1 AN ACT in relation to insurance.

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

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

7 (215 ILCS 5/368b new)
8 Sec. 368b. Contracting procedures.
9 (a) A health care professional or health care provider
10 offered a contract by an insurer, health maintenance
11 organization, independent practice association, or physician
12 hospital organization for signature after the effective date
13 of this amendatory Act of the 93rd General Assembly shall be
14 provided with a proposed health care professional or health
15 care provider services contract including, if any, exhibits
16 and attachments that the contract indicates are to be
17 attached. Within 35 days after a written request, the health
18 care professional or health care provider offered a contract
19 shall be given the opportunity to review and obtain a copy of
20 the following: a specialty-specific fee schedule sample based
21 on a minimum of the 50 highest volume fee schedule codes with
22 the rates applicable to the health care professional or
23 health care provider to whom the contract is offered, the
24 network provider administration manual, and a summary
25 capitation schedule, if payment is made on a capitation
26 basis. If 50 codes do not exist for a particular specialty,
27 the health care professional or health care provider offered
28 a contract shall be given the opportunity to review or obtain
29 a copy of a fee schedule sample with the codes applicable to
30 that particular specialty. This information may be provided
31 electronically. An insurer, health maintenance organization,

1 independent practice association, or physician hospital
2 organization may substitute the fee schedule sample with a
3 document providing reference to the information needed to
4 calculate the fee schedule that is available to the public at
5 no charge and the percentage or conversion factor at which
6 the insurer, health maintenance organization, preferred
7 provider organization, independent practice association, or
8 physician hospital organization sets its rates.
9 (b) The fee schedule, the capitation schedule, and the
10 network provider administration manual constitute
11 confidential, proprietary, and trade secret information and
12 are subject to the provisions of the Illinois Trade Secrets
13 Act. The health care professional or health care provider
14 receiving such protected information may disclose the
15 information on a need to know basis and only to individuals
16 and entities that provide services directly related to the
17 health care professional's or health care provider's decision
18 to enter into the contract or keep the contract in force. Any
19 person or entity receiving or reviewing such protected
20 information pursuant to this Section shall not disclose the
21 information to any other person, organization, or entity,
22 unless the disclosure is requested pursuant to a valid court
23 order or required by a state or federal government agency.
24 Individuals or entities receiving such information from a
25 health care professional or health care provider as
26 delineated in this subsection are subject to the provisions
27 of the Illinois Trade Secrets Act.
28 (c) The health care professional or health care provider
29 shall be allowed at least 30 days to review the health care
30 professional or health care provider services contract,
31 including exhibits and attachments, if any, before signing.
32 The 30-day review period begins upon receipt of the health
33 care professional or health care provider services contract,
34 unless the information available upon request in subsection

1 (a) is not included. If information is not included in the
2 professional services contract and is requested pursuant to
3 subsection (a), the 30-day review period begins on the date
4 of receipt of the information. Nothing in this subsection
5 shall prohibit a health care professional or health care
6 provider from signing a contract prior to the expiration of
7 the 30-day review period.
8 (d) The insurer, health maintenance organization,
9 independent practice association, or physician hospital
10 organization shall provide all contracted health care
11 professionals or health care providers with any changes to
12 the fee schedule provided under subsection (a) not later than
13 35 days after the effective date of the changes, unless such
14 changes are specified in the contract and the health care
15 professional or health care provider is able to calculate the
16 changed rates based on information in the contract and
17 information available to the public at no charge. For the
18 purposes of this subsection, "changes" means an increase or
19 decrease in the fee schedule referred to in subsection (a).
20 This information may be made available by mail, e-mail,
21 newsletter, website listing, or other reasonable method. Upon
22 request, a health care professional or health care provider
23 may request an updated copy of the fee schedule referred to
24 in subsection (a) every calendar quarter.
25 (e) Upon termination of a contract with an insurer,
26 health maintenance organization, independent practice
27 association, or physician hospital organization and at the
28 request of the patient, a health care professional or health
29 care provider shall transfer copies of the patient's medical
30 records. Any other provision of law notwithstanding, the
31 costs for copying and transferring copies of medical records
32 shall be assigned per the arrangements agreed upon, if any,
33 in the health care professional or health care provider
34 services contract.

1 (215 ILCS 5/368c new)
2 Sec. 368c. Remittance advice and procedures.
3 (a) A remittance advice shall be furnished to a health
4 care professional or health care provider that identifies the
5 disposition of each claim. The remittance advice shall
6 identify the services billed; the patient responsibility, if
7 any; the actual payment, if any, for the services billed; and
8 the reason for any reduction to the amount for which the
9 claim was submitted. For any reductions to the amount for
10 which the claim was submitted, the remittance shall identify
11 any withholds and the reason for any denial or reduction.
12 A remittance advice for capitation or prospective payment
13 arrangements shall be furnished to a health care professional
14 or health care provider pursuant to a contract with an
15 insurer, health maintenance organization, independent
16 practice association, or physician hospital organization in
17 accordance with the terms of the contract.
18 (b) When health care services are provided by a
19 non-participating health care professional or health care
20 provider, an insurer, health maintenance organization,
21 independent practice association, or physician hospital
22 organization may pay for covered services either to a patient
23 directly or to the non-participating health care professional
24 or health care provider.
25 (c) When a person presents a benefits information card,
26 a health care professional or health care provider shall make
27 a good faith effort to inform the person if the health care
28 professional or health care provider has a participation
29 contract with the insurer, health maintenance organization,
30 or other entity identified on the card.

31 (215 ILCS 5/368d new)
32 Sec. 368d. Recoupments.
33 (a) A health care professional or health care provider

1 shall be provided a remittance advice, which must include an
2 explanation of a recoupment or offset taken by an insurer,
3 health maintenance organization, independent practice
4 association, or physician hospital organization, if any. The
5 recoupment explanation shall, at a minimum, include the name
6 of the patient; the date of service; the service code or if
7 no service code is available a service description; the
8 recoupment amount; and the reason for the recoupment or
9 offset. In addition, an insurer, health maintenance
10 organization, independent practice association, or physician
11 hospital organization shall provide with the remittance
12 advice a telephone number or mailing address to initiate an
13 appeal of the recoupment or offset.
14 (b) It is not a recoupment when a health care
15 professional or health care provider is paid an amount
16 prospectively or concurrently under a contract with an
17 insurer, health maintenance organization, independent
18 practice association, or physician hospital organization that
19 requires a retrospective reconciliation based upon specific
20 conditions outlined in the contract.

21 (215 ILCS 5/368e new)
22 Sec. 368e. Administration and enforcement.
23 (a) Other than the duties specifically created in
24 Sections 368b, 368c, and 368d, nothing in those Sections is
25 intended to preclude, prevent, or require the adoption,
26 modification, or termination of any utilization management,
27 quality management, or claims processing methodologies or
28 other provisions of a contract applicable to services
29 provided under a contract between an insurer, health
30 maintenance organization, independent practice association,
31 or physician hospital organization and a health care
32 professional or health care provider.
33 (b) Nothing in Sections 368b, 368c, and 368d precludes,

1 prevents, or requires the adoption, modification, or
2 termination of any health plan term, benefit, coverage or
3 eligibility provision, or payment methodology.
4 (c) The provisions of Sections 368b, 368c, and 368d are
5 deemed incorporated into health care professional and health
6 care provider service contracts entered into on or before the
7 effective date of this amendatory Act of the 93rd General
8 Assembly and do not require an insurer, health maintenance
9 organization, independent practice association, or physician
10 hospital organization to renew or renegotiate the contracts
11 with a health care professional or health care provider.
12 (d) The Department shall enforce the provisions of this
13 Section and Sections 368b, 368c, and 368d pursuant to the
14 enforcement powers granted to it by law.
15 (e) The Department is hereby granted specific authority
16 to issue a cease and desist order against, fine, or otherwise
17 penalize independent practice associations and
18 physician-hospital organizations for violations.
19 (f) The Department shall adopt reasonable rules to
20 enforce compliance with this Section and Sections 368b, 368c,
21 and 368d.

22 (215 ILCS 5/370k) (from Ch. 73, par. 982k)
23 Sec. 370k. Registration.
24 (a) All administrators of a preferred provider program
25 subject to this Article shall register with the Department of
26 Insurance, which shall by rule establish criteria for such
27 registration including minimum solvency requirements and an
28 annual registration fee for each administrator.
29 (b) The Department of Insurance shall compile and
30 maintain a listing updated at least annually of
31 administrators and insurers offering agreements authorized
32 under this Article.
33 (c) Preferred provider administrators are subject to the

1 provisions of Sections 368b, 368c, 368d, and 368e of this
2 Code.
3 (Source: P.A. 84-618.)

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

6 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)
7 Sec. 5-3. Insurance Code provisions.
8 (a) Health Maintenance Organizations shall be subject to
9 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
10 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
11 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x,
12 356y, 356z.2, 367i, 368a, 368b, 368c, 368d, 368e, 401, 401.1,
13 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,
14 paragraph (c) of subsection (2) of Section 367, and Articles
15 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of
16 the Illinois Insurance Code.
17 (b) For purposes of the Illinois Insurance Code, except
18 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
19 Health Maintenance Organizations in the following categories
20 are deemed to be "domestic companies":
21 (1) a corporation authorized under the Dental
22 Service Plan Act or the Voluntary Health Services Plans
23 Act;
24 (2) a corporation organized under the laws of this
25 State; or
26 (3) a corporation organized under the laws of
27 another state, 30% or more of the enrollees of which are
28 residents of this State, except a corporation subject to
29 substantially the same requirements in its state of
30 organization as is a "domestic company" under Article
31 VIII 1/2 of the Illinois Insurance Code.
32 (c) In considering the merger, consolidation, or other

1 acquisition of control of a Health Maintenance Organization
2 pursuant to Article VIII 1/2 of the Illinois Insurance Code,
3 (1) the Director shall give primary consideration
4 to the continuation of benefits to enrollees and the
5 financial conditions of the acquired Health Maintenance
6 Organization after the merger, consolidation, or other
7 acquisition of control takes effect;
8 (2)(i) the criteria specified in subsection (1)(b)
9 of Section 131.8 of the Illinois Insurance Code shall not
10 apply and (ii) the Director, in making his determination
11 with respect to the merger, consolidation, or other
12 acquisition of control, need not take into account the
13 effect on competition of the merger, consolidation, or
14 other acquisition of control;
15 (3) the Director shall have the power to require
16 the following information:
17 (A) certification by an independent actuary of
18 the adequacy of the reserves of the Health
19 Maintenance Organization sought to be acquired;
20 (B) pro forma financial statements reflecting
21 the combined balance sheets of the acquiring company
22 and the Health Maintenance Organization sought to be
23 acquired as of the end of the preceding year and as
24 of a date 90 days prior to the acquisition, as well
25 as pro forma financial statements reflecting
26 projected combined operation for a period of 2
27 years;
28 (C) a pro forma business plan detailing an
29 acquiring party's plans with respect to the
30 operation of the Health Maintenance Organization
31 sought to be acquired for a period of not less than
32 3 years; and
33 (D) such other information as the Director
34 shall require.

1 (d) The provisions of Article VIII 1/2 of the Illinois
2 Insurance Code and this Section 5-3 shall apply to the sale
3 by any health maintenance organization of greater than 10% of
4 its enrollee population (including without limitation the
5 health maintenance organization's right, title, and interest
6 in and to its health care certificates).
7 (e) In considering any management contract or service
8 agreement subject to Section 141.1 of the Illinois Insurance
9 Code, the Director (i) shall, in addition to the criteria
10 specified in Section 141.2 of the Illinois Insurance Code,
11 take into account the effect of the management contract or
12 service agreement on the continuation of benefits to
13 enrollees and the financial condition of the health
14 maintenance organization to be managed or serviced, and (ii)
15 need not take into account the effect of the management
16 contract or service agreement on competition.
17 (f) Except for small employer groups as defined in the
18 Small Employer Rating, Renewability and Portability Health
19 Insurance Act and except for medicare supplement policies as
20 defined in Section 363 of the Illinois Insurance Code, a
21 Health Maintenance Organization may by contract agree with a
22 group or other enrollment unit to effect refunds or charge
23 additional premiums under the following terms and conditions:
24 (i) the amount of, and other terms and conditions
25 with respect to, the refund or additional premium are set
26 forth in the group or enrollment unit contract agreed in
27 advance of the period for which a refund is to be paid or
28 additional premium is to be charged (which period shall
29 not be less than one year); and
30 (ii) the amount of the refund or additional premium
31 shall not exceed 20% of the Health Maintenance
32 Organization's profitable or unprofitable experience with
33 respect to the group or other enrollment unit for the
34 period (and, for purposes of a refund or additional

1 premium, the profitable or unprofitable experience shall
2 be calculated taking into account a pro rata share of the
3 Health Maintenance Organization's administrative and
4 marketing expenses, but shall not include any refund to
5 be made or additional premium to be paid pursuant to this
6 subsection (f)). The Health Maintenance Organization and
7 the group or enrollment unit may agree that the
8 profitable or unprofitable experience may be calculated
9 taking into account the refund period and the immediately
10 preceding 2 plan years.

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

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

27 (Source: P.A. 91-357, eff. 7-29-99; 91-406, eff. 1-1-00;
28 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff.
29 6-9-00; 92-764, eff. 1-1-03.)

30 Section 99. Effective date. This Act takes effect January
31 1, 2004.