> (Mar. 25, 2021).

²⁴⁴ S.B. 772, 100th Gen. Assemb., Reg. Sess. (Ill. 2017).

²⁴⁵ H.B. 122, 101st Gen. Assemb., Reg. Sess. (Ill. 2021) (as referred to the House Judiciary Criminal Committee, Jan. 13, 2021).

²⁴⁶ *Id.*

²⁴⁷ *Id.*

²⁴⁸ *Id.*

violations . . . of State and federal rules . . . concerning . . . benefits for mental health conditions or substance use disorders” from the Ombudsman.²⁴⁹

Beginning in 2020, Illinois physicians became required to take three hours of Continuing Medical Education (CME), specifically on safe opioid prescribing practices.²⁵⁰ Two bills (S.B. 2340 and H.B. 4997) were also introduced in January 2020, requiring a mandatory discussion of the risks associated with opioid use for minors.²⁵¹ For patients under 18 years of age, a prescriber would be required to discuss with the patient’s parent or guardian (or with the patient, if they are an emancipated minor) the risks of developing a physical or psychological dependence on the opioid and alternative treatments that the prescriber deems appropriate prior to issuing a prescription for an opioid that is a Schedule II controlled substance.²⁵² These two bills have not been signed into law yet and are still in legislative committees in the 2021 session.

In January 2020, Governor Pritzker signed Executive Order (EO) 2020-02 titled “Strengthening the State’s Commitment to Ending the Opioid Epidemic.”²⁵³ This EO built on established initiatives and identified new strategies from the SOAP with a more direct focus on social equity and harm reduction.²⁵⁴ Illinois state agencies responded by creating programs to address the opioid epidemic in communities at the highest risk of overdose.²⁵⁵ The Illinois Department of Public Health (IDPH) has implemented reporting requirements and surveillance programs to identify locations and populations of need as well as established the Syringe Service Program Registry.²⁵⁶ The Illinois Department of Human Services (DHS) implemented multiple state and community-level programs.²⁵⁷ Several bills are being considered that “would mandate that physicians offer a prescription for naloxone” with certain opioid prescriptions, “amend[] the Illinois Controlled Substances Act and provide that an initial prescription for an opioid may only be issued for

²⁴⁹ *Id.*

²⁵⁰ *Resources for Opioid Prescribers*, ILL. ACAD. OF FAM. PHYSICIANS, <https://www.iafp.com/opioid-safety-il-state-requirements> (Feb. 13, 2020, 2:41 PM).

²⁵¹ S.B. 2340, 101st Gen. Assemb., Reg. Sess. (Ill. 2021) (as referred to Assignment, April 12, 2020); H.B. 4997, 101st Gen. Assemb., Reg. Sess. (Ill. 2021) (as re-referred to the House Rules Committee, June 23, 2021).

²⁵² *Id.*

²⁵³ Ill. Exec. Order No. 2020-02 (Jan. 27, 2020), https://www2.illinois.gov/HISNews/21086-Executive_Order_2020-02.pdf.

²⁵⁴ Ill. Exec. Order No. 2020-02 (Jan. 27, 2020), https://www2.illinois.gov/HISNews/21086-Executive_Order_2020-02.pdf. Harm reduction is a set of ideas and interventions that seek to reduce the harms associated with both drug use and ineffective, racialized drug policies. *Harm Reduction*, DRUG POL’Y ALL., <https://drugpolicy.org/issues/harm-reduction> (last visited Feb. 25, 2021).

²⁵⁵ *Statewide Semiannual Opioid Report*, *supra* note 220.

²⁵⁶ *Id.*

²⁵⁷ *Id.*

a seven-day supply,” and require physicians to have a mandatory discussion with minors about the risks of opioids and alternative treatments.²⁵⁸ Additionally, the State has aggressively been enforcing mental health parity laws, which prohibit insurance plans from offering mental health or substance abuse services on less favorable terms than other types of medical care.²⁵⁹ For example, the Illinois Department of Insurance fined “five major health insurance companies found to be in violation of the Mental Health Parity and Addiction Equity Act (MHPAEA).”²⁶⁰

Governor Pritzker also “earmark[ed] \$4.1 million [in January 2020,] to expand opioid-related services across the state . . . [and develop] a Rapid Deployment Project that teams with local health departments to target specific communities that have seen spikes in overdoses.”²⁶¹ In response to the COVID-19 pandemic, Illinois “allow[ed] patients to take home longer-lasting supplies of methadone,” ensured that “residential [treatment] facilities [were] taking extra measures to protect residents and staff” from the spread of COVID-19, and encouraged community organizations to ensure that their patients have better access to naloxone.²⁶² The City of Chicago aimed “to create a robust response to the epidemic” by “studying data on overdoses to identify demographic and geographic patterns and determine which neighborhoods need the most resources, including naloxone, syringe exchanges, and community health education.”²⁶³ “The city has already increased funding for naloxone distribution, . . . and in June [2020] . . . [began] issuing monthly reports showing year-to-date trends.”²⁶⁴

Finally, according to the Illinois Department of Human Services, Division of Substance Use Prevention and Recovery, one way the Governor's Office will address this public health crisis is by establishing an "Opioid Social Equity Committee" dedicated to researching solutions that will decrease social and racial inequities in the opioid crisis response.²⁶⁵ Another proposed solution is to implement "local recovery-oriented systems of care

²⁵⁸ STATE MED. SOC'Y., 2020 LEGISLATIVE REPORT (2020), isms.org/Governmental_Affairs/Legislative_Action_Hub/2020/documents/2020End-of-SessionLegislativeReport/.

²⁵⁹ *State of Illinois Opioid Action Plan Implementation Report*, ILL. DEP'T OF PUB. HEALTH (JAN. 2020), <http://dph.illinois.gov/sites/default/files/publications/soap-implementation-report-january-2020.pdf>.

²⁶⁰ Press Release, Ill. Dep't. of Ins., Pritzker Administration Announces Over \$2 million in Fines for Major Health Insurance Companies Violating Illinois Mental Health Parity Laws (July 15, 2020) (on file at https://www2.illinois.gov/IISNews/21819-IDOI_Press_Release.pdf).

²⁶¹ *Statewide Semiannual Opioid Report*, *supra* note 220.

²⁶² Melissa Sanchez & Duaa Eldeib, *Overdose Deaths Have Skyrocketed in Chicago, and the Coronavirus Pandemic May be Making it Worse*, PROPUBLICA (May 30, 2020, 4:00 AM CDT), www.propublica.org/article/overdose-deaths-have-skyrocketed-in-chicago-and-the-coronavirus-pandemic-may-be-making-it-worse.

²⁶³ *Id.*

²⁶⁴ *Id.*

²⁶⁵ H.B. 4998, 101st Gen. Assemb., Reg. Sess. (Ill. 2020).

councils" in areas most affected by the crisis.²⁶⁶ This will allow more individualized engagement and follow-up throughout recovery.²⁶⁷ Finally, the Governor's Office will raise awareness on safer use of opioids through "harm reduction strategies."²⁶⁸ Harm reduction is a practical approach to substance-use disorder aimed at reducing negative consequences.²⁶⁹ "The Executive Order also focuses on harm reduction strategies that promote safer use of opioids to save lives."²⁷⁰

Harm reduction is a practical approach to substance-use disorder aimed at reducing negative consequences.²⁷¹

These strategies help reduce both the risks of infectious HIV, HCV, and Hepatitis A and fatal overdoses . . . [and] include[] supervised consumption sites where individuals with opioid use disorder are under the supervision of trained staff with the goal of ensuring the safety of both the individual and the general public. Last year Governor Pritzker signed the Overdose Prevention and Harm Reduction Act (PA101-0356), which also focuses on harm reduction and allows for the establishment and operation of a needle and hypodermic syringe access program or syringe services programs to help prevent the spread of infection and disease.²⁷²

According to the Illinois Department of Human Services, Division of Substance Use Prevention and Recovery, several programs will be funded to address this crisis. In addition to the above-mentioned funding of \$4.1 million, \$500,000 is being used to fund syringe services programs in line with the Governor's Office's harm reduction strategies. Moreover, \$550,000 serves to promote medication-assisted treatment (MAT) as a viable treatment to be prescribed by doctors. Finally, \$2.75 million is being dedicated to the "Prescription Drug Monitoring Program," which helps first responders and doctors act immediately when overdoses increase in a certain community.²⁷³

²⁶⁶ *Id.*

²⁶⁷ *Id.*

²⁶⁸ *Id.*

²⁶⁹ *Id.*

²⁷⁰ *Governor Pritzker Signs Executive Order to Fight Opioid Crisis and Reduce Racial Disparities*, ILL. DEP'T HUMAN SERVICES (2020), https://www.dhs.state.il.us/OneNetLibrary/27896/documents/2020SmartAlerts/Smart_Alert_Volume_XIII_Issue_XX_Executive_Order_Regarding_Opioid_Crisis.pdf.

²⁷¹ *See generally*, Diane E. Logan & G. Alan Marlatt, *Harm Reduction Therapy: A Practice-Friendly Review of Research*, J. CLINICAL PSYCH. Feb. 2010.

²⁷² *Governor Pritzker Signs Executive Order to Fight Opioid Crisis and Reduce Racial Disparities*, ILL. DEP'T HUMAN SERVICES (2020), https://www.dhs.state.il.us/OneNetLibrary/27896/documents/2020SmartAlerts/Smart_Alert_Volume_XIII_Issue_XX_-_Executive_Order_Regarding_Opioid_Crisis.pdf.

²⁷³ *Id.*

This response includes overdose prevention training, local public awareness messages, and the purchase of 50,000 doses of naloxone to put directly in the hands of community residents.²⁷⁴ The state has created a comprehensive online repository that streamlines and makes available all opioid use disorder prevention, treatment, and recovery resources, to increase transparency and accessibility of resources.²⁷⁵

In February 2020, House Bill 4998 amended the Illinois Controlled Substances Act and provided that “an initial prescription for an opioid may only be issued for a 7-day supply.”²⁷⁶ Under the Act, “opioid” was defined as a “narcotic drug or substance that is a Schedule II controlled substance.”²⁷⁷

In May 2020, recognizing that the “stay-at-home order [] created a lack of physical access to addiction support and harm reduction groups during the COVID-19 pandemic . . . and [that] [s]ocial isolation [could be] an additional mental health and physical burden on people with substance abuse issues,” Illinois passed Senate Resolution 1184.²⁷⁸ This resolution “urge[d] the Illinois Department of Public Health, the Illinois Department of Human Services, and all other relevant agencies and boards to examine the rise in opioid overdoses due to COVID-19.”²⁷⁹ The resolution also urged the State of Illinois to increase access to naloxone.²⁸⁰ Given that this is a resolution, however, there are no binding legal consequences.

Most recently, in January 2021, Illinois House Bill 0099 was introduced, creating the Prescription Drug Repository Program Act.²⁸¹ It required the Department of Public Health to, “by rule, establish a prescription drug repository program, under which [any person] may donate a prescription drug or supplies needed to administer a prescription drug for use by an individual who meets [] eligibility criteria” specified by the Department.²⁸² The bill also “set forth requirements that prescription drugs or supplies must meet in order to be accepted and dispensed under the program . . . [and] provide[d] that uninsured and underinsured individuals be given priority over other eligible persons for drugs and supplies donated under the Act.”²⁸³

Additionally, the Act provided that the term “Controlled substance” refers to a “drug, substance, or immediate precursor in Schedules I through

²⁷⁴ *Id.*

²⁷⁵ *Id.*

²⁷⁶ H.B. 4998, 101st Gen. Assemb., Reg. Sess. (Ill. 2020).

²⁷⁷ *Id.*

²⁷⁸ S.R. 1184, 101st Gen. Assemb., Reg. Sess. (Ill. 2020).

²⁷⁹ *Id.*

²⁸⁰ *Id.*

²⁸¹ H.B. 0099, 102nd Gen. Assemb., Reg. Sess. (Ill. 2021).

²⁸² *Id.*

²⁸³ *Id.*

V of 21 CFR 1308,” which includes opioids.²⁸⁴ “[C]ivil and criminal immunity for drug and supply manufacturers and individuals in relation to the donation, acceptance, or dispensing of prescription drugs or supplies” would be provided under the prescription drug repository program.²⁸⁵ The bill also provided an amendment to the following:

[T]he Pharmacy Practice Act, the Wholesale Drug Distribution Licensing Act, the Senior Pharmaceutical Assistance Act, the Illinois Food, Drug and Cosmetic Act, the Illinois Controlled Substances Act, and the Cannabis and Controlled Substances Tort Claims Act [] provid[ing] that persons engaged in donating or accepting, or packaging, repackaging, or labeling, prescription drugs to the extent permitted or required under the Prescription Drug Repository Program Act be exempt from provisions of those other Acts that might prohibit or otherwise regulate such activity.²⁸⁶

2. *Caselaw*

There were several reported Illinois cases related to the opioid epidemic in 2020. This section presents a summary of some of them. A common theme is a profoundly addictive nature and risks to public health presented by prescription and non-prescription opioids alike.

3. *City of Chicago v. Purdue Pharma, IL, July 2020*²⁸⁷

In 2014, the plaintiff, the City of Chicago (“the City”), challenged pharmaceutical manufacturers’ marketing and distribution of prescription opioids, alleging false claims under the City’s municipal code and insurance fraud under state law.²⁸⁸ The City claimed that it would not have reimbursed these opioid prescriptions if it had known that the Defendants’ marketing practices were deceptive.²⁸⁹ The damages sought by the City included the cost to reimburse these medically unnecessary opioid prescriptions.²⁹⁰ During discovery in July 2017, The Defendants moved to compel the City to provide detailed reports of the allegedly medically unnecessary opioids that

²⁸⁴ *Id.*

²⁸⁵ *Id.*

²⁸⁶ H.B. 0099, 102nd Gen. Assemb., Reg. Sess. (Ill. 2021).

²⁸⁷ *City of Chi. v. Purdue Pharma, L.P.*, No. 14 CV 4361, 2020 WL 3578497 (N.D. Ill. July 1, 2020).

²⁸⁸ *Id.* at *1.

²⁸⁹ *Id.*

²⁹⁰ *Id.*

were reimbursed.²⁹¹ [The] court granted the motion in part in August 2017 and ordered the City to identify:

(1) the prescription claims submitted to and paid for by [the City] that it assert[ed] were medically unnecessary and to whom they were written; (2) the physicians or health care providers who wrote the prescriptions [the City] allege[d] to have been medically unnecessary; and (3) [the City's] basis for identifying the prescription claims to be medically unnecessary.²⁹²

In December 2017, before the City complied with this order, this case was transferred to the United States District Court for the Northern District of Ohio as part of the Judicial Panel on Multidistrict Litigation (“MDL”) for consolidated pre-trial proceedings, which will be discussed below.²⁹³

In December 2019, the City was granted leave to file its Fifth Amended Complaint.²⁹⁴ The City dropped its false claims and insurance fraud claims entirely.²⁹⁵ Instead of seeking damages in the form of reimbursement for medically unnecessary prescriptions, the City pursued civil penalties and damages in the form of the costs it incurred for services rendered in response to opioid-related addiction and deaths.²⁹⁶ The case remains pending.

4. *Biundo v. Bolton, IL, Sep 2020*²⁹⁷

Fara Biundo is the mother of the plaintiff in this case, a 17-year-old female who was admitted to the Advocate Christ Medical Center's (ACMC) emergency department for heroin overdose and subsequently died immediately following her discharge.²⁹⁸ As special administrator of her estate, Biundo initiated a lawsuit against ACMC and three emergency department doctors on the grounds of "negligence, breach of the standard of care when the plaintiff was not admitted or held after her first overdose until she could be placed in an inpatient substance abuse facility."²⁹⁹ Biundo appealed the decision favoring the defendants in September 2019.³⁰⁰

At the time of the plaintiff's overdose, someone “left [her] at the entrance of ACMC's emergency department.”³⁰¹ [Plaintiff] was unresponsive

²⁹¹ *Id.*

²⁹² *Id.*

²⁹³ *Id.*

²⁹⁴ *Id.*

²⁹⁵ *Id.*

²⁹⁶ *Id.*

²⁹⁷ *Biundo v. Bolton*, No. 1-19-1970, 2020 WL 5407735 (App. Ct. Ill. Sept. 9, 2020).

²⁹⁸ *Id.*

²⁹⁹ *Id.*

³⁰⁰ *Id.* at ¶ 2.

³⁰¹ *Id.* ¶ 8.

and cyanotic but immediately attended to by [two doctors] who administered oxygen and Narcan, a heroin reversal agent.”³⁰² Both doctors had experience treating overdoses.³⁰³ “[Plaintiff] said that she had snorted two baggies of heroin but denied that she tried to harm herself.”³⁰⁴ The medical standard of “someone who overdosed on heroin would typically be [to hold the person] for observation for four to six hours and then reassess.”³⁰⁵ Once medically stable, the patient would be discharged.³⁰⁶ At issue in the case was the determination of whether the hospital and the doctors met the standard of care when they discharged the plaintiff.³⁰⁷

The standard of care was established in this case by relying on Dr. Saltzberg’s testimony, the expert chosen by Biundo.³⁰⁸ Per Dr. Saltzberg’s testimony: “the standard of care for an emergency room physician in treating a heroin overdose required that the patient be admitted to the hospital until inpatient substance abuse treatment could be procured.”³⁰⁹ “[Biundo] contends the standard of care required that [plaintiff] be admitted to the hospital until she could be transferred to an inpatient facility rather than being discharged into the same environment that resulted in her overdose.”³¹⁰ Thus, Biundo claimed that the case was unfairly prejudiced when the trial court barred Dr. Saltzberg from testifying that plaintiff was not medically cleared for discharge.³¹¹ However, the court noted that the “[d]efinition of medically cleared means the patient is in a stable condition in order to continue functioning.”³¹² The defendants argued that “[t]he hospital did not have inpatient substance abuse treatment on its premises, and the standard of care did not require it to offer that service.”³¹³

The appellate court judge rejected all of Biundo’s arguments and affirmed the trial court’s judgment.³¹⁴

5. *Rogers et al. v. Sheriff of Cook County and Cook County, IL, Nov 2020*³¹⁵

³⁰² *Id.*

³⁰³ *Id.*

³⁰⁴ *Id.*

³⁰⁵ *Id.*

³⁰⁶ *Id.*

³⁰⁷ *Id.*

³⁰⁸ *Id.* ¶ 43.

³⁰⁹ *Id.* ¶ 44.

³¹⁰ *Id.* ¶ 43.

³¹¹ *Id.* ¶ 32.

³¹² *Id.* ¶ 35.

³¹³ *Id.* ¶ 44.

³¹⁴ *Id.* ¶ 60-61.

³¹⁵ *Rogers v. Sheriff of Cook Cnty.*, No. 15-CV-11632, 2020 WL 7027556 (N.D. Ill. Nov. 29, 2020).

Plaintiffs in this class action are detainees in the Cook County Jail.³¹⁶ The plaintiffs sued the jail subsequent to its policy, which denies prisoners to continue taking “stable maintenance doses of methadone” unless pregnant. Instead, the jail mandated that prisoners should “taper off” their methadone by gradually lowering their dosage. The plaintiffs argue that this policy led to significant “physical and psychological pain to the detainees and caused them to be less likely to seek out treatment after leaving custody, according to the plaintiffs’ complaint.” However, the opinion granting class certification declared that “experts had advocated for both methadone approached in different circumstances.”³¹⁷

The lawsuit was originally filed in 2015 by Keith Rogers, who entered the Cook County Jail on January 21, 2014. Rogers was enrolled in a methadone program at that time but did not receive his regular 200 mg dosage until January 26, 2014. His dosage was then reduced by 7 mg per day until he left the jail on February 16, 2014. Rogers experienced withdrawal symptoms before receiving his first doses of methadone in jail. These symptoms, including nausea, vomiting, and diarrhea, returned after he began receiving tapered doses of methadone. The plaintiffs identified at least 1,090 people who were affected by the jail’s methadone-taper policy, most of whom were detained there pre-trial. . . Cook County Jail adopted a new written policy permitting ongoing methadone treatment in October 2019.³¹⁸

The judge’s definition of the class included all detainees who entered the jail while the previous methadone-taper policy was in effect, who were taking an opioid use disorder medication at the time, and who took at least one dose of methadone while detained. The class also included detainees who opted out of or were excluded from the settlement of *Parish v. Sheriff of Cook County*, another case that was settled in March 2020. It excluded people who were pregnant (as they were not subject to the jail’s mandatory tapering policy) and those who were on parole or held on another jurisdiction’s warrant. [The class definition] consist[ed] of two subclasses: one consisting of pre-trial detainees and one of post-sentence prisoners. In order for their case to succeed in the next stage, those who were detained pre-trial will need to demonstrate that the methadone-taper policy was “not rationally related to a legitimate governmental objective or that it [was] excessive in relation to that purpose.” . . . Those who were incarcerated post-trial will need to show that the jail’s staff violated their Eighth Amendment rights by demonstrating “deliberate indifference.” The lawsuit

³¹⁶ *Id.* at *1.

³¹⁷ Lucia Geng, *Judge Grants Class Action Status to Methadone-Taper Jail Lawsuit*, FILTER (Dec. 7, 2020), <https://filtermag.org/methadone-taper-jail-lawsuit/>; Rogers, No. 15-CV-11632, 2020 WL 7027556, at *1.

³¹⁸ *Id.*

[] continue[s] amid a growing national campaign for incarcerated people to have access to lifesaving opioid use disorder medications.³¹⁹

6. *Finnigan v. Mendrick, Feb. 2021*³²⁰

Starting on February 25, 2021, Plaintiff Finnigan will serve 30 days in jail on a 2016 driving under the influence charge.³²¹ In August 2019, she was diagnosed with an opioid use disorder and prescribed a daily methadone maintenance dose, a medication that is essential to her recovery.³²² “Medication Assisted Treatment (MAT) is an approach that incorporates medication with counseling and behavioral therapy to treat substance use disorders and decrease the risk of an opioid overdose.”³²³

Since taking office in December 2018, the DuPage County Sheriff claims to have partnered with the DuPage County Health Department to institute MAT for inmates fighting opioid addiction.³²⁴ However, DuPage County is alleged to only provide MAT to pregnant inmates³²⁵ and “has an unwritten policy that forces all other detainees to go through withdrawal, specifically refusing to approve a plan for people facing imminent incarceration to be medically treated with methadone or another MAT medication known as buprenorphine.³²⁶ Other corrections facilities, including the Cook County Jail, provide these medications.”³²⁷

On February 8, 2021, the “American Civil Liberties Union, the ACLU of Illinois, Legal Action Center, and the Roderick and Solange MacArthur Justice Center filed a motion for a preliminary injunction in a lawsuit against the DuPage County Sheriff on behalf of [Ms.] Finnigan” to ensure she has access to her medication.³²⁸ “Other federal courts have granted preliminary injunctions requiring jails to provide individuals with their prescribed MAT,

³¹⁹ Geng, *supra* note 317.

³²⁰ *Finnigan v. Mendrick*, No. 21-CV-00341, 2021 WL 736228 (N.D. Ill. Feb. 24, 2021).

³²¹ *DuPage County Sheriff Sued for Access to Life-Saving Medication to Treat Opioid Use Disorder*, LEGAL ACTION CTR. (Feb. 8, 2021), <https://www.lac.org/assets/files/DuPage-County-Sheriff-Sued-for-Access-to-Life-Saving-Medication-to-Treat-Opioid-Use-Disorder.pdf>.

³²² *Id.*

³²³ *Treat Opioid Use Disorder*, CDC, <https://www.cdc.gov/drugoverdose/prevention/treatment.html> (last visited Feb. 27, 2021).

³²⁴ *About the Sheriff*, DUPAGE CNTY. SHERIFF, <https://www.dupagesheriff.org/AboutUs/42/> (last visited Feb. 27, 2021).

³²⁵ *Finnigan*, No. 21-CV-00341, 2021 WL 736228, at *3; see also John Keilman, *Giving addicted inmates opioid meds behind bars can reduce overdose deaths. Why don't more jails use them?*, CHI. TRIB. (July 6, 2018), https://www.chicagotribune.com/news/ct-met-jail-inmates-opioid-addiction-20180703-story.html?int=lat_digitaladshouse_bx-modal_acquisition-subscriber_ngux_display-ad-interstitial_bx-bonus-story.

³²⁶ *DuPage County Sheriff Sued for Access to Life-Saving Medication to Treat Opioid Use Disorder*, *supra* note 321.

³²⁷ *Id.*

³²⁸ *Id.*; see also Brief for Plaintiff, *Finnigan v. Mendrick*, No. 21-CV-00341 (N.D. Ill. Feb. 8, 2021).

based upon findings that failure to do so likely violates the Eighth Amendment and the Americans with Disabilities Act.³²⁹ If Ms. Finnegan's lawsuit is successful, it imposes an obligation on DuPage County to provide opioid treatment in the jail, which would be a significant advance from a health rights perspective.

7. *Multidistrict Litigation*

*a. Re National Prescription Opiate Litigation*³³⁰

The multidistrict litigation (MDL) in the Northern District of Ohio consolidated over 2,000 individual actions brought by state and local governments against pharmaceutical manufacturers, distributors, and pharmacies.³³¹ The plaintiffs argued that the long-term side-effects of using prescription opioids for persons with chronic pain were downplayed by manufacturers.³³² In addition, suspicious orders of prescription drugs were not properly monitored by distributors.³³³

The MDL parties engaged in extensive negotiations, overseen by a court-appointed Special Master and expert. Eventually, however, the negotiations reached an impasse, ostensibly because the parties could not develop a settlement structure that gave the defendants the necessary assurances that they would not face extensive and debilitating liability from plaintiffs with high-value claims that chose to opt-out of any settlement class. In an attempt to remedy this issue, the plaintiffs sought to dispense with the traditional settlement class process in favor of a process that instead conducts class certification and the opt-out period prior to actually reaching a settlement with any defendant. To implement this proposal, the plaintiffs first developed a sophisticated voting plan that assigned weighted values to each class member's vote and set an allocation mechanism to distribute any settlements that may eventually be obtained from the defendants.

In June of 2019, the plaintiffs filed—on behalf of 51 cities and counties—a motion seeking certification of a negotiation class along the parameters set out above. The motion drew numerous objections from several Defendants, some class members, parties litigating similar claims in state courts, and numerous attorneys general from across the United States.

³²⁹ Brief for Plaintiff at 2, *Finnigan v. Mendrick*, No. 21-CV-00341 (N.D. Ill. Feb. 8, 2021).

³³⁰ *In re Nat'l Prescription Opiate Litig.*, 332 F.R.D. 523 (N.D. Ohio 2019), *rev'd and remanded*, 976 F.3d 664 (6th Cir. 2020).

³³¹ *Id.* at 536.

³³² *MDL 2804 Docket*, U.S. DIST. CT. N.D. OHIO, www.ohnd.uscourts.gov/mdl-2804 (last visited Mar. 5, 2021); *Id.* at 10.

³³³ *Id.*

After conducting hearings, the court granted the motion to certify the negotiation class. The court determined that the defendants' desire for a "global settlement" and the public interest in expediting relief to affected communities necessitated "creative thinking." Finally, the court reasoned that the negotiation class was not violative of due process because the procedural protections in Rule 23 remained intact.

The court then engaged in a traditional class certification analysis and determined the Rule 23 factors were satisfied. Additionally, the court conducted a preliminary analysis of the proposed allocation and voting plan under Rule 23(e) and determined that any settlement would likely be approved. After certification, the class members were given a window to opt-out, after which time the class size was set. Those that opted out were free to separately pursue their claims. The court ruled that if a settlement that garners support from 75% of the class was reached, and the court approves that settlement, the funds would be allocated according to the procedures set in place prior to certification.³³⁴

The 11 pharmacies settled with the plaintiff Counties, agreeing to pay \$260 million. The district court then allowed the Counties to amend their complaints to add "dispenser" claims and ordered discovery to proceed anew. The court refused to rule on dismissal motions and ordered the pharmacies to produce data on every prescription that they had filled for any opioid medication, anywhere in the U.S., dating back to 2006.³³⁵

"In the interim, numerous parties that objected to certification of the negotiation class appealed to the Sixth Circuit, arguing, primarily, that the negotiation class was not permitted under Rule 23 and that the court's Rule 23 analysis was not supported by sufficient evidence."³³⁶ In April 2020, "the Sixth Circuit ordered that the amendments to the complaints be stricken, noting that the Federal Rules of Civil Procedure apply in MDL under 28 U.S.C. 1407 and had been disregarded in several instances."³³⁷ The certification proponents have petitioned for rehearing *en banc*.³³⁸

³³⁴ Genender et al., *In re National Prescription Opiate Litigation: Lessons Learned from the Novel "Negotiation Class,"* LEXOLOGY (June 16, 2020), <https://www.lexology.com/library/detail.aspx?g=defc00bc-ad37-4e27-a371-d49ce8cb2aea>.

³³⁵ *In re National Prescription Opiate Litigation, Justia Opinion Summary*, JUSTIA (Apr. 15, 2020), <https://law.justia.com/cases/federal/appellate-courts/ca6/20-3075/20-3075-2020-04-15.html>.

³³⁶ Genender et al., *supra* note 334.

³³⁷ *In re National Prescription Opiate Litigation, Justia Opinion Summary, supra* note 348; *In re Nat'l Prescription Opiate Litig.*, 956 F.3d 838, 846 (6th Cir. 2020).

³³⁸ Petition for Rehearing En Banc, *In re Nat'l Prescription Opiate Litig.*, No. 19-4097/19-4099 (6th Cir. Oct. 8, 2020).

D. Conclusion: The Long Path Forward

COVID-19 notwithstanding, Illinois implemented a range of law and policy efforts to address the opioid epidemic in 2020, reflecting the prioritization of equitable access to treatment by both the executive and legislative branches. This mirrors the national trend to frame the epidemic not as a question of law and order but rather as a public health crisis. Recent national proposals to create a nationwide multimedia public education campaign stressing the dangers of substance use disorders, to establish “drug courts” in every one of the 93 federal court districts, and to increase access to medication-assisted treatment and recovery services all manifest recognition of the epidemic as a substance-use disorder on an epic scale, and a shared goal of saving lives and getting individuals into treatment. If public health consistently informs law and policy in all branches of local, state, and federal government, then Illinois and indeed the nation will slowly carve out a forward path and crest the arc of this devastating epidemic.