AMENDMENT TO HOUSE BILL 1074

AMENDMENT NO. _____. Amend House Bill 1074 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Section 370k and adding Sections 368b, 368c, 368d, and 368e as follows:

(215 ILCS 5/368b new)

Sec. 368b. Contracting procedures.

(a) A health care professional or health care provider offered a contract by an insurer, health maintenance organization, independent practice association, or physician hospital organization for signature after the effective date of this amendatory Act of the 93rd General Assembly shall be provided with a proposed health care professional or health care provider services contract including, if any, exhibits and attachments that the contract indicates are to be attached. Within 35 days after a written request, the health care professional or health care provider offered a contract shall be given the opportunity to review and obtain a copy of the following: a specialty-specific fee schedule sample based on a minimum of the 50 highest volume fee schedule codes with the rates applicable to the health care professional or

health care provider to whom the contract is offered, the network provider administration manual, and a summary capitation schedule, if payment is made on a capitation basis. If 50 codes do not exist for a particular specialty, the health care professional or health care provider offered a contract shall be given the opportunity to review or obtain a copy of a fee schedule sample with the codes applicable to that particular specialty. This information may be provided electronically. An insurer, health maintenance organization, independent practice association, or physician hospital organization may substitute the fee schedule sample with a document providing reference to the information needed to calculate the fee schedule that is available to the public at no charge and the percentage or conversion factor at which the insurer, health maintenance organization, preferred provider organization, independent practice association, or physician hospital organization sets its rates.

(b) The fee schedule, the capitation schedule, and the network provider administration manual constitute confidential, proprietary, and trade secret information and are subject to the provisions of the Illinois Trade Secrets Act. The health care professional or health care provider receiving such protected information may disclose the information on a need to know basis and only to individuals and entities that provide services directly related to the health care professional's or health care provider's decision to enter into the contract or keep the contract in force. Any person or entity receiving or reviewing such protected information pursuant to this Section shall not disclose the information to any other person, organization, or entity, unless the disclosure is requested pursuant to a valid court order or required by a state or federal government agency. Individuals or entities receiving such information from a health care professional or health care provider as

delineated in this subsection are subject to the provisions of the Illinois Trade Secrets Act.

(c) The health care professional or health care provider shall be allowed at least 30 days to review the health care professional or health care provider services contract, including exhibits and attachments, if any, before signing. The 30-day review period begins upon receipt of the health care professional or health care provider services contract, unless the information available upon request in subsection (a) is not included. If information is not included in the professional services contract and is requested pursuant to subsection (a), the 30-day review period begins on the date of receipt of the information. Nothing in this subsection shall prohibit a health care professional or health care provider from signing a contract prior to the expiration of the 30-day review period.

(d) The insurer, health maintenance organization, independent practice association, or physician hospital organization shall provide all contracted health care professionals or health care providers with any changes to the fee schedule provided under subsection (a) not later than 35 days after the effective date of the changes, unless such changes are specified in the contract and the health care professional or health care provider is able to calculate the changed rates based on information in the contract and information available to the public at no charge. For the purposes of this subsection, "changes" means an increase or decrease in the fee schedule referred to in subsection (a). This information may be made available by mail, e-mail, newsletter, website listing, or other reasonable method. Upon request, a health care professional or health care provider may request an updated copy of the fee schedule referred to in subsection (a) every calendar quarter.

(e) Upon termination of a contract with an insurer,

health maintenance organization, independent practice association, or physician hospital organization and at the request of the patient, a health care professional or health care provider shall transfer copies of the patient's medical records. Any other provision of law notwithstanding, the costs for copying and transferring copies of medical records shall be assigned per the arrangements agreed upon, if any, in the health care professional or health care provider services contract.

(215 ILCS 5/368c new)

Sec. 368c. Remittance advice and procedures.

(a) A remittance advice shall be furnished to a health care professional or health care provider that identifies the disposition of each claim. The remittance advice shall identify the services billed; the patient responsibility, if any; the actual payment, if any, for the services billed; and the reason for any reduction to the amount for which the claim was submitted. For any reductions to the amount for which the claim was submitted, the remittance shall identify any withholds and the reason for any denial or reduction.

A remittance advice for capitation or prospective payment arrangements shall be furnished to a health care professional or health care provider pursuant to a contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization in accordance with the terms of the contract.

(b) Health care professionals and health care providers may not provide a statement that requires payment from the patient or group contract holder, or collect and have any recourse against an insured patient or group contract holder for services provided pursuant to a contract in which an insurer, health maintenance organization, independent practice association, or physician hospital organization has

contractually agreed with a health care professional or health care provider that the health care professional or health care provider does not have such a right or rights, except as otherwise provided by law. Health care professionals and health care providers shall be allowed to collect payment for applicable co-payments, co-insurance, and deductibles and payment for non-covered services directly from patients, except as otherwise provided by law. When health care services are provided by a non-participating health care professional or health care provider, an insurer, health maintenance organization, independent practice association, or physician hospital organization may pay for covered services either to a patient directly or to the non-participating health care professional or health care provider.

(c) When a person presents a benefits information card, a health care professional or health care provider shall make a good faith effort to inform the person if the health care professional or health care provider has a participation contract with the insurer, health maintenance organization, or other entity identified on the card.

(215 ILCS 5/368d new)

Sec. 368d. Recoupments.

(a) A health care professional or health care provider shall be provided a remittance advice, which must include an explanation of a recoupment or offset taken by an insurer, health maintenance organization, independent practice association, or physician hospital organization, if any. The recoupment explanation shall, at a minimum, include the name of the patient; the date of service; the service code or if no service code is available a service description; the recoupment amount; and the reason for the recoupment or offset. In addition, an insurer, health maintenance

organization, independent practice association, or physician hospital organization shall provide with the remittance advice a telephone number or mailing address to initiate an appeal of the recoupment or offset.

(b) It is not a recoupment when a health care professional or health care provider is paid an amount prospectively or concurrently under a contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization that requires a retrospective reconciliation based upon specific conditions outlined in the contract.

(215 ILCS 5/368e new)

Sec. 368e. Administration and enforcement.

(a) Other than the duties specifically created in Sections 368b, 368c, and 368d, nothing in those Sections is intended to preclude, prevent, or require the adoption, modification, or termination of any utilization management, quality management, or claims processing methodologies or other provisions of a contract applicable to services provided under a contract between an insurer, health maintenance organization, independent practice association, or physician hospital organization and a health care professional or health care provider.

(b) Nothing in Sections 368b, 368c, and 368d precludes, prevents, or requires the adoption, modification, or termination of any health plan term, benefit, coverage or eligibility provision, or payment methodology.

(c) The provisions of Sections 368b, 368c, and 368d are deemed incorporated into health care professional and health care provider service contracts entered into on or before the effective date of this amendatory Act of the 93rd General Assembly and do not require an insurer, health maintenance organization, independent practice association, or physician

hospital organization to renew or renegotiate the contracts with a health care professional or health care provider.

(d) The Department shall enforce the provisions of this Section and Sections 368b, 368c, and 368d pursuant to the enforcement powers granted to it by law.

(e) The Department is hereby granted specific authority to issue a cease and desist order against, fine, or otherwise penalize independent practice associations and physician-hospital organizations for violations.

(f) The Department shall adopt reasonable rules to enforce compliance with this Section and Sections 368b, 368c, and 368d.

(215 ILCS 5/370k) (from Ch. 73, par. 982k)

Sec. 370k. Registration.

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

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

(c) Preferred provider administrators are subject to the provisions of Sections 368b, 368c, 368d, and 368e of this Code.

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

Section 10. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 367i, 368a, 368b, 368c, 368d, 368e, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

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

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

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

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

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

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

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not

apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

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

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

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

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

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

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

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria

specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

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

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately

preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

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

(Source: P.A. 91-357, eff. 7-29-99; 91-406, eff. 1-1-00; 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff. 6-9-00; 92-764, eff. 1-1-03.)

Section 99. Effective date. This Act takes effect January 1, 2004.".