HB3923

LRB09608394RPM18506b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB3923

Introduced 2/26/2009, by Rep. Greg Harris, Susana A Mendoza and LaShawn K. Ford

SYNOPSIS AS INTRODUCED:

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Creates the Individual Market Fairness Reform Law. Provides that a managed care entity shall (1) fairly and affirmatively offer all of its managed care plans that are sold to all individuals in each service area in which the managed care entity provides or arranges for the provision of health care services and (2) may not reject an application for an individual managed care plan if certain requirements are met. Provides that the Division of Insurance shall develop a system to categorize all managed care plans offered and sold to individuals pursuant to this Law into 5 coverage choice categories. Creates the Minimum Medical Loss Ratio Law. Provides that any company selling a health benefit plan in the individual or small group market shall expend in the form of health care benefits no less than 85 percent of the aggregate dues, fees, and premiums received by the company. Creates the Health Sure Illinois Law to establish a program for the purpose of making managed care plans affordable and accessible to small employers and individuals. Provides that the program is limited to active managed care entities. Amends the Illinois Insurance Code. Creates new Articles in the Code establishing the Office of Patient Protection and the Illinois Health Carrier External Review Law. Amends the Small Employer Health Insurance Rating Act, Illinois Health Insurance Portability and Accountability Act, and Managed Care Reform and Patient Rights Act in provisions concerning small employers, individuals, review, and rates. Repeals a provision of the Small Employer Health Insurance Rating Act concerning establishment of a class of business. Makes other changes.

LRB096 08394 RPM 18506 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning insurance.

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

ARTICLE 5. CONSUMER CHOICE AND PROMOTING
RATE FAIRNESS IN ILLINOIS' INDIVIDUAL
HEALTH INSURANCE MARKET

Section 5-1. Short title. This Law may be cited as the Individual Market Fairness Reform Law.

Section 5-5. Purpose. Illinois health insurance markets are critical to the health and well being of Illinois citizens. The General Assembly recognizes that the design of Illinois health insurance markets, therefore, must promote the public's health and welfare. It is the intent of this Law to do both of the following:

(1) Guarantee the availability and renewability of health coverage through the private health insurance market to individuals.

(2) Require that health maintenance organizations and health insurers issuing coverage in the individual market compete on the basis of price, quality, and service and not on risk selection.

Section 5-10. Definitions. In this Law:

"Anniversary date" means the calendar date one year from, and each subsequent year thereafter, the date an individual enrolls in a managed care plan.

"Coverage choice category" means one of the 5 categories of managed care plans established by the Division pursuant to this Law.

"Creditable coverage" means creditable coverage as defined by Section 20 of the Illinois Health Insurance Portability and Accountability Act.

"Dependent" means the spouse, domestic partner, or child of an individual, subject to applicable laws and the applicable terms of the managed care plan covering the individual.

"Division" means the Division of Insurance within the Illinois Department of Financial and Professional Regulation.

"Enrollment date" means the first day of coverage of an individual under a managed care plan or, if earlier, the first day of the waiting period that must pass with respect to an individual before such individual is eligible to be covered for benefits.

"Health care plan" means a health care plan as defined by Section 1-2 of the Health Maintenance Organization Act that is offered to individuals.

"Health insurance policy" means an individual policy of accident and health insurance offered, sold, amended, or renewed to individuals and their dependents that provides

coverage for hospital, medical, or surgical benefits. The term shall not include any of the following kinds of insurance: hospital indemnity, accidental death and dismemberment, workers' compensation, credit accident and health, short-term accident and health, accident only, long term care, Medicare supplement, student blanket, stand-alone policies, dental, vision care, prescription drug benefits, disability income, specified disease, or similar supplementary benefits.

"Health insurer" means any insurance company authorized to sell health insurance policies.

"Health maintenance organization" means commercial health maintenance organizations as defined by Section 1-2 of the Health Maintenance Organization Act and shall not include health maintenance organizations which participate solely in government-sponsored programs.

"Managed care entity" means any health maintenance organization or health insurer, as those terms are defined in this Section.

"Managed care plan" means any health care plan or health insurance policy, as those terms are defined in this Section, offered, issued, sold, amended, or renewed by a managed care entity.

"Policyholder" means an individual who is enrolled in a health insurance policy or health care plan, is the basis for eligibility for enrollment in the policy or plan, and is responsible for payment to the managed care entity.

"Preexisting condition exclusion" means "preexisting condition exclusion" as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act. The term shall include exclusionary riders.

"Rating period" means the period for which premium rates established by a managed care entity are in effect and shall be no less than 12 months beginning on the effective date of the policyholder's managed care plan.

"Risk adjustment factor" means the percentage adjustment to be applied to the standard risk rate for a particular individual, based upon expected deviations from standard claims due to the health status of the individual.

"Risk category" means the following characteristics of an individual: age, geographic region, and family composition of the individual, plus the managed care plan selected by the individual. The following provisions apply to rates:

(1) No more than the following age categories may be used in determining premium rates: under one; 1-18; 19-24; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; 65 and over.

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the managed care plan will be primary or secondary to benefits provided by the federal Medicare Program pursuant to Title XVIII of the federal Social Security Act.

(2) Managed care entities shall determine rates using no more than the following family size categories:

(A) Single.

(B) More than one child 18 years of age or under and no adults.

(C) Married couple or domestic partners.

(D) One adult and child.

(E) One adult and children.

(F) Married couple and child or children, or domestic partners and child or children.

(3) The following provisions shall apply to rates:

(A) In determining rates for individuals, a managed care entity that operates statewide shall use no more than 5 geographic regions in the State, according to the following provisions:

(i) The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions established pursuant to this Section shall, as a group, cover the entire State.

(ii) The rate for each geographic region must be based on the different costs and availability of providing health services in the respective regions.

(iii) A rate must not be established for a region smaller than a single county.

(iv) A proposed region must not appear, in the determination of the Division, to contain configurations designed to avoid, or segregate into a separate region, particular areas within a county.

Managed care entities shall be deemed to be operating statewide if their coverage area includes 90% or more of the State's population.

(B) The following provisions shall apply to rates for individuals:

(i) In determining rates for individuals, a managed care entity that does not operate statewide shall use no more than the number of geographic regions in the State that is determined by the following formula: the population, as determined in the last federal census, of all counties that are included in their entirety in a managed care entity's service area divided by the total population of the State, as determined in the last federal census, multiplied by 5. The resulting number shall be rounded to the nearest whole integer. No managed care entity shall have less than one geographic region. Geographic regions must be determined according to the requirements in sub-items (i) through (iv) of item (3) of this definition of "risk category".

(ii) If the formula in clause (i) results in a managed care entity that operates in more than one county having only one geographic region, then the formula in clause (i) shall not apply and the managed care entity may have 2 geographic regions, provided that no county is divided into more than one region.

Nothing in this Section shall be construed to require a managed care entity to establish a new service area or to offer managed care plans on a statewide basis, outside of the managed care entity's existing service area.

(4) A managed care entity may rate all its managed care plans in accordance with expected costs or other market considerations, but the rate for each managed care plan shall be set in relation to all the other managed care plans offered by the managed care entity, as certified by an actuary.

(5) Each managed care plan shall be priced as determined by each managed care entity to reflect the difference in benefit variation, or the effectiveness of a provider network, and each managed care entity may adjust the rate for a specific managed care plan for risk selection only to the extent permitted by subsection (d) of Section 5-30 of this Law.

"Standard risk rate" means the rate applicable to an

individual in a particular risk category.

"Waiting period" means, with respect to an individual who seeks and obtains coverage under a managed care plan, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage.

Section 5-15. Guaranteed issue of all plans in the individual market.

(a) A managed care entity shall fairly and affirmatively offer, market, and sell all of its managed care plans that are sold to all individuals in each service area in which the managed care entity provides or arranges for the provision of health care services.

(b) A managed care entity may not reject an application from an individual, or his or her dependents, for an individual managed care plan, or refuse to renew an individual managed care plan, if all of the following requirements are met:

(1) The individual agrees to make the required premium payments.

(2) The individual and his or her dependents who are to be covered by the managed care plan work or reside in the service area in which the managed care entity provides or otherwise arranges for the provision of health care services.

(3) The individual provides the information requested

on the application to determine the appropriate rate.

(c) Notwithstanding subsection (b) of this Section, if an individual, or his or her dependents, applies for a managed care plan in a coverage choice category for which he or she is not eligible pursuant to subsections (h), (i), and (j) of Section 5-20 of this Law, the managed care entity may reject that application, provided that the managed care entity also offers the individual and his or her dependents coverage in the appropriate coverage choice category.

(d) Notwithstanding subsection (b) of this Section, a managed care entity is not required to renew an individual health insurance policy if any of the conditions listed in item (B) of Section 50 of the Illinois Health Insurance Portability and Accountability Act are met.

(e) Notwithstanding subsection (b) of this Section, a managed care entity is not required to offer an individual managed care plan and may reject an application for an individual managed care plan in the case of any of the following:

(1) The individual and dependents who are to be covered by the managed care plan do not work or reside in a managed care entity's approved service area.

(2) Within a specific service area or portion of a service area, if a managed care entity reasonably anticipates and demonstrates to the satisfaction of the Division that it will not have sufficient health care

delivery resources to ensure that health care services will be available and accessible to the eligible individual and dependents of the individual because of its obligations to existing policyholders.

(2.5) A managed care entity that cannot offer a managed care plan to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a managed care plan in the area in which the managed care entity is not offering coverage to individuals until the managed care entity notifies the Division that it has the ability to deliver services to new policyholders, and certifies to the Division that from the date of the notice it will enroll all individuals and groups requesting coverage in that area from the managed care entity.

(3) A person who has been a resident of Illinois for 6 months or less, unless one of the following applies:

(A) the person is a federally eligible individual as defined by Section 2 of the Comprehensive Health Insurance Plan Act; or

(B) the person can demonstrate a minimum of 2 years of prior creditable coverage and providing the person applies for coverage in Illinois within 62 days after termination or cancellation of the prior creditable coverage.

(f) A managed care entity may require an individual to

provide information on his or her health status or health history, or that of his or her dependents, in the application for enrollment to the extent required to apply the risk adjustment factor permitted pursuant to subsection (d) of Section 5-30 of this Law. The managed care entity shall use the standard individual market health statement developed by the Division pursuant to Section 359a.2 of the Illinois Insurance Code for the purpose of collecting health status or health history information. After the individual managed care plan's effective date of coverage, a managed care entity may request that the policyholder provide information voluntarily on his or her health history or health status, or that of his or her dependents, for purposes of providing care management services, including disease management services.

(g) A managed care entity shall not impose any preexisting condition exclusions on any managed care plan issued, amended, or renewed pursuant to this Law, except as provided under subsection (h) of this Section.

(h) The following provisions shall apply concerning preexisting conditions:

(1) A managed care entity may impose a preexisting condition exclusion only if:

(A) the exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the

6-month period ending on the enrollment date; and

(B) the exclusion extends for a period of not more than 12 months after the enrollment date.

(2) In determining whether a preexisting condition exclusion applies to a covered individual, the managed care entity shall credit the time the individual was previously covered under creditable coverage, if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new coverage.

(3) A managed care entity may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Genetic information shall not be treated as a condition described in paragraph (A) of item (1) of this subsection (h) in the absence of a diagnosis of the condition related to such information.

(5) All preexisting condition exclusions must comply with rules relating to crediting previous coverage as promulgated by the Division.

(i) This Law shall not apply to managed care plans for coverage of Medicare services pursuant to contracts with the United States government, a Medicare supplement, medical program contracts with the State Department of Healthcare and Family Services, or long-term care coverage.

Section 5-20. Coverage choice categories.

(a) On or before March 1, 2010, the Division shall, by rule, develop a system to categorize all managed care plans offered and sold to individuals pursuant to this Law into 5 coverage choice categories. These coverage choice categories shall do all of the following:

(1) Reflect a reasonable continuum between the coverage choice category with the lowest level of health care benefits and the coverage choice category with the highest level of health care benefits.

(2) Permit reasonable benefit variation that will allow for diverse options within each coverage choice category.

(3) Be enforced consistently among managed care entities in the same marketplace regardless of licensure.

(4) Within each coverage choice category, include one standard managed care plan, which is the managed care plan with the lowest benefit level in that category.

(b) All managed care entities shall submit the filings required pursuant to subsections (d), (e), (f), and (g) of Section 5-35 of this Law no later than September 1, 2010, for all individual managed care plans to be sold on or after June 1, 2011, to comply with this Law, and thereafter any additional managed care plans shall be filed pursuant to subsections (d), (e), (f), and (g) of Section 5-35. The Division shall categorize each managed care plan offered by a managed care entity into the appropriate coverage choice category on or

before February 28, 2011.

(c) To facilitate consumer comparisons, all managed care entities that offer coverage on an individual basis shall offer at least one managed care plan in each coverage choice category, including offering at least one of the standard managed care plans developed pursuant to item (4) of subsection (a) of this Section, but a managed care entity may offer multiple managed care plans in each category.

(d) If a managed care entity offers a specific type of managed care plan in one coverage choice category, it must offer that specific type of managed care plan in each coverage choice category. A "type of managed care plan" includes a health maintenance organization model, a preferred provider organization model, an exclusive provider organization model, a traditional indemnity model, and a point of service model.

(e) A provider network offered for one managed care plan in one coverage choice category shall be offered for at least one managed care plan in each coverage choice category.

(f) A managed care entity shall establish prices for its managed care plans that reflect a reasonable continuum between the managed care plans offered in the coverage choice category with the lowest level of benefits and the managed care plans offered in the coverage choice category with the highest level of benefits. A managed care entity shall not establish a standard risk rate for a managed care plan in a coverage choice category at a lower rate than a managed care plan offered in a

lower coverage choice category.

(g) A managed care entity shall offer coverage for a wellness program in at least one managed care plan in every coverage choice category. The Division shall by rule define "wellness program" for the purposes of this Section.

(h) If an individual disenrolls from a managed care plan or if the individual's managed care plan is canceled pursuant to one of the general exceptions listed in item (B) of Section 50 of the Illinois Health Insurance Portability and Accountability Act prior to the anniversary date of the managed care plan, subsequent enrollment in an individual managed care plan shall be limited to the same coverage choice category the individual was enrolled in prior to disenrollment or cancellation.

(i) The following provisions shall apply:

(1) An individual may change to a managed care plan in a different coverage choice category only on the anniversary date of the policyholder or upon a qualifying event.

(2) In no case, however, may an individual move up more than one coverage choice category on the anniversary date of the policyholder unless there is also a qualifying event.

(j) For purposes of this Section, a qualifying event occurs upon any of the following:

(1) Upon the death of the policyholder, on whose

coverage an individual was a dependent.

(2) Upon marriage of the policyholder or entrance by the policyholder into a domestic partnership.

(3) Upon divorce or legal separation of an individual from the policyholder.

(4) Upon loss of dependent status by a dependent enrolled in group health care coverage through a managed care entity.

(5) Upon the birth or adoption of a child.

Section 5-25. Policy rescissions.

(a) On or after June 1, 2011, a managed care entity shall not rescind the managed care plan of any individual.

(b) Nothing in this Law shall limit any other remedies available at law to a health insurer.

Section 5-30. Adjusted community rating for individual market premiums. Premiums for managed care plans offered or delivered by managed care entities on or after the effective date of this Section shall be subject to the following requirements:

(1) The premium for a new or existing business shall be the standard risk rate for an individual in a particular risk category.

(2) The premium rates charged to a policyholder shall be in effect for no less than 12 months from the date of

the managed care plan's issuance or renewal.

(3) When determining the premium rate for more than one covered individual, the managed care entity shall determine the rate based on the standard risk rate for the policyholder. If more than one individual is a policyholder, the premium rate shall be based on the age of the youngest spouse or domestic partner.

(4) The following provisions shall apply:

(A) Notwithstanding subsection (a), for the first 2 years following the implementation of this Section, a managed care entity may apply a risk adjustment factor to the standard risk rate that may not be more than 120% or less than 80% of the applicable standard risk rate. In determining the risk adjustment factor, a managed care entity shall use the standard individual market health statement developed pursuant to Section 359a.2 of the Illinois Insurance Code.

(B) After the first 2 years following the implementation of this Section, the adjustments applicable under paragraph (A) shall not be more than 110% or less than 90% of the standard risk rate.

(C) Upon the renewal of any managed care plan, the risk adjustment factor applied to the individual's rate may not be more than 5 percentage points different than the factor applied to that rate prior to renewal. The same limitation shall be applied to individuals

with respect to the risk adjustment factor applicable for the purchase of a new managed care plan where the individual's prior managed care entity has discontinued that managed care plan.

(D) After the first 4 years following the implementation of this Section, a managed care entity shall base rates on the standard risk rate with no risk adjustment factor.

(5) The Division shall establish limits on allowable variation between the standard risk rates for individuals in the age categories established by Section 5-10 of this Law.

(6) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(7) This Section shall become operative on June 1, 2010.

Section 5-35. Disclosure requirements and filing of rates with the Division.

(a) In connection with the offering for sale of any managed care plan to an individual, each managed care entity shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The provisions concerning the managed care entity's right to change premium rates on an annual basis

and the factors other than provision of services experience that affect changes in premium rates.

(2) Provisions relating to the guaranteed issue and renewal of individual managed care plans.

(3) Provisions relating to the individual's right to obtain any managed care plan the individual is eligible to enroll in pursuant to Sections 5-15 and 5-20 of this Law.

(4) The availability, upon request, of a listing of all the individual managed care plans offered by the managed care entity, including the rates for each managed care plan.

(b) Every insurance producer contracting with one or more managed care plans to solicit enrollments or subscriptions from individuals shall, before making recommendations on any particular managed care plan, do both of the following:

(1) Advise the individual of a managed care entity's obligation to sell to any individual any managed care plan it offers to individuals and provide him or her, upon request, with the actual rates that would be charged to that individual for a given managed care plan.

(2) Notify the individual that the insurance producer will procure rate and benefit information for the individual on any managed care plan offered by a managed care entity whose managed care plan the insurance producer sells.

(c) Prior to filing an application for a particular

individual managed care plan, the managed care entity shall obtain a signed statement from the individual acknowledging that the individual has received the disclosures required by this Section.

(d) At least 20 business days prior to offering a managed care plan subject to this Law, all managed care entities shall file with the Division a statement certifying that the managed care entity is in compliance with Sections 5-15 and 5-30 of this Law. The certified statement shall set forth the standard risk rate for each risk category that will be used in setting the rates at which the managed care plan will be offered. Any action by the Division to disapprove, suspend, or postpone the managed care entity's use of a managed care plan shall be in writing, specifying the reasons that the managed care plan does not comply with the requirements of this Law.

(e) Prior to making any changes in the standard risk rates filed with the Division pursuant to subsection (d) of this Section, the managed care entity shall file as an amendment a statement setting forth the changes and certifying that the managed care entity is in compliance with Sections 5-15 and 5-30 of this Law. If the standard risk rate is being changed, a managed care entity may commence offering managed care plans utilizing the changed standard risk rate upon filing the certified statement, unless the Division disapproves the amendment by written notice.

(f) Periodic changes to the standard risk rate that a

managed care plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subsection (d) or (e) of this Section.

(g) Each managed care entity shall maintain at its principal place of business all of the information required to be filed with the Division pursuant to this Law.

(h) A managed care entity shall include all of the following in the statement filed pursuant to subsection (d):

(1) A summary explanation of the following for each managed care plan offered to individuals:

(A) Eligibility requirements.

(B) The full premium cost of each managed care plan in each risk category, as defined in Section 5-10 of this Law.

(C) When and under what circumstances benefits cease.

(D) Other coverage that may be available if benefits under the described managed care plan cease.

(E) The circumstances under which choice in the selection of physicians and providers is permitted.

(F) Deductibles.

(G) Annual out-of-pocket maximums.

(2) A summary explanation of coverage for the following, together with the corresponding copayments, coinsurance, and applicable limitations for each managed

care plan offered to individuals:

(A) Professional services.

(B) Outpatient services.

(C) Preventive services.

(D) Hospitalization services.

(E) Emergency health coverage.

(F) Ambulance services.

(G) Prescription drug coverage.

(H) Durable medical equipment.

(I) Mental health and substance abuse services.

(J) Home health services.

(3) The telephone number or numbers that may be used by an applicant to access a managed care entity customer service representative to request additional information about the managed care plan.

(i) If any information provided pursuant to subsection (h) of this Section changes, the managed care entity shall provide to the Division, on an annual basis, an update of that information.

(j) This Section shall become operative on June 1, 2010.

Section 5-40. Any contrary provisions. The provisions contained in this Law shall supersede any contrary provisions in the Illinois Insurance Code or in any other insurance law of this State.

ARTICLE 10. ENSURING ACCOUNTABILITY IN ILLINOIS' INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE MARKETS

Section 10-1. Short title. This Law may be cited as the Minimum Medical Loss Ratio Law.

Section 10-5. Purpose. The General Assembly recognizes that a significant share of the premium dollars paid by individuals and small employers to health insurers and health maintenance organizations is directed toward administrative and marketing activities and profit. It is the intent of this Law to ensure that premium costs for consumers more accurately reflect the value of health care they receive by increasing the portion of premium dollars dedicated to medical services.

Section 10-10. Definitions. In this Law:

"Company" means any entity that provides health insurance in this State. For the purposes of this Law, company includes a licensed insurance company, a health maintenance organization, or any other entity providing a plan of health insurance or health benefits subject to State insurance regulation.

"Division" means the Division of Insurance within the Illinois Department of Financial and Professional Regulation.

"Health benefit plan" means any hospital or medical expense-incurred policy, hospital or medical service plan

contract, or health maintenance organization subscriber contract. "Health benefit plan" shall not include accident-only, credit, dental, vision, Medicare supplement, hospital indemnity, long term care, specific disease, stop loss or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

"Health care benefits" means health care services that are either provided or reimbursed by a managed care entity or its contracted providers as benefits to its policyholders and insurers. Health care benefits shall include:

(A) The costs of programs or activities, including training and the provision of informational materials that are determined as part of the regulation to improve the provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine.

(B) Disease management expenses using cost-effective evidence-based guidelines.

(C) Plan medical advice by telephone.

(D) Payments to providers as risk pool payments of pay-for-performance initiatives.

"Health care benefits" shall not include administrative costs as determined by the Division.

"Individual market" means the individual market as defined by the Illinois Health Insurance Portability and Accountability Act.

"Small group market" means "small group market" as defined by the Illinois Health Insurance Portability and Accountability Act.

Section 10-15. Minimum medical loss requirement for companies offering coverage in the individual and small group market.

(a) Any company selling a health benefit plan in the individual or small group market shall, on and after June 1, 2011, expend in the form of health care benefits no less than 85% of the aggregate dues, fees, premiums, or other periodic payments received by the company. For purposes of this Section, the company may deduct from the aggregate dues, fees, premiums, or other periodic payments received by the company the amount of income taxes or other taxes that the company expensed.

(b) To assess compliance with this Section, a company with a valid certificate of authority may average its total costs across all health benefit plans issued, amended, or renewed in Illinois, and all health benefit plans issued, amended, or renewed by its affiliated companies that are licensed to operate in Illinois.

(c) The Division shall adopt rules to implement this Section and to establish uniform reporting by companies of the information necessary to determine compliance with this Section.

(d) The Division may exclude from the determination of

compliance with the requirement of subsection (a) of this Section any new health benefit plans for up to the first 2 years that these health benefit plans are offered for sale in Illinois, provided that the Division determines that the new health benefit plans are substantially different from the existing health benefit plans being issued, amended, or renewed by the company seeking the exclusion.

ARTICLE 15. EXPANDING ACCESS TO HEALTH INSURANCE THROUGH THE HEALTH SURE ILLINOIS PROGRAM

Section 15-1. Short title. This Article may be cited as the Health Sure Illinois Law.

Section 15-5. Purpose. The General Assembly recognizes that individuals and small employers in this State struggle every day to pay the costs of health insurance coverage that allows for the delivery of comprehensive and quality health care services. The General Assembly acknowledges that the high cost of health care for individuals and small groups is driven by unpredictable and high cost medical events. Therefore, the General Assembly, in order to provide Illinoisans greater access to affordable health insurance, seeks to reduce the premium impact of high-cost medical events by enacting this Law.

Section 15-10. Definitions. In this Law:

"Active managed care entity" means any health maintenance organization or insurer, as those terms are defined in this Section, whose gross Illinois premium equals or exceeds 1% of the applicable market share.

"Department" means the Department of Healthcare and Family Services.

"Division" means the Division of Insurance within the Department of Financial and Professional Regulation.

"Employed person" means, for purposes of determining eligibility for Sure Standard individual managed care plans, any person employed on a full-time or part-time basis either currently or within the past 12 months for which monetary compensation was received.

"Federal poverty level" means the federal poverty level income guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902 (2).

"Full-time employee" means a full-time employee as defined by Section 5-5 of the Economic Development for a Growing Economy Tax Credit Act.

"Health care plan" means a health care plan as defined by Section 1-2 of the Health Maintenance Organization Act.

"Health maintenance organization" means commercial health maintenance organizations as defined by Section 1-2 of the Health Maintenance Organization Act and shall not include

health maintenance organizations that participate solely in government-sponsored programs.

"Health Sure Illinois" means the program established under this Law.

"Individual market" means the individual market as defined by the Illinois Health Insurance Portability and Accountability Act.

"Insurer" means any insurance company authorized to sell group or individual policies of hospital, surgical, or major medical insurance coverage, or any combination thereof, that contains agreements or arrangements with providers relating to health care services that may be rendered to beneficiaries as defined by the Health Care Reimbursement Reform Act of 1985 in Sections 370f and following of the Illinois Insurance Code and its accompanying rule, 50 Illinois Administrative Code 2051. The term "insurer" does not include insurers that sell only policies of hospital indemnity, accidental death and dismemberment, workers' compensation, credit accident and health, short-term accident and health, accident only, long term care, Medicare supplement, student blanket, stand-alone policies, dental, vision care, prescription drug benefits, disability income, specified disease, or similar supplementary benefits.

"Small employer" means "small employer" as defined by the Illinois Health Insurance Portability and Accountability Act.

"Small group market" means "small group market" as defined

by the Illinois Health Insurance Portability and Accountability Act.

"Sure Standard group managed care plan" means any group plan offered pursuant to Section 15-15 of this Law.

"Sure Standard individual managed care plan" means any individual plan offered pursuant to Section 15-15 of this Law.

"Veteran" means "veteran" as defined by Section 5 of the Veterans' Health Insurance Program Act.

Section 15-15. Sure Standard managed care plans for eligible small employers and individuals.

(a) The State hereby establishes a program for the purpose of making managed care plans affordable and accessible to small employers and individuals as defined in this Section. The program is designed to encourage small employers to offer affordable health insurance to employees and to make affordable health insurance available to eligible Illinoisans, including small business employees, veterans, and individuals whose employers do not offer or sponsor group health insurance.

(b) Participation in this program is limited to active managed care entities as defined by Section 15-10 of this Law. Participation by all active managed care entities is mandatory. On January 1, 2010, or as soon as practicable as determined by the Department, all active managed care entities offering health insurance coverage or a health care plan in the small group market shall offer one or more Sure Standard group

managed care plans to qualifying small employers as defined in subsection (c) of this Section. All active managed care entities offering health insurance coverage or a health care plan in the individual market shall offer one or more Sure Standard individual managed care plans. For purposes of this Section and Section 15-20 of this Law, all active managed care entities that comply with the program requirements shall be eligible for reimbursement from the Health Sure Illinois stop loss funds made available pursuant to Section 15-20 of this Law.

(c) For purposes of this Law, a qualifying small employer is a small employer that:

(1) employs not more than 50 eligible employees;

(2) does not sponsor group health insurance and has not sponsored group health insurance with benefits on an expense-reimbursed or prepaid basis covering employees in effect during the 12-month period prior to the small employer's application for group health insurance under the program established by this Section;

(3) contributes towards the Sure Standard group managed care plan at least 50% of an individual employee's premium;

(4) has at least 30% of its eligible employees receiving annual wages from the employer at a level equal to or less than $34,000; this dollar figure shall be adjusted periodically pursuant to subsection (g) of this

Section; and

(5) uses Illinois as its principal place of business, management, and administration.

For purposes of this Section, "eligible employee" shall include any individual who receives compensation from the qualifying employer for at least 20 hours of work per week.

(c-5) The employer premium contribution must be the same percentage for all covered employees and may not vary based on class of employee.

(c-10) The Division shall by rule define "health insurance" for the purposes of this Section.

(d) For purposes of this Section, a self-employed individual shall be considered a qualifying employer only if the self-employed individual:

(1) does not have and has not had health insurance with benefits on an expense-reimbursed or prepaid basis during the 12-month period prior to the individual's application for health insurance under the program established by this Law;

(2) resides in a household having a household income at or below 250% of the federal poverty level;

(3) is ineligible for Medicare, except that the Department may determine that it shall require an individual who is eligible under subdivision 2(b) of Section 5-2 of the Illinois Public Aid Code to participate as a qualifying individual; and

(4) is a resident of Illinois.

However, the requirements set forth in item (1) of this subsection (d) shall not be applicable where a self-employed individual had health insurance coverage during the previous 12 months and such coverage terminated due to one of the reasons set forth in items (1) through (8) of subsection (m) of this Section.

(e) A small employer or self-employed individual shall cease to be a qualifying small employer if any health insurance that provides benefits on an expense reimbursed or prepaid basis covering the self-employed individual or an employer's employees, other than a Sure Standard group managed care plan purchased pursuant to this Section, is purchased or otherwise takes effect subsequent to purchase of a Sure Standard group managed care plan under the program established by this Section.

(f) An active managed care entity may enter into an agreement with an employer to offer a Sure Standard managed care plan pursuant to this Section only if that employer offers that plan to all eligible employees.

(g) The wage levels utilized in item (4) of subsection (c) of this Section shall be adjusted annually, beginning in 2011. The adjustment shall take effect on July 1st of each year. For July 1, 2011, the adjustment shall be a percentage of the annual wage figure specified in item (4) of subsection (c). For subsequent years, the adjustment shall be a percentage of the

annual wage figure that took effect on July 1st of the prior year. The percentage adjustment shall be the same percentage by which the current year's non-farm federal poverty level, as defined and updated by the federal Department of Health and Human Services, for a family unit of 4 persons for the 48 contiguous states and Washington, D.C., changed from the same level established for the prior year.

(h) Illinois-based chambers of commerce or other associations, including bona fide associations as defined by the Illinois Health Insurance Portability and Accountability Act, may be eligible to participate in the Health Sure Illinois Program subject to approval by the Division.

(i) A qualifying small employer shall elect whether to make coverage under the Sure Standard group managed care plan available to dependents of employees. Any employee or dependent who is enrolled in Medicare is ineligible for coverage, unless required by federal law. Dependents of an employee who is enrolled in Medicare shall be eligible for dependent coverage provided the dependent is not also enrolled in Medicare.

(j) A Sure Standard group managed care plan must provide the benefits set forth in subsection (q) of this Section. The contract must insure not less than 50% of the eligible employees.

(k) For purposes of this Law, a qualifying individual is an employed individual:

(1) who does not have and has not had health insurance

with benefits on an expense-reimbursed or prepaid basis during the 12-month period prior to the individual's application for health insurance under the program established by this Section;

(2) who is not an eligible employee as defined in subsection (c) of this Section, or whose employer does not sponsor group health insurance and has not sponsored group health insurance with benefits on an expense-reimbursed or prepaid basis in effect during the 12-month period prior to the individual's application for health insurance under the program established by this Section;

(3) who resides in a household having a household income at or below 250% of the federal poverty level;

(4) who is ineligible for Medicare, except that the Department may determine that it shall require an individual who is eligible under subdivision 2(b) of Section 5-2 of the Illinois Public Aid Code to participate as a qualifying individual; and

(5) who is a resident of Illinois.

(l) The requirements set forth in item (3) of subsection (k) of this Section shall not be applicable to individuals who have served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and have received a release or discharge other than dishonorable discharge.

(m) The requirements set forth in items (1) and (3) of

subsection (k) of this Section shall not be applicable to individuals who had health insurance coverage during the previous 12 months and such coverage terminated due to:

(1) loss of employment due to factors other than voluntary separation;

(2) death of a family member that results in termination of coverage under a health insurance contract under which the individual is covered;

(3) change to a new employer that does not provide group health insurance with benefits on an expense-reimbursed or prepaid basis;

(4) change of residence so that no employer-based health insurance with benefits on an expense-reimbursed or prepaid basis is available;

(5) discontinuation of a group health insurance contract with benefits on an expense-reimbursed or prepaid basis covering the qualifying individual as an employee or dependent;

(6) expiration of the coverage periods established by the continuation provisions of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq. and the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq. established by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or the continuation provisions of Sections 367.2, 367.2-5, or 367e of the Illinois Insurance Code.

(7) legal separation, dissolution of marriage or domestic partnership, or declaration of invalidity of marriage or domestic partnership that results in termination of coverage under a health insurance contract under which the individual is covered; or

(8) loss of eligibility under a group health plan.

(n) The 12-month period set forth in item (1) of subsection (k), item (2) of subsection (c), and item (1) of subsection (d) of this Section may be adjusted by the Division from 12 months to 18 months if the Division determines that the 12-month period is insufficient to prevent inappropriate substitution of Sure Standard individual and group managed care plans for other health insurance contracts.

(o) A Sure Standard individual managed care plan must provide the benefits set forth in subsection (q) of this Section. At the option of the qualifying individual, such contract may include coverage for dependents of the qualifying individual.

(p) The contracts issued pursuant to this Section by participating managed care entities and approved by the Department shall provide only in-plan benefits, except for emergency care or where services are not available through a plan provider.

(q) Covered services shall include only the following:

(1) inpatient hospital services consisting of daily room and board, general nursing care, special diets, and

miscellaneous hospital services and supplies;

(2) outpatient hospital services consisting of diagnostic and treatment services;

(3) physician services consisting of diagnostic and treatment services, consultant and referral services, surgical services, including breast reconstruction surgery after a mastectomy, anesthesia services, second surgical opinion, and a second opinion for cancer treatment;

(4) outpatient surgical facility charges related to a covered surgical procedure;

(5) preadmission testing;

(6) maternity care;

(7) adult preventive health services consisting of mammography screening; cervical cytology screening; periodic physical examinations no more than once every 3 years; and adult immunizations;

(8) preventive and primary health care services for dependent children including routine well-child visits and necessary immunizations;

(9) equipment, supplies, and self-management education for the treatment of diabetes;

(10) diagnostic x-ray and laboratory services;

(11) emergency services;

(12) therapeutic services consisting of radiologic services, chemotherapy, and hemodialysis;

(13) blood and blood products furnished in connection

with surgery or inpatient hospital services;

(14) prescription drugs obtained at a participating pharmacy. In addition to providing coverage at a participating pharmacy, managed care entities may utilize a mail order prescription drug program. Managed care entities may provide prescription drugs pursuant to a drug formulary; however, managed care entities must implement an appeals process so that the use of non-formulary prescription drugs may be requested by a physician;

(15) mental health benefits in accordance with item (2) of subdivision (c) of Section 370c of the Illinois Insurance Code; and

(16) inpatient and outpatient services for the treatment of alcohol and substance abuse, including inpatient residential treatment.

Active managed care entities may offer dental and vision coverage at the option and expense of the eligible individual.

(r) The benefits described in subsection (q) of this Section shall be subject to the following deductibles and copayments:

(1) in-patient hospital services shall have a $500 copayment for each continuous hospital confinement as defined in Part 2007 of Title 50 of the Illinois Administrative Code;

(2) surgical services shall be subject to a copayment of the lesser of 20% of the cost of such services or $200

per occurrence;

(3) outpatient surgical facility charges shall be subject to a facility copayment charge of $75 per occurrence;

(4) emergency services shall have a $50 copayment, which must be waived if hospital admission results from the emergency room visit;

(5) prescription drugs shall have a $100 calendar year deductible per individual; after the deductible is satisfied, each 34-day supply of a prescription drug shall be subject to a copayment; the copayment shall be $10 if the drug is generic. The copayment for a brand name drug shall be $20 plus the difference in cost between the brand name drug and the equivalent generic drug. If a mail order drug program is utilized, a $20 copayment shall be imposed on a 90-day supply of generic prescription drugs. A $40 copayment plus the difference in cost between the brand name drug and the equivalent generic drug shall be imposed on a 90-day supply of brand name prescription drugs; in no event shall the copayment exceed the cost of the prescribed drug;

(6) the maximum coverage for prescription drugs shall be $3,000 per individual in a calendar year; and

(7) all other services shall have a $20 copayment with the exception of prenatal care, which shall have no copayment.

(s) The Department may determine rates for providers of services, but such rates shall in aggregate be no lower than base Medicare. Hospitals shall be reimbursed under the Health Sure Illinois Program in an amount that equals the actuarial equivalent of 105% of base Medicare for critical access hospitals and equals the actuarial equivalent of 112% of base Medicare for all other hospitals. The Department shall define what constitutes "base Medicare" by rule, which shall include the weighting factors used by Medicare, the wage index adjustment, capital costs, and outlier adjustments. For hospital services provided for which a Medicare rate is not prescribed or cannot be calculated, the hospital shall be reimbursed 90% of the lowest rate paid by the applicable insurer under its contract with that hospital for that same service. The Department may by rule heighten the 112% rate ceiling for hospitals engaged in medical research, medical education, and highly complex medical care and for hospitals that serve a disproportionate share of patients covered by governmental sponsored programs and uninsured patients.

(s-5) Nothing in this Law shall be used by any private or public managed care entity or health care plan as a basis for reducing the managed care entity's or health care plan's rates or policies with any hospital. Notwithstanding any other provision of law, rates authorized under this Law shall not be used by any private or public managed care entities or health care plans to determine a hospital's usual and customary

charges for any health care service.

(t) Except as included in the list of covered services in subsection (q) of this Section, the mandated benefits set forth in the Illinois Insurance Code and the Managed Care Reform and Patients Rights Act shall not be applicable to the contracts issued pursuant to this Section. Mandated benefits included in such contracts shall be subject to the deductibles and copayments set forth in subsection (r) of this Section.

(u) The Division shall be authorized to modify, by rule, the copayment and deductible amounts described in this Section if the Division determines such amendments are necessary to facilitate implementation of this Section. The modifications authorized by this subsection (u) shall not exceed 20% of the original copayment or deductible amounts. On or after January 1, 2011, the Division shall be authorized to establish, by regulation, one or more additional standardized benefit packages if the Division determines additional benefit packages with different levels of benefits are necessary to meet the needs of the public.

(v) An active managed care entity must offer the benefit package without change or additional benefits. Qualifying small employers shall be issued the benefit package in a Sure Standard group managed care plan. Qualifying individuals shall be issued the benefit package in a Sure Standard individual managed care plan.

(w) No active managed care entity shall issue a Sure

Standard group managed care plan or Sure Standard individual managed care plan until the plan has been certified as such by the Department.

(x) A participating managed care entity shall obtain from the employer or individual, on forms approved by the Department or in a manner prescribed by the Department, written certification at the time of initial application and annually thereafter 90 days prior to the contract renewal date that the employer or individual meets and expects to continue to meet the requirements of a qualifying small employer or a qualifying individual pursuant to this Section. A participating managed care entity may require the submission of appropriate documentation in support of the certification, including proof of income status.

(y) Applications to enroll in Sure Standard group managed care plans and Sure Standard individual managed care plans must be received and processed from any qualifying individual and any qualifying small employer during the open enrollment period each year. This subsection (y) does not restrict open enrollment guidelines set by Sure Standard managed care plan contracts, but every such contract must include standard employer group open enrollment guidelines.

(z) All coverage under Sure Standard group managed care plans and Sure Standard individual managed care plans must be subject to a preexisting condition limitation provision, including the crediting requirements thereunder. Prenatal care

shall be available without consideration of pregnancy as a preexisting condition. An active managed care entity may waive or reduce deductibles and other cost-sharing payments for individuals participating in chronic care management or wellness and prevention programs.

(aa) Premium rates for qualifying individuals under Sure Standard individual managed care plans shall be determined consistent with the rate-setting provisions in the Individual Market Fairness Reform Act. Premium rates for qualifying groups under Sure Standard group managed care plans shall be determined consistent with the rate-setting provisions in the Small Employer Health Insurance Rating Act.

(aa-5) Claims experience under contracts issued to qualifying small employers and to qualifying individuals must be combined for rate setting purposes.

(bb) Participating managed care entities shall submit reports to the Department in such form and such media as the Department shall prescribe. The reports shall be submitted at times as may be reasonably required by the Department to evaluate the operations and results of Sure Standard managed care plans established by this Section. The Department shall make such reports available to the Division.

(cc) All providers that contract with an active managed care entity for any other network established by that active managed care entity, as defined by this Law, must participate as a network provider under the same active managed care

entity's Sure Standard managed care plan or plans under this Law.

(dd) The Department shall conduct public education and outreach to facilitate enrollment of qualifying small employers, eligible employees, and qualifying individuals in the Health Sure Illinois Program.

Section 15-20. Stop loss funding for Sure Standard managed care plans issued to qualifying small employers and qualifying individuals.

(a) The Department shall provide a claims reimbursement program for participating managed care entities.

(b) The claims reimbursement program, also known as "Health Sure Illinois Stop Loss Protection", shall operate as a stop loss program for participating managed care entities and shall reimburse participating managed care entities for a certain percentage of health care claims above a certain attachment amount or within certain attachment amounts. The stop loss attachment amount or amounts shall be determined by the Division consistent with the purpose of the Health Sure Illinois Program.

(c) Commencing on January 1, 2010, participating managed care entities shall be eligible to receive reimbursement for 90% of claims paid between $5,000 and $75,000 in a calendar year for any member covered under a contract issued pursuant to Section 15-15 of this Law after the participating managed care

entity pays claims for that same member in the same calendar year. Based on pre-determined attachment amounts, verified claims paid for members covered under Sure Standard group and individual managed care plans shall be reimbursable from the Health Sure Illinois Stop Loss Protection Program. For purposes of this Section, claims shall include health care claims paid by or on behalf of a covered member pursuant to such Sure Standard contracts.

(d) The Department shall set forth procedures for operation of the Health Sure Illinois Stop Loss Protection Program and distribution of monies therefrom.

(e) Claims shall be reported and funds shall be distributed by the Department on a calendar year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims are paid. Once claims paid on behalf of a covered member reach or exceed $75,000 in a given calendar year, no further claims paid on behalf of such member in that calendar year shall be eligible for reimbursement.

(f) Each participating managed care entity shall submit a request for reimbursement from the Health Sure Illinois Stop Loss Protection Program on forms prescribed by the Department. Each request for reimbursement shall be submitted no later than April 1 following the end of the calendar year for which the reimbursement requests are being made. In connection with reimbursement requests, the Department may require participating managed care entities to submit such claims data

deemed necessary to enable proper distribution of funds and to oversee the effective operation of the Health Sure Illinois Stop Loss Protection Program. The Department may require that such data be submitted on a per-member, aggregate, or categorical basis, or any combination of those. Data shall be reported separately for Sure Standard group managed care plans and Sure Standard individual managed care plans issued pursuant to Section 15-15 of this Law.

(f-5) In each request for reimbursement from the Health Sure Illinois Stop Loss Protection Program, active managed care entities shall certify that provider reimbursement rates are consistent with the reimbursement rates as defined by subsection (s) of Section 15-15 of this Law. The Department, in collaboration with the Division, shall audit, as necessary, claims data submitted pursuant to subsection (f) of this Section to ensure that reimbursement rates paid by active managed care entities are consistent with reimbursement rates as defined by subsection (s) of Section 15-15 of this Law.

(g) At all times, the Health Sure Illinois Stop Loss Protection Program shall be implemented and operated subject to limitations made necessary by the funds available for its operation. The Department shall calculate the total claims reimbursement amount for all participating managed care entities for the calendar year for which claims are being reported. In the event that the total amount requested for reimbursement for a calendar year exceeds appropriations

available for distribution for claims paid during that same calendar year, the Department shall provide for the pro-rata distribution of the available funds. Each participating managed care entity shall be eligible to receive only such proportionate amount of the available appropriations as the individual participating managed care entity's total eligible claims paid bears to the total eligible claims paid by all participating managed care entities.

(h) Each participating managed care entity shall provide the Department with monthly reports of the total enrollment under the Sure Standard group managed care plans and Sure Standard individual managed care plans issued pursuant to Section 15-15 of this Law. The reports shall be in a form prescribed by the Department.

(i) The Department shall estimate the per member annual cost of total claims reimbursement from the Health Sure Illinois Stop Loss Protection Program based upon available data and appropriate actuarial assumptions. Upon request, each participating managed care entity shall furnish to the Department claims experience data for use in such estimations.

(j) Every participating managed care entity shall file with the Division the base rates and rating schedules it uses to provide Sure Standard group managed care plans and Sure Standard individual managed care plans. All rates proposed for Sure Standard managed care plans are subject to the prior regulatory review of the Division and shall be effective only

upon approval by the Division. The Division has authority to approve, reject, or modify the proposed base rate subject to the following:

(1) Rates for suitable managed care plans must account for the availability of reimbursement pursuant to this Section.

(2) Rates must not be excessive or inadequate nor shall the rates be unfairly discriminatory.

(3) Consideration shall be given to the managed care entity's actuarial support, enrollment levels, premium volume and risk-based capital.

(k) If the Department deems it appropriate for the proper administration of the program, the Department shall be authorized to purchase stop loss insurance or reinsurance, or both, from an insurance company licensed to write such type of insurance in Illinois.

(k-5) Nothing in this Section shall require modification of stop loss provisions of an existing contract between the managed care entity and a healthcare provider.

(l) The Department may obtain the services of an organization to administer the stop loss program established by this Section. The Department shall establish guidelines for the submission of proposals by organizations for the purposes of administering the program. The Department shall make a determination whether to approve, disapprove, or recommend modification to the proposal of an applicant to administer the

program. An organization approved to administer the program shall submit reports to the Department in such form and at times as may be required by the Department in order to facilitate evaluation and ensure orderly operation of the program, including, but not limited to, an annual report of the affairs and operations of the program. An organization approved to administer the program shall maintain records in a form prescribed by the Department and which shall be available for inspection by or at the request of the Department. The Department shall determine the amount of compensation to be allocated to an approved organization as payment for program administration. An organization approved to administer the program may be removed by the Department and must cooperate in the orderly transition of services to another approved organization or to the Department.

Section 15-25. Program publicity duties of active managed care entities and Department.

(a) In conjunction with the Department, all active managed care entities shall participate in and share the cost of annually publishing and disseminating a consumer's shopping guide or guides for Sure Standard group managed care plans and Sure Standard individual managed care plans issued pursuant to Section 15-15 of this Law. The contents of all consumer shopping guides published pursuant to this Section shall be subject to review and approval by the Department.

(b) Participating managed care entities may distribute additional sales or marketing brochures describing Sure Standard group managed care plans and Sure Standard individual managed care plans subject to review and approval by the Department.

(c) Commissions available to insurance producers from active managed care entities for sales of Sure Standard managed care plans shall not be less than those available for sale of plans other than plans issued pursuant to the Health Sure Illinois Program. Information on such commissions shall be reported to the Division in the rate approval process.

Section 15-30. Data reporting.

(a) The Department, in consultation with the Division and other State agencies, shall report on the program established pursuant to Sections 15-15 and 15-20 of this Law. The report shall examine:

(1) employer and individual participation, including an income profile of covered employees and individuals and an estimate of the per-member annual cost of total claims reimbursement as required by subsection (i) of Section 15-20 of this Law;

(2) claims experience and the program's projected costs through December 31, 2015; and

(3) the impact of the program on the uninsured population in Illinois and the impact of the program on

health insurance rates paid by Illinois residents.

(b) The study shall be completed and a report submitted by October 1, 2011 to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 15-35. Duties assigned to the Department. Unless otherwise specified, all duties assigned to the Department by this Law shall be carried out in consultation with the Division.

Section 15-40. Applicability of other Illinois Insurance Code provisions. Unless otherwise specified in this Section, policies for all Sure Standard group managed care plans and Sure Standard individual managed care plans must meet all other applicable provisions of the Illinois Insurance Code.

ARTICLE 90. AMENDATORY PROVISIONS

Section 90-5. The Illinois Insurance Code is amended by adding Sections 359a.1 and 359a.2 and Articles XLV and XLVI and by changing Sections 155.36, 368b, and Section 370c as follows:

(215 ILCS 5/155.36)

Sec. 155.36. Managed Care Reform and Patient Rights Act. Insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of this

Code shall comply with Sections 45 and ~~Section~~ 85 and the definition of the term "emergency medical condition" in Section 10 of the Managed Care Reform and Patient Rights Act.

(Source: P.A. 91-617, eff. 1-1-00.)

(215 ILCS 5/359a.1 new)

Sec. 359a.1. Standard Small Group Applications. The Director shall develop, by rule, a standard application form for use by small employers applying for coverage under a health benefit plan offered by small employer carriers. Small employer carriers shall be required to use the standard application form not less than 6 months after the rules developing the form become effective. The Director shall revise the standard application form at least every 3 years. For purposes of this Section, "health benefit plan", "small employer", and "small employer carrier" shall have the meaning given those terms in the Small Employer Health Insurance Rating Act.

(215 ILCS 5/359a.2 new)

Sec. 359a.2. Standard Individual Market Health Statements. The Director shall develop, by rule, a standard health statement for use by individuals applying for a health benefit plan in the individual market. All carriers who offer health benefit plans in the individual market and evaluate the health status of individuals shall be required to use the standard health statement not less than 6 months after the statement

becomes effective and thereafter may not use any other method to determine the health status of an individual. Nothing in this Section shall prevent a carrier from using health information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan. For purposes of this Section, "health benefit plan" shall have the meaning given the term in the Small Employer Health Insurance Rating Act and "individual market" shall have meaning given the term in the Illinois Health Insurance Portability and Accountability Act.

(215 ILCS 5/368b)

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.

(f) On and after January 1, 2010, all providers that contract with an active managed care entity as defined by the

Health Sure Illinois Law must participate as a network provider under the same active managed care entity's Sure Standard managed care plan or plans as authorized by the Health Sure Illinois Law.

(Source: P.A. 93-261, eff. 1-1-04.)

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

Sec. 370c. Mental and emotional disorders.

(a) (1) On and after the effective date of this Section, every insurer which delivers, issues for delivery or renews or modifies group A&H policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall offer to the applicant or group policyholder subject to the insurers standards of insurability, coverage for reasonable and necessary treatment and services for mental, emotional or nervous disorders or conditions, other than serious mental illnesses as defined in item (2) of subsection (b), up to the limits provided in the policy for other disorders or conditions, except (i) the insured may be required to pay up to 50% of expenses incurred as a result of the treatment or services, and (ii) the annual benefit limit may be limited to the lesser of $10,000 or 25% of the lifetime policy limit.

(2) Each insured that is covered for mental, emotional or nervous disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches,

licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist of his choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his profession.

(3) Insofar as this Section applies solely to licensed clinical social workers, licensed clinical professional counselors, and licensed marriage and family therapists, those persons who may provide services to individuals shall do so after the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist has informed the patient of the desirability of the patient conferring with the patient's primary care physician and the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist has provided written notification to the patient's

primary care physician, if any, that services are being provided to the patient. That notification may, however, be waived by the patient on a written form. Those forms shall be retained by the licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist for a period of not less than 5 years.

(b) (1) An insurer that provides coverage for hospital or medical expenses under a group policy of accident and health insurance or health care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 92nd General Assembly shall provide coverage under the policy for treatment of serious mental illness under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. The coverage required under this Section must provide for same durational limits, amount limits, deductibles, and co-insurance requirements for serious mental illness as are provided for other illnesses and diseases. This subsection does not apply to coverage provided to employees by employers who have 50 or fewer employees.

(2) "Serious mental illness" means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

(A) schizophrenia;

(B) paranoid and other psychotic disorders;

(C) bipolar disorders (hypomanic, manic, depressive,

and mixed);

(D) major depressive disorders (single episode or recurrent);

(E) schizoaffective disorders (bipolar or depressive);

(F) pervasive developmental disorders;

(G) obsessive-compulsive disorders;

(H) depression in childhood and adolescence;

(I) panic disorder;

(J) post-traumatic stress disorders (acute, chronic, or with delayed onset); and

(K) anorexia nervosa and bulimia nervosa.

(3) (Blank). ~~Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. An insurer shall provide a mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or herself), the patient's provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity of a treatment proposed by a patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the~~

~~treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for serous mental illness, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process.~~

(4) A group health benefit plan:

(A) shall provide coverage based upon medical necessity for the following treatment of mental illness in each calendar year:

(i) 45 days of inpatient treatment; and

(ii) beginning on June 26, 2006 (the effective date of Public Act 94-921), 60 visits for outpatient treatment including group and individual outpatient treatment; and

(iii) for plans or policies delivered, issued for delivery, renewed, or modified after January 1, 2007 (the effective date of Public Act 94-906), 20 additional outpatient visits for speech therapy for treatment of pervasive developmental disorders that will be in addition to speech therapy provided pursuant to item (ii) of this subparagraph (A);

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and

(C) shall include the same amount limits, deductibles, copayments, and coinsurance factors for serious mental illness as for physical illness.

(5) An issuer of a group health benefit plan may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

(6) An issuer of a group health benefit plan may provide or offer coverage required under this Section through a managed care plan.

(7) This Section shall not be interpreted to require a group health benefit plan to provide coverage for treatment of:

(A) an addiction to a controlled substance or cannabis that is used in violation of law; or

(B) mental illness resulting from the use of a controlled substance or cannabis in violation of law.

(8) (Blank).

(9) On and after June 1, 2010, coverage for the treatment of mental and emotional disorders as provided by subsections (a) and (b) of this Section shall not be denied under the policy, provided that services are medically necessary as

determined by the insured's treating physician. For purposes of this Section, "medically necessary" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must be intended to either help restore or maintain the enrollee's health or prevent deterioration of the enrollee's condition. Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary.

(Source: P.A. 94-402, eff. 8-2-05; 94-584, eff. 8-15-05; 94-906, eff. 1-1-07; 94-921, eff. 6-26-06; 95-331, eff. 8-21-07; 95-972, eff. 9-22-08; 95-973, eff. 1-1-09; revised 10-14-08.)

(215 ILCS 5/Art. XLV heading new)

ARTICLE XLV. PATIENT PROTECTION

(215 ILCS 5/1501 new)

Sec. 1501. Office of Patient Protection. There is hereby established within the Division of Insurance an Office of

Patient Protection to ensure that persons covered by health insurance companies or health care plans are provided benefits due them under this Code and related statutes and are protected from health insurance company and health care plan actions or policy provisions that are unjust, unfair, inequitable, ambiguous, misleading, inconsistent, deceptive, or contrary to the law or to the public policy of this State or that unreasonably or deceptively affect the risk purposed to be assumed.

(215 ILCS 5/1505 new)

Sec. 1505. Powers of the Office of Patient Protection. Acting under the authority of the Director, the Office of Patient Protection shall: (1) have the power established by Section 401 of this Code to institute such actions or other lawful procedures as may by necessary for the enforcement of this Code; and (2) oversee the responsibilities of the Office of Consumer Health Insurance, including, but not limited to, responding to consumer questions relating to health insurance.

(215 ILCS 5/1510 new)

Sec. 1510. External review responsibilities of the Office of Patient Protection. The Office of Patient Protection shall assist health insurance company and health care plan consumers with respect to the exercise of the grievance and appeals rights established by Section 1520 of this Article.

(215 ILCS 5/1515 new)

Sec. 1515. Health insurance oversight. The responsibilities of the Office of Patient Protection shall include, but not be limited to, the oversight of health insurance companies and health care plans with respect to:

(1) Improper claims practices (Sections 154.5 and 154.6 of this Code).

(2) Emergency services.

(3) Compliance with the Managed Care Reform and Patient Rights Act and the Illinois Health Carrier External Review Law.

(4) Ensuring proper coverage for mental health treatment.

(5) Reviewing insurance company and health care plan underwriting, rating, and rescission practices.

(6) Reviewing insurance company and health care plan billing practices, including, but not limited to, consumer cost-sharing that results from co-pay, deductible, and provider network provisions.

(7) Ensuring insurance company and health care plan compliance with the Health Sure Illinois Law and the Individual Market Fairness Reform Law.

(215 ILCS 5/1520 new)

Sec. 1520. Powers of the Director.

(a) The Director, in his or her discretion, may issue a Notice of Hearing requiring a health insurance company or health care plan to appear at a hearing for the purpose of determining the health insurance company's or health care plan's compliance with the duties and responsibilities listed in Section 1520.

(b) Nothing in this Article XLV shall diminish or affect the powers and authority of the Director of Insurance otherwise set forth in this Code.

(215 ILCS 5/1525 new)

Sec. 1525. Operative date. This Article XLV is operative on and after January 1, 2010.

(215 ILCS 5/Art. XLVI heading new)

ARTICLE XLVI. HEALTH CARRIER EXTERNAL REVIEW LAW

(215 ILCS 5/1601 new)

Sec. 1601. Short title. This Law may be cited as the Illinois Health Carrier External Review Law.

(215 ILCS 5/1605 new)

Sec. 1605. Purpose and intent. The purpose of this Law is to provide uniform standards for the establishment and maintenance of external review procedures to ensure that

covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this Law.

(215 ILCS 5/1610 new)

Sec. 1610. Definitions. For purposes of this Law:

"Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

"Authorized representative" means:

(1) a person to whom a covered person has given express written consent to represent the covered person in an external review;

(2) a person authorized by law to provide substituted consent for a covered person;

(3) a family member of the covered person; or

(4) the covered person's health care provider.

"Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the

necessity and appropriateness of health care services.

"Director" means the Director of the Division of Insurance within the Illinois Department of Financial and Professional Regulation.

"Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

"Emergency medical condition" means the sudden onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions or a serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.

"Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

"Evidence-based standard" means a standard of care developed through the judicious use of the current best evidence and based on an overall systematic review of applicable research.

"Facility" means an institution providing health care services or a health care setting.

"Final adverse determination" means an adverse

determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in the Managed Care Reform and Patient Rights Act.

"Health benefit plan" means a policy, contract, certificate, plan, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care provider" or "provider" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with State law, responsible for recommending health care services on behalf of a covered person.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and rules of this State, or subject to the jurisdiction of the Director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. "Health carrier" also means Limited

Health Service Organizations (LHSO) and Voluntary Health Service Plans.

"Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(1) the past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(2) the provision of health care services to an individual; or

(3) payment for the provision of health care services to an individual.

"Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

"Medical or scientific evidence" means evidence found in the following sources:

(1) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical

compendia, and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(3) medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;

(4) the following standard reference compendia:

(a) the American Hospital Formulary Service-Drug Information;

(b) Drug Facts and Comparisons;

(c) the American Dental Association Accepted Dental Therapeutics; and

(d) the United States Pharmacopoeia-Drug Information;

(5) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(a) the federal Agency for Healthcare Research and Quality;

(b) the National Institutes of Health;

(c) the National Cancer Institute;

(d) the National Academy of Sciences;

(e) the Centers for Medicare & Medicaid Services;

(f) the federal Food and Drug Administration; and

(g) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(6) any other medical or scientific evidence that is comparable to the sources listed in items (1) through (5).

"Protected health information" means health information:

(1) that identifies an individual who is the subject of the information; or

(2) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

"Utilization review" has the meaning provided by the Managed Care Reform and Patient Rights Act.

"Utilization review organization" means a utilization review program as defined by the Managed Care Reform and Patient Rights Act.

(215 ILCS 5/1615 new)

Sec. 1615. Applicability and scope.

(a) Except as provided in subsection (b), this Law shall apply to all health carriers.

(b) The provisions of this Law shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care

insurance, as defined by Article XIXA of this Code, vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the Director by rule, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as a supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

(215 ILCS 5/1620 new)

Sec. 1620. Notice of right to external review.

(a) At the same time the health carrier sends written notice of a covered person's right to appeal a coverage decision as provided by the Managed Care Reform and Patient Rights Act, a health carrier shall notify a covered person and a covered person's health care provider in writing of the covered person's right to request an external review as provided by this Law.

(1) The written notice required shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You have the

right to have our decision reviewed by an independent review organization not associated with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a written request for an external review to us. Upon receipt of your request, an independent review organization registered with the Department of Financial and Professional Regulation, Division of Insurance will be assigned to review our decision.

(2) The notice shall also include the appropriate statements and information set forth in subsection (b) of this Section.

(b) The health carrier shall inform the insured of his or her right to an expedited review prior to a final adverse determination. The health carrier shall include in the notice required under subsection (a) for a notice related to an adverse determination, a statement informing the covered person that:

(1) If the covered person has a medical condition where the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in the Managed Care Reform and Patient Rights Act (215 ILCS 134/45(b)) would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the

covered person or the covered person's authorized representative may file a request for an expedited external review.

(2) The covered person, or the covered person's authorized representative may file a request for an expedited external review at the same time the covered person or the covered person's authorized representative files a request for an expedited internal appeal involving an adverse determination as set forth in the Managed Care Reform and Patient Rights Act (215 ILCS 134/45(b)), if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated. The independent review organization assigned to conduct the expedited external review shall determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review.

(c) The health carrier shall include in the notice required under subsection (a) for a notice related to an adverse determination, a statement informing the covered person that:

(1) if the covered person has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review;

(2) if a final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person, or the covered person's authorized representative, may request an expedited external review; or

(3) if a final adverse determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, and the covered person's health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may request an expedited external review.

(d) In addition to the information to be provided pursuant to subsections (a), (b), and (c), the health carrier shall

include a copy of the description of both the required standard and expedited external review procedures. The description shall highlight the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information, including any forms used to process an external review.

(e) In addition to the information to be provided under subsection (a), (b), or (c), the health carrier shall include an authorization form that complies with the requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) (45 CFR Section 164.508), by which the covered person, for purposes of conducting an external review under this Law, authorizes the health carrier and the covered person's health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

(215 ILCS 5/1625 new)

Sec. 1625. Request for external review.

(a) A covered person or the covered person's authorized representative may make a request for an external or expedited external review of an adverse determination or final adverse determination.

(b) Requests under subsection (a) shall be made directly to the health carrier that made the adverse or final adverse

determination.

(c) All requests for external review shall be in writing except for requests for expedited external reviews, which may be made orally.

(d) Health carriers must provide covered persons with forms to request external reviews.

(215 ILCS 5/1630 new)

Sec. 1630. Exhaustion of internal grievance process. Except as provided in subsection (b) of Section 1620, a request for an external review shall not be made until the covered person has exhausted the health carrier's internal grievance process as set forth in the Managed Care Reform and Patient Rights Act. A covered person shall also be considered to have exhausted the health carrier's internal grievance process for purposes of this Section:

(1) if the covered person or the covered person's authorized representative filed a request for an internal review of an adverse determination pursuant to the Managed Care Reform and Patient Rights Act and has not received a written decision on the request from the health carrier within 15 days, except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay; or

(2) if the covered person or the covered person's authorized representative filed a request for an expedited

internal review of an adverse determination pursuant to the Managed Care Reform and Patient Rights Act and has not received a decision on request from the health carrier within 48 hours, except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay.

A covered person need not exhaust a heath carrier's internal grievance procedures as set forth in the Managed Care Reform and Patient Rights Act if the health carrier agrees to waive the exhaustion requirement.

(215 ILCS 5/1635 new)

Sec. 1635. Standard external review.

(a) Within 4 months after the date of receipt of a notice of an adverse determination or final adverse determination, a covered person or the covered person's authorized representative may file a request for an external review with the health carrier. Within 5 business days following the date of receipt of the external review request, the health carrier shall complete a preliminary review of the request to determine whether:

(1) the individual is or was a covered person in the health benefit plan at the time the health care service was requested or at the time the health care service was provided;

(2) the health care service that is the subject of the

adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but the health carrier has determined that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

(3) the covered person has exhausted the health carrier's internal grievance process as set forth in Section 1635 of this Law;

(4) for appeals relating to determination based on treatment being experimental or investigational, the covered person's health care provider has certified that one of the following situations is applicable:

(A) standard health care services or treatments have not been effective in improving the condition of the covered person;

(B) standard health care services or treatments are not medically appropriate for the covered person;

(C) there is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment;

(D) the health care service or treatment is likely to be more beneficial to the covered person, in the health care provider's opinion, than any available

standard health care services or treatments; or

(E) that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to the covered person than any available standard health care services or treatments; and

(5) the covered person has attempted to provide all the information and forms minimally required to process an external review, as specified in this Law.

(c) Within one business day after completion of the preliminary review, the health carrier shall notify the covered person, the covered person's health care provider, and, if applicable, the covered person's authorized representative in writing whether the request is complete and eligible for external review.

(1) If the request:

(A) is not complete, the health carrier shall inform the covered person, the covered person's health care provider, and, if applicable, the covered person's authorized representative in writing and include in the notice what information or materials are required by this Law to make the request complete; or

(B) is not eligible for external review, the health carrier shall inform the covered person, the covered person's health care provider and, if applicable, the covered person's authorized representative in writing

and include in the notice the reasons for its ineligibility.

(2) The notice of initial determination of ineligibility shall include a statement informing the covered person, the covered person's health care provider and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Director by filing a complaint with the Director.

(3) Notwithstanding a health carrier's initial determination that the request is ineligible and requires that it be referred for external review, the Director may determine that a request is eligible for external review.

(d) Whenever a request is eligible for external review the health carrier shall, within 3 business days:

(1) assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director; and

(2) notify in writing the covered person, the covered person's health care provider, and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review and the name of the independent review organization.

(3) the health carrier shall include in the notice provided to the covered person, the covered person's health

care provider, and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may, within 5 business days following the date of receipt of the notice provided pursuant to item (1) of this subsection (d), submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external review; the independent review organization is not required to, but may, accept and consider additional information submitted after 5 business days.

(e) The assignment of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those approved independent review organizations qualified to conduct external review, except for instances of conflict of interest concerns pursuant to this Law.

(f) Upon assignment of an independent review organization, the health carrier or its designee utilization review organization shall, within 5 business days, provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

(1) Except as provided in item (2) of this subsection (f), failure by the health carrier or its utilization

review organization to provide the documents and information within the specified time frame shall not delay the conduct of the external review.

(2) If the health carrier or its utilization review organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(3) Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination under item (2) of this subsection (f), the independent review organization shall notify the health carrier, the covered person, the covered person's health care provider, and, if applicable, the covered person's authorized representative of its decision to reverse the adverse determination.

(g) Upon receipt of the information from the health carrier or its utilization review organization, the assigned independent review organization shall review all of the information and documents and any other information submitted in writing to the independent review organization by the covered person and the covered person's authorized representative.

(h) Upon receipt of any information submitted by the

covered person or the covered person's authorized representative, the independent review organization shall forward the information to the health carrier within one business day.

(1) Upon receipt of the information, if any, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.

(3) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(A) Within one business day after making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the covered person, the covered person's health care provider, if applicable, the covered person's authorized representative, and the assigned independent review organization in writing of its decision.

(B) Upon notice from the health carrier that the

health carrier has made a decision to reverse its adverse determination or final adverse determination, the assigned independent review organization shall terminate the external review.

(i) In addition to the documents and information provided by the health carrier or its utilization review organization, and the covered person and the covered person's authorized representative, if any, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) the covered person's pertinent medical records;

(2) the covered person's health care provider's recommendation;

(3) consulting reports from appropriate health care providers and other documents submitted by the health carrier, the covered person, and the covered person's authorized representative;

(4) the terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the health care service or treatment that is the subject of the opinion is experimental or investigational would otherwise be covered under the terms of coverage of the covered person's health benefit plan with the health carrier;

(5) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(6) any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and

(7) the opinion of the independent review organization's clinical reviewer or reviewers after considering items (1) through (6) of this subsection (i) to the extent the information or documents are available and the clinical reviewer or reviewers considers the information or documents relevant.

(j) Within 5 days after the date of receipt of all necessary information, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the health carrier, the covered person, the covered person's health care provider, and, if applicable, the covered person's authorized representative.

(1) The independent review organization shall include in the notice:

(A) a general description of the reason for the request for external review;

(B) the date the independent review organization

received the assignment from the health carrier to conduct the external review;

(C) the time period during which the external review was conducted;

(D) references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision;

(E) the date of its decision; and

(F) the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision.

(2) For reviews of experimental or investigational treatments, the notice shall include the following information:

(A) a description of the covered person's medical condition;

(B) a description of the indicators relevant to whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care

services or treatments;

(C) a description and analysis of any medical or scientific evidence considered in reaching the opinion;

(D) a description and analysis of any evidence-based standards; and

(E) whether the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, for the condition; or

(F) whether medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments. In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance or appeals process.

(3) Upon receipt of a notice of a decision reversing

the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

(215 ILCS 5/1640 new)

Sec. 1640. Expedited external review.

(a) A covered person or a covered person's authorized representative may file a request for an expedited external review with the health carrier either orally or in writing:

(1) immediately after the date of receipt of a notice a final adverse determination; or

(2) if a health carrier fails to provide a decision on request for an expedited internal appeal within 48 hours.

(b) Upon receipt of a request for an expedited external review as provided in subsections (b) and (c) of Section 1620 of this Law, the health carrier shall immediately assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Director to conduct the expedited review.

(1) The assignment by the health carrier of an approved independent review organization to conduct an external review in accordance with this Section shall be done on a random basis among those approved independent review organizations except as may be prohibited by conflict of interest concerns pursuant to this Law.

(2) Immediately upon assigning an independent review organization to perform an expedited external review, but in no case less than 24 hours after assigning the independent review organization, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(3) If the health carrier or its utilization review organization fails to provide the documents and information within the specified time frame, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(4) Within one business day after making the decision to terminate the external review and make a decision to reverse the adverse determination or final adverse determination under item (2) of this subsection (b), the independent review organization shall notify the health carrier, the covered person, the covered person's health care provider, and, if applicable, the covered person's authorized representative of its decision to reverse the adverse determination.

(c) In addition to the documents and information provided

by the health carrier or its utilization review organization, and any documents and information provided by the covered person and the covered person's authorized representative, the independent review organization shall consider the following in reaching a decision:

(1) the covered person's pertinent medical records;

(2) the covered person's health care provider's recommendation;

(3) consulting reports from appropriate health care providers and other documents submitted by the health carrier, the covered person, and the covered person's authorized representative;

(4) the terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the health care service or treatment that is the subject of the opinion is experimental or investigational would otherwise be covered under the terms of coverage of the covered person's health benefit plan with the health carrier;

(5) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(6) any applicable clinical review criteria developed and used by the health carrier or its designee utilization

review organization; and

(7) whether for experimental or investigational denials:

(A) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

(B) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(d) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than 48 hours after the receipt of all pertinent information, the assigned independent review organization shall:

(1) make a decision to uphold or reverse the final adverse determination;

(2) notify the health carrier, the covered person, the covered person's health care provider, and, if applicable, the covered person's authorized representative of the

decision;

(3) in reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process as set forth in the Managed Care Reform and Patient Rights Act;

(4) upon receipt of notice of a decision reversing the final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the final adverse determination; and

(5) within 48 hours after the date of providing the notice required in item (2) of this subsection (d), the assigned independent review organization shall provide written confirmation of the decision to the health carrier, the covered person, the covered person's health care provider, and, if applicable, the covered person's authorized representative, including:

(A) a general description of the reason for the request for external review;

(B) the date the independent review organization received the assignment from the health carrier to conduct the external review;

(C) the date the external review was conducted;

(D) the date of its decision;

(E) the principal reason or reasons for its

decision, including what applicable, if any, evidence-based standards were a basis for its decision; and

(F) references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

(215 ILCS 5/1645 new)

Sec. 1645. Binding nature of external review decision and final appeal for covered persons.

(a) An external review decision is binding on the health carrier.

(b) A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this Law.

(c) If the external review decision upholds the adverse determination, the covered person has the right to appeal the final decision to the Office of Patient Protection.

(1) In cases where the external review decision is found by the Director, through the Office of Patient Protection, to have been made in an arbitrary and capricious manner, the Director may overturn the external review decision and require the health carrier to pay for the health care service or treatment.

(d) Nothing in this Section shall limit other remedies that may be available to the covered person under applicable federal or State law.

(215 ILCS 5/1650 new)

Sec. 1650. Approval of independent review organizations.

(a) The Director shall approve independent review organizations eligible to be assigned to conduct external reviews under this Law.

(b) In order to be eligible for approval by the Director under this Section to conduct external reviews under this Law an independent review organization:

(1) except as otherwise provided in this Section, shall be accredited by a nationally recognized private accrediting entity that the Director has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review; and

(2) shall submit an application for approval in accordance with subsection (d) of this Section.

(c) The Director shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

(d) Any independent review organization wishing to be approved to conduct external reviews under this Law shall submit the application form and include with the form all

documentation and information necessary for the Director to determine if the independent review organization satisfies the minimum qualifications established under this Law.

(1) The Director may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(2) The Director may by rule establish an application fee that independent review organizations shall submit to the Director with an application for approval and renewing.

(e) An approval is effective for 2 years, unless the Director determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under this Law.

(f) Whenever the Director determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under this Law, the Director shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Law that is maintained by the Director.

(g) The Director shall maintain and periodically update a list of approved independent review organizations.

(h) The Department may promulgate rules to carry out the provisions of this Section.

(215 ILCS 5/1655 new)

Sec. 1655. Minimum qualifications for independent review organizations.

(a) To be approved to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this Law that include, at a minimum:

(1) a quality assurance mechanism that ensures:

(A) that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(B) the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and the suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(C) in assigning clinical reviewers, the independent review organization selects physicians or other health care professionals who, through clinical

experience in the past 3 years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(D) the health carrier, the covered person, and the covered person's authorized representative shall not choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review;

(E) confidentiality of medical and treatment records and clinical review criteria; and

(F) any person employed by or under contract with the independent review organization adheres to the requirements of this Law.

(2) a toll-free telephone service operating on a 24-hour-day, 7-day-a-week basis that accepts, receives, and records information related to external reviews and provides appropriate instructions; and

(3) an agreement to maintain and provide to the Director the information set out in Section 1670 of this Law.

(b) All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(1) be an expert in the treatment of the covered

person's medical condition that is the subject of the external review;

(2) be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(3) hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(4) have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a) of this Section, an independent review organization may not own or control, be a subsidiary of, or in any way be owned or controlled by or exercise control with a health benefit plan, a national, State, or local trade association of health benefit plans, or a national, State, or local trade association of health care providers.

(d) Conflicts of interest are prohibited as follows:

(1) In addition to the requirements set forth in subsections (a), (b), and (c), to be approved pursuant to this Law to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(A) the health carrier that is the subject of the external review;

(B) the covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(C) any officer, director, or management employee of the health carrier that is the subject of the external review;

(D) the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the external review;

(E) the facility at which the recommended health care service or treatment would be provided; or

(F) the developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is

the subject of the external review.

(e) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the Director has determined are equivalent to or exceed the minimum qualifications of this Section shall be presumed to be in compliance with this Section and shall be eligible for approval under Section 1655 of this Law.

(f) An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this Section.

(215 ILCS 5/1660 new)

Sec. 1660. Hold harmless for independent review organizations. No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent, or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this Law, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

(215 ILCS 5/1665 new)

Sec. 1665. External review reporting requirements.

(a) Each health carrier shall maintain written records in the aggregate on all requests for external review for each calendar year and submit a report to the Director in the format specified by the Director by March 1 of each year.

(b) The report shall include in the aggregate:

(1) the total number of requests for external review;

(2) the total number of requests for expedited external review;

(3) the total number of requests for external review denied;

(4) the number of requests for external review resolved, including:

(A) the number of requests for external review resolved upholding the adverse determination or final adverse determination;

(B) the number of requests for external review resolved reversing the adverse determination or final adverse determination;

(C) the number of requests for expedited external review resolved upholding the adverse determination or final adverse determination; and

(D) the number of requests for expedited external review resolved reversing the adverse determination or final adverse determination;

(5) the average length of time for resolution for an external review;

(6) the average length of time for resolution for an expedited external review;

(7) a summary of the types of coverages or cases for which an external review was sought, as specified below:

(A) denial of care or treatment; dissatisfaction regarding prospective non-authorization of a request for care or treatment recommended by a provider, excluding diagnostic procedures and referral requests; partial approvals and care terminations are also considered to be denials;

(B) denial of diagnostic procedure; dissatisfaction regarding prospective non-authorization of a request for a diagnostic procedure recommended by a provider; partial approvals are also considered to be denials;

(C) denial of referral request; dissatisfaction regarding non-authorization of a request for a referral to another provider recommended by a primary care provider; and

(D) claims and utilization review; dissatisfaction regarding the concurrent or retrospective evaluation of the coverage, medical necessity, efficiency or appropriateness of health care services or treatment plans; prospective "denials of care or treatment",

"denials of diagnostic procedures", and "denials of referral requests" must not be classified in this category, but the appropriate one above;

(8) the number of external reviews that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(9) any other information the Director may request or require.

(215 ILCS 5/1670 new)

Sec. 1670. Funding of external review. The health carrier shall be solely responsible for paying the cost of external reviews conducted by independent review organizations.

(215 ILCS 5/1675 new)

Sec. 1675. Disclosure requirements.

(a) Each health carrier shall include a description of the external review procedures in, or attached to, the policy, certificate, membership booklet, and outline of coverage or other evidence of coverage it provides to covered persons.

(b) The description required under subsection (a) of this Section shall include a statement that informs the covered person of the right of the covered person to file a request for

an external review of an adverse determination or final adverse determination with the health carrier. The statement shall explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The statement shall include the toll-free telephone number and address of the Office of Consumer Health Insurance within the Division of Insurance.

(c) In addition to subsection (b), the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

Section 90-10. The Small Employer Health Insurance Rating Act is amended by changing Sections 1, 5, 10, 15, 25, and 30 as follows:

(215 ILCS 93/1)

Sec. 1. Short title. This Act may be cited as the Small Employer Health Insurance Rating Act.

(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/5)

Sec. 5. Purpose. The legislature recognizes that all too

often, small employers are forced to increase employee co-pays and deductibles or drop health insurance coverage altogether because of unexpected rate increases as a result of one major medical problem. It is the intent of this Act to improve the efficiency and fairness of the small employer ~~group~~ health insurance marketplace.

(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/10)

Sec. 10. Definitions. For purposes of this Act:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director that a small employer carrier is in compliance with the provisions of Section 25 of this Act, based upon an examination which includes a review of the appropriate records and of the actuarial assumptions and methods utilized by the small employer carrier in establishing premium rates for the applicable health benefit plans.

~~"Base premium rate" means for each class of business as to a rating period, the lowest premium rate charged or which could be charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.~~

"Carrier" means any entity which provides health insurance in this State. For the purposes of this Act, carrier includes a

licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

~~"Case characteristics" means demographic, geographic or other objective characteristics of a small employer, that are considered by the small employer carrier, in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage shall not be characteristics for the purposes of the Small Employer Health Insurance Rating Act.~~

~~"Class of business" means all or a separate grouping of small employers established pursuant to Section 20.~~

"Director" means the Director of the Division of Insurance.

"Division ~~Department~~" means the Division of Insurance within the Department of Financial and Professional Regulation ~~Insurance~~.

"Health benefit plan" or "plan" shall mean any hospital or medical expense-incurred policy, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan shall not include individual, accident-only, credit, dental, vision, medicare supplement, hospital indemnity, long term care, specific disease, stop loss or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

~~"Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic mean of the applicable base premium rate and the corresponding highest premium rate.~~

"Late enrollee" has the meaning given that term in the Illinois Health Insurance Portability and Accountability Act.

~~"New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.~~

~~"Objective characteristics" means measurable or observable phenomena. An example of a measurable characteristic would be the number of employees who were late enrollees. Examples of observable characteristics would be geographic location of the employer or gender of the employee.~~

"Premium" means all monies paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

"Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

"Small employer" has the meaning given that term in the Illinois Health Insurance Portability and Accountability Act.

"Small employer carrier" means a carrier that offers health benefit plans covering employees of one or more small employers in this State.

(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/15)

Sec. 15. Applicability and scope. This Act shall apply to each health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this State after July 1, 2000. For purposes of this Section, the date a plan is continued shall be the first rating period which commences after July 1, 2000. The Act shall apply to any such health benefit plan which provides coverage to employees of a small employer, except that the Act shall not apply to individual health insurance policies.

(Source: P.A. 91-510, eff. 1-1-00; 92-16, eff. 6-28-01.)

(215 ILCS 93/25)

Sec. 25. Premium Rates. Premium rates for health benefit plans for small employers as defined in this Section shall be subject to the following provisions:

(a) The insurer shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate based on:

(i) geographic area;

(ii) family size;

(iii) age; and

(iv) wellness activities.

(b) The adjustment for age in paragraph (a) may not use age brackets smaller than 5-year increments, which shall begin with age 20 and end with age 65. Employees under the age of 20 shall be treated as those age 20.

(c) The insurer shall be permitted to develop separate rates for individuals age 65 or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates shall be subject to the requirements of this Section.

(d) The permitted rates for any age group shall be no more than 425% of the lowest rate for all age groups on January 1, 2010, 400% on January 1, 2011, and 375% on January 1, 2013, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this Section may not be adjusted more frequently than annually, except that the premium may be changed to reflect:

(i) changes to the enrollment of the small employer;

(ii) changes to the family composition of the employee;

(iii) changes to the health benefit plan requested by the small employer; or

(iv) changes in government requirements affecting the

health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this Section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs due to network provider reimbursement schedules or type of network.

(i) Adjusted community rates established under this Section shall pool the medical experience of all small employers purchasing coverage. However, annual rate adjustments for each small employer health benefit plan may vary by up to plus or minus 4 percentage points from the overall adjustment of a carrier's entire small employer pool, such overall adjustment to be approved by the Director, upon a showing by the carrier, certified by a member of the American Academy of Actuaries, that: (i) the variation is a result of deductible levels, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small employer benefit plans will have a revenue neutral effect on the carrier's small

employer pool. Variations of greater than 4 percentage points are subject to review by the Director, and must be approved or denied within 60 days after submittal. A variation that is not denied within 60 days shall be deemed approved. The Director must provide to the carrier an actuarial justification for any denial within 30 days of the denial. ~~(a) Premium rates for health benefit plans subject to this Act shall be subject to all of the following provisions:~~

~~(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20%.~~

~~(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25% of the index rate.~~

~~(3) The percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:~~

~~(A) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use~~

~~the percentage change in the base premium rate;~~

~~(B) an adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and~~

~~(C) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.~~

~~(4) Adjustments in rates for a new rating period due to claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.~~

~~(5) In the case of health benefit plans delivered or issued for delivery prior to the effective date of this Act, a premium rate for a rating period may exceed the ranges set forth in items (1) and (2) of subsection (a) for a period of 3 years following the effective date of this Act. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:~~

~~(A) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a class of business into which the small employer carrier is no longer enrolling new small employes, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar class of business into which the small employer carrier is actively enrolling new small employers; and~~

~~(B) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.~~

~~(6) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.~~

~~(7) For the purposes of this subsection, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision,~~

~~provided that the restriction of benefits to network providers results in substantial differences in claim costs.~~

~~(b) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.~~

(Source: P.A. 91-510, eff. 1-1-00.)

(215 ILCS 93/30)

Sec. 30. Rating and underwriting records.

(a) A small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) A small employer carrier shall file with the Director annually on or before May 15, an actuarial certification certifying that the carrier is in compliance with this Act, and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and

manner, and shall contain such information, as specified by the Director. A copy of the certification shall be retained by the small employer carrier at its principal place of business for a period of three years from the date of certification. This shall include any work papers prepared in support of the actuarial certification.

(c) A small employer carrier shall make the information and documentation described in subsection (a) available to the Director upon request. Except in cases of violations of this Act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Director to persons outside of the Division ~~Department~~ except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(Source: P.A. 91-510, eff. 1-1-00.)

Section 90-15. The Illinois Health Insurance Portability and Accountability Act is amended by changing Section 5 as follows:

(215 ILCS 97/5)

Sec. 5. Definitions.

"Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person specified.

"Beneficiary" has the meaning given such term under Section

3(8) of the Employee Retirement Income Security Act of 1974.

"Bona fide association" means, with respect to health insurance coverage offered in a State, an association which:

(1) has been actively in existence for at least 5 years;

(2) has been formed and maintained in good faith for purposes other than obtaining insurance;

(3) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(4) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(5) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(6) meets such additional requirements as may be imposed under State law.

"Church plan" has the meaning given that term under Section 3(33) of the Employee Retirement Income Security Act of 1974.

"COBRA continuation provision" means any of the following:

(1) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of that Section insofar as it relates to pediatric vaccines.

(2) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than Section 609 of that Act.

(3) Title XXII of federal Public Health Service Act.

"Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, the holding of policyholders' proxies by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is solely the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds shareholders' proxies representing 10% or more of the voting securities of any other person or holds or controls sufficient policyholders' proxies to elect the majority of the board of directors of the domestic company. This presumption may be rebutted by a showing made in a manner as the Secretary may provide by rule. The Secretary may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

"Department" means the Department of Insurance.

"Employee" has the meaning given that term under Section 3(6) of the Employee Retirement Income Security Act of 1974.

"Employer" has the meaning given that term under Section 3(5) of the Employee Retirement Income Security Act of 1974~~, except that the term shall include only employers of 2 or more employees~~.

"Enrollment date" means, with respect to an individual covered under a group health plan or group health insurance coverage, the date of enrollment of the individual in the plan or coverage, or if earlier, the first day of the waiting period for enrollment.

"Federal governmental plan" means a governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of that government.

"Governmental plan" has the meaning given that term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

"Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with the plan.

"Group health plan" means an employee welfare benefit plan (as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2) of that Section and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or

otherwise.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"Health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined herein) which is licensed to engage in the business of insurance in a state and which is subject to Illinois law which regulates insurance (within the meaning of Section 514(b)(2) of the Employee Retirement Income Security Act of 1974). The term does not include a group health plan.

"Health maintenance organization (HMO)" means:

(1) a Federally qualified health maintenance organization (as defined in Section 1301(a) of the Public Health Service Act.);

(2) an organization recognized under State law as a health maintenance organization; or

(3) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

"Individual health insurance coverage" means health

insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(1) Application of aggregation rule for large employers. All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

(2) Employers not in existence in preceding year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(3) Predecessors. Any reference in this Act to an employer shall include a reference to any predecessor of such employer.

"Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

"Late enrollee" means with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(1) the first period in which the individual is eligible to enroll under the plan; or

(2) a special enrollment period under subsection (F) of Section 20.

"Medical care" means amounts paid for:

(1) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) amounts paid for transportation primarily for and essential to medical care referred to in item (1); and

(3) amounts paid for insurance covering medical care referred to in items (1) and (2).

"Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set

of providers under contract with the issuer.

"Participant" has the meaning given that term under Section 3(7) of the Employee Retirement Income Security Act of 1974.

"Person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing acting in concert, but does not include any securities broker performing no more than the usual and customary broker's function or joint venture partnership exclusively engaged in owning, managing, leasing, or developing real or tangible personal property other than capital stock.

"Placement" or being "placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by the person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation.

"Plan sponsor" has the meaning given that term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not

any medical advice, diagnosis, care, or treatment was recommended or received before such date.

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee ~~2 employees~~ on the first day of the plan year. This term shall include self-employed persons.

(1) Application of aggregation rule for small employers. All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

(2) Employers not in existence in preceding year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

(3) Predecessors. Any reference in this Act to a small employer shall include a reference to any predecessor of that employer.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage

(directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

"State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"Waiting period" means with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period of time that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(Source: P.A. 94-502, eff. 8-8-05.)

Section 90-20. The Managed Care Reform and Patient Rights Act is amended by changing Sections 40 and 45 as follows:

(215 ILCS 134/40)

Sec. 40. Access to specialists.

(a) All health care plans that require each enrollee to select a health care provider for any purpose including coordination of care shall permit an enrollee to choose any available primary care physician licensed to practice medicine in all its branches participating in the health care plan for that purpose. The health care plan shall provide the enrollee with a choice of licensed health care providers who are accessible and qualified. Nothing in this Act shall be

construed to prohibit a health care plan from requiring a health care provider to meet the health care plan's criteria in order to coordinate access to health care.

(b) A health care plan shall establish a procedure by which an enrollee who has a condition that requires ongoing care from a specialist physician or other health care provider may apply for a standing referral to a specialist physician or other health care provider if a referral to a specialist physician or other health care provider is required for coverage. The application shall be made to the enrollee's primary care physician. This procedure for a standing referral must specify the necessary criteria and conditions that must be met in order for an enrollee to obtain a standing referral. A standing referral shall be effective for the period necessary to provide the referred services or one year, except in the event of termination of a contract or policy in which case Section 25 on transition of services shall apply, if applicable. A primary care physician may renew and re-renew a standing referral.

(c) The enrollee may be required by the health care plan to select a specialist physician or other health care provider who has a referral arrangement with the enrollee's primary care physician or to select a new primary care physician who has a referral arrangement with the specialist physician or other health care provider chosen by the enrollee. If a health care plan requires an enrollee to select a new physician under this subsection, the health care plan must provide the enrollee with

both options provided in this subsection. When a participating specialist with a referral arrangement is not available, the primary care physician, in consultation with the enrollee, shall arrange for the enrollee to have access to a qualified participating health care provider, and the enrollee shall be allowed to stay with his or her primary care physician. If a secondary referral is necessary, the specialist physician or other health care provider shall advise the primary care physician. The primary care physician shall be responsible for making the secondary referral. In addition, the health care plan shall require the specialist physician or other health care provider to provide regular updates to the enrollee's primary care physician.

(d) When the type of specialist physician or other health care provider needed to provide ongoing care for a specific condition is not represented in the health care plan's provider network, the primary care physician shall arrange for the enrollee to have access to a qualified non-participating health care provider within a reasonable distance and travel time at no additional cost beyond what the enrollee would otherwise pay for services received within the network. The referring physician shall notify the plan when a referral is made outside the network.

(e) The enrollee's primary care physician shall remain responsible for coordinating the care of an enrollee who has received a standing referral to a specialist physician or other

health care provider. If a secondary referral is necessary, the specialist physician or other health care provider shall advise the primary care physician. The primary care physician shall be responsible for making the secondary referral. In addition, the health care plan shall require the specialist physician or other health care provider to provide regular updates to the enrollee's primary care physician.

(f) If an enrollee's application for any referral is denied, an enrollee may appeal the decision through the health care plan's external independent review process as provided by the Illinois Health Carrier External Review Law ~~in accordance with subsection (f) of Section 45 of this Act~~.

(g) Nothing in this Act shall be construed to require an enrollee to select a new primary care physician when no referral arrangement exists between the enrollee's primary care physician and the specialist selected by the enrollee and when the enrollee has a long-standing relationship with his or her primary care physician.

(h) In promulgating rules to implement this Act, the Department shall define "standing referral" and "ongoing course of treatment".

(Source: P.A. 91-617, eff. 1-1-00.)

(215 ILCS 134/45)

Sec. 45. Health care services appeals and~~,~~ complaints~~, and external independent reviews~~.

(a) A health care plan shall establish and maintain an appeals procedure as outlined in this Act. Compliance with this Act's appeals procedures shall satisfy a health care plan's obligation to provide appeal procedures under any other State law or rules. All appeals of a health care plan's administrative determinations and complaints regarding its administrative decisions shall be handled as required under Section 50.

(b) When an appeal concerns a decision or action by a health care plan, its employees, or its subcontractors that relates to (i) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, or (ii) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, the health care plan must allow for the filing of an appeal either orally or in writing. Upon submission of the appeal, a health care plan must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 24 hours after receipt of the required information. The health care plan shall notify the party filing the appeal and the enrollee, enrollee's

primary care physician, and any health care provider who recommended the health care service involved in the appeal of its decision orally followed-up by a written notice of the determination.

(c) For all appeals related to health care services including, but not limited to, procedures or treatments for an enrollee and not covered by subsection (b) above, the health care plan shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection, a health care plan must notify the party filing an appeal, within 3 business days, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 15 business days after receipt of the required information. The health care plan shall notify the party filing the appeal, the enrollee, the enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal orally of its decision followed-up by a written notice of the determination.

(d) An appeal under subsection (b) or (c) may be filed by the enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health care provider. A health care plan shall designate a clinical peer to review appeals, because these appeals pertain to medical or clinical matters and such an appeal must be reviewed by an appropriate health care professional. No one reviewing an appeal may have had any involvement in the initial

determination that is the subject of the appeal. The written notice of determination required under subsections (b) and (c) shall include (i) clear and detailed reasons for the determination, (ii) the medical or clinical criteria for the determination, which shall be based upon sound clinical evidence and reviewed on a periodic basis, and (iii) in the case of an adverse determination, the procedures for requesting an external independent review as provided by the Illinois Health Carrier External Review Law ~~under subsection (f)~~.

(e) If an appeal filed under subsection (b) or (c) is denied for a reason including, but not limited to, the service, procedure, or treatment is not viewed as medically necessary, denial of specific tests or procedures, denial of referral to specialist physicians or denial of hospitalization requests or length of stay requests, any involved party may request an external independent review as provided by the Illinois Health Carrier External Review Law ~~under subsection (f) of the adverse determination~~.

~~(f) External independent review.~~

~~(1) The party seeking an external independent review shall so notify the health care plan. The health care plan shall seek to resolve all external independent reviews in the most expeditious manner and shall make a determination and provide notice of the determination no more than 24 hours after the receipt of all necessary information when a delay would significantly increase the risk to an~~

~~enrollee's health or when extended health care services for an enrollee undergoing a course of treatment prescribed by a health care provider are at issue.~~

~~(2) Within 30 days after the enrollee receives written notice of an adverse determination, if the enrollee decides to initiate an external independent review, the enrollee shall send to the health care plan a written request for an external independent review, including any information or documentation to support the enrollee's request for the covered service or claim for a covered service.~~

~~(3) Within 30 days after the health care plan receives a request for an external independent review from an enrollee, the health care plan shall:~~

~~(A) provide a mechanism for joint selection of an external independent reviewer by the enrollee, the enrollee's physician or other health care provider, and the health care plan; and~~

~~(B) forward to the independent reviewer all medical records and supporting documentation pertaining to the case, a summary description of the applicable issues including a statement of the health care plan's decision, the criteria used, and the medical and clinical reasons for that decision.~~

~~(4) Within 5 days after receipt of all necessary information, the independent reviewer shall evaluate and analyze the case and render a decision that is based on~~

~~whether or not the health care service or claim for the health care service is medically appropriate. The decision by the independent reviewer is final. If the external independent reviewer determines the health care service to be medically appropriate, the health care plan shall pay for the health care service.~~

~~(5) The health care plan shall be solely responsible for paying the fees of the external independent reviewer who is selected to perform the review.~~

~~(6) An external independent reviewer who acts in good faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external independent review, unless the acts or omissions constitute wilful and wanton misconduct. For purposes of any proceeding, the good faith of the person participating shall be presumed.~~

~~(7) Future contractual or employment action by the health care plan regarding the patient's physician or other health care provider shall not be based solely on the physician's or other health care provider's participation in this procedure.~~

~~(8) For the purposes of this Section, an external independent reviewer shall:~~

~~(A) be a clinical peer;~~

~~(B) have no direct financial interest in connection with the case; and~~

~~(C) have not been informed of the specific identity of the enrollee.~~

~~(g)~~ Nothing in this Section shall be construed to require a health care plan to pay for a health care service not covered under the enrollee's certificate of coverage or policy.

(Source: P.A. 91-617, eff. 1-1-00.)

(215 ILCS 93/20 rep.)

Section 90-25. The Small Employer Health Insurance Rating Act is amended by repealing Section 20.

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