AMENDMENT TO SENATE BILL 1776

AMENDMENT NO. _____. Amend Senate Bill 1776 by replacing the title with the following:

"AN ACT concerning insurance."; and

by replacing everything after the enacting clause with the following:

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

(215 ILCS 5/368b new)

Sec. 368b. Prohibition of waiver of requirements and prohibitions. No contract between an insurer, health maintenance organization, independent practice association, or physician hospital organization and a health care professional or health care provider shall contain any provision, term, or condition that limits, restricts, or otherwise waives any of the requirements and prohibitions set forth in this Article. Any provision purporting to make such a waiver is void and unenforceable.

(215 ILCS 5/368c new)

Sec. 368c. Payments.

(a) After the effective date of this amendatory Act of the 93rd General Assembly, health care professionals or health care providers offered a contract for signature by an insurer, health maintenance organization, independent practice association, or physician hospital organization to be paid on a service by service basis shall, upon request, be provided copies of the fee schedule or payment arrangement and amounts for each health care service to be provided under the contract prior to signing the contract. If the health care professional or health care provider is not paid on a service by service basis, the amounts payable and terms of payment under that alternative payment system shall be provided upon request.

(b) Payments under a contract with a health care professional or health care provider shall not be changed based upon rates agreed to by the professional or provider in another contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization. Nothing in this Section shall be construed to prevent an insurer, health maintenance organization, independent practice association, or physician hospital organization from renegotiating its payments under a contract with a health care professional or health care provider.

(c) A payment statement shall be furnished to a health care professional or health care provider paid on a service by service basis for services provided under the contract that identifies the disposition of each claim, including services billed, the patient responsibility, if any, the actual payment, if any, for the services billed by CPT or other appropriate code, and the reason for any payment reduction to the claim submitted, including any withholds, and the reason for denial of any claim. Nothing in this Section requires that a health care professional or health

care provider be paid on a service by service basis. Payments may be made based on capitation and other payment arrangements. Health care professionals and health care providers shall be allowed to collect co-payments, co-insurance, deductibles, and payment for non-covered services directly from patients except as otherwise provided by law. An insurer, health maintenance organization, independent practice association, or physician hospital organization may pay for covered services either to a patient directly or a non-participating health care professional or health care provider.

(d) When a person presents a health care service benefits information card, a health care professional or health care provider shall inform the person if he or she is not participating with the insurer, health maintenance organization, independent practice organization, or physician hospital organization issuing the card.

(215 ILCS 5/368e new)

Sec. 368e. Recoupments. Any attempt to recoup payment made to a health care professional or health care provider by an insurer, health maintenance organization, independent practice association, or physician-hospital organization shall be initiated by providing a written explanation of any proposed recoupment, including, but not limited to, the name of the patient, the date of service, the service code, and the payment amount, the details concerning the reasons for the recoupment, and an explanation of the appeal process. A health care professional or health care provider shall be given 60 days to appeal the proposed recoupment or to repay the recoupment amount. If the health care professional or health care provider chooses to appeal the proposed recoupment and, upon appeal, the proposed recoupment is determined to be appropriate, the health care professional or

health care provider must pay the recoupment within 30 days of receiving the notice of the final appeal's decision. If the health care professional or health care provider does not make any required recoupment payment within these time frames, the insurer, health maintenance organization, independent practice association, or physician hospital organization may offset future payments to effectuate the recoupment. Except in an instance in which the health care professional or health care provider has been found guilty of committing civil or criminal insurance fraud, no recoupment of any payments may be initiated 24 months after the date the moneys were paid, except when requested or initiated by a governmental unit. It is not a recoupment when a health care professional or health care provider is paid an amount prospectively under a contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization that includes a retrospective reconciliation based on the services provided.

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, 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 15. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

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

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c, 149, 155.37, 354, 355.2, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 367.2, 368a, <u>368b, 368c, 368e,</u> 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 91-406, eff. 1-1-00; 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff. 6-9-00; 92-130, eff. 7-20-01; 92-440, eff. 8-17-01; 92-651, eff. 7-11-02; 92-764, eff. 1-1-03.)

Section 99. Effective date. This Act takes effect December 1, 2003.".