

1 AN ACT concerning insurance.

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

4 Section 1. Short title. This Act may be cited as the Health
5 Carrier External Review Act.

6 Section 5. Purpose and intent. The purpose of this Act is
7 to provide uniform standards for the establishment and
8 maintenance of external review procedures to assure that
9 covered persons have the opportunity for an independent review
10 of an adverse determination or final adverse determination, as
11 defined in this Act.

12 Section 10. Definitions. For the purposes of this Act:

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

22 "Authorized representative" means:

1 (1) a person to whom a covered person has given express
2 written consent to represent the covered person in an
3 external review, including the covered person's health
4 care provider;

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

7 (3) the covered person's health care provider when the
8 covered person is unable to provide consent.

9 "Best evidence" means evidence based on:

10 (1) randomized clinical trials;

11 (2) if randomized clinical trials are not available,
12 then cohort studies or case-control studies;

13 (3) if items (1) and (2) are not available, then
14 case-series; or

15 (4) if items (1), (2), and (3) are not available, then
16 expert opinion.

17 "Case-series" means an evaluation of a series of patients
18 with a particular outcome, without the use of a control group.

19 "Clinical review criteria" means the written screening
20 procedures, decision abstracts, clinical protocols, and
21 practice guidelines used by a health carrier to determine the
22 necessity and appropriateness of health care services.

23 "Cohort study" means a prospective evaluation of 2 groups
24 of patients with only one group of patients receiving specific
25 intervention.

26 "Covered benefits" or "benefits" means those health care

1 services to which a covered person is entitled under the terms
2 of a health benefit plan.

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

6 "Director" means the Director of the Department of
7 Insurance.

8 "Emergency medical condition" means a medical condition
9 manifesting itself by acute symptoms of sufficient severity,
10 including, but not limited to, severe pain, such that a prudent
11 layperson who possesses an average knowledge of health and
12 medicine could reasonably expect the absence of immediate
13 medical attention to result in:

14 (1) placing the health of the individual or, with
15 respect to a pregnant woman, the health of the woman or her
16 unborn child, in serious jeopardy;

17 (2) serious impairment to bodily functions; or

18 (3) serious dysfunction of any bodily organ or part.

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

22 "Evidence-based standard" means the conscientious,
23 explicit, and judicious use of the current best evidence based
24 on an overall systematic review of the research in making
25 decisions about the care of individual patients.

26 "Expert opinion" means a belief or an interpretation by

1 specialists with experience in a specific area about the
2 scientific evidence pertaining to a particular service,
3 intervention, or therapy.

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

6 "Final adverse determination" means an adverse
7 determination involving a covered benefit that has been upheld
8 by a health carrier, or its designee utilization review
9 organization, at the completion of the health carrier's
10 internal grievance process procedures as set forth by the
11 Managed Care Reform and Patient Rights Act.

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

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

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

25 "Health carrier" means an entity subject to the insurance
26 laws and regulations of this State, or subject to the

1 jurisdiction of the Director, that contracts or offers to
2 contract to provide, deliver, arrange for, pay for, or
3 reimburse any of the costs of health care services, including a
4 sickness and accident insurance company, a health maintenance
5 organization, or any other entity providing a plan of health
6 insurance, health benefits, or health care services. "Health
7 carrier" also means Limited Health Service Organizations
8 (LHSO) and Voluntary Health Service Plans.

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

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

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

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

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

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

24 (1) peer-reviewed scientific studies published in or
25 accepted for publication by medical journals that meet
26 nationally recognized requirements for scientific

1 manuscripts and that submit most of their published
2 articles for review by experts who are not part of the
3 editorial staff;

4 (2) peer-reviewed medical literature, including
5 literature relating to therapies reviewed and approved by a
6 qualified institutional review board, biomedical
7 compendia, and other medical literature that meet the
8 criteria of the National Institutes of Health's Library of
9 Medicine for indexing in Index Medicus (Medline) and
10 Elsevier Science Ltd. for indexing in Excerpta Medicus
11 (EMBASE);

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

15 (4) the following standard reference compendia:

16 (a) The American Hospital Formulary Service-Drug
17 Information;

18 (b) Drug Facts and Comparisons;

19 (c) The American Dental Association Accepted
20 Dental Therapeutics; and

21 (d) The United States Pharmacopoeia-Drug
22 Information;

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

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

3 (b) the National Institutes of Health;

4 (c) the National Cancer Institute;

5 (d) the National Academy of Sciences;

6 (e) the Centers for Medicare & Medicaid Services;

7 (f) the federal Food and Drug Administration; and

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

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

13 "Protected health information" means health information
14 (i) that identifies an individual who is the subject of the
15 information; or (ii) with respect to which there is a
16 reasonable basis to believe that the information could be used
17 to identify an individual.

18 "Retrospective review" means a review of medical necessity
19 conducted after services have been provided to a patient, but
20 does not include the review of a claim that is limited to an
21 evaluation of reimbursement levels, veracity of documentation,
22 accuracy of coding, or adjudication for payment.

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

25 "Utilization review organization" means a utilization
26 review program as defined in the Managed Care Reform and

1 Patient Rights Act.

2 Section 15. Applicability and scope.

3 (a) Except as provided in subsection (b) of this Section,
4 this Act shall apply to all health carriers.

5 (b) The provisions of this Act shall not apply to a policy
6 or certificate that provides coverage only for a specified
7 disease, specified accident or accident-only coverage, credit,
8 dental, disability income, hospital indemnity, long-term care
9 insurance as defined by Article XIXA of the Illinois Insurance
10 Code, vision care, or any other limited supplemental benefit; a
11 Medicare supplement policy of insurance as defined by the
12 Director by regulation; coverage under a plan through Medicare,
13 Medicaid, or the federal employees health benefits program; any
14 coverage issued under Chapter 55 of Title 10, U.S. Code and any
15 coverage issued as supplement to that coverage; any coverage
16 issued as supplemental to liability insurance, workers'
17 compensation, or similar insurance; automobile medical-payment
18 insurance or any insurance under which benefits are payable
19 with or without regard to fault, whether written on a group
20 blanket or individual basis.

21 Section 20. Notice of right to external review.

22 (a) At the same time the health carrier sends written
23 notice of a covered person's right to appeal a coverage
24 decision upon an adverse determination or a final adverse

1 determination as provided by the Managed Care Reform and
2 Patient Rights Act, a health carrier shall notify a covered
3 person and a covered person's health care provider in writing
4 of the covered person's right to request an external review as
5 provided by this Act. The written notice required shall include
6 the following, or substantially equivalent, language: "We have
7 denied your request for the provision of or payment for a
8 health care service or course of treatment. You have the right
9 to have our decision reviewed by an independent review
10 organization not associated with us if our decision involved
11 making a judgment as to the medical necessity, appropriateness,
12 health care setting, level of care, or effectiveness of the
13 health care service or treatment you requested by submitting a
14 written request for an external review to us. Upon receipt of
15 your request an independent review organization registered
16 with the Department of Insurance will be assigned to review our
17 decision.

18 (b) This subsection (b) shall apply to an expedited review
19 prior to a final adverse determination. In addition to the
20 notice required in subsection (a), the health carrier shall
21 include a notice related to an adverse determination, a
22 statement informing the covered person all of the following:

- 23 (1) If the covered person has a medical condition where
24 the timeframe for completion of (A) an expedited internal
25 review of a grievance involving an adverse determination,
26 (B) a final adverse determination as set forth in the

1 Managed Care Reform and Patient Rights Act, or (C) a
2 standard external review as established in this Act, would
3 seriously jeopardize the life or health of the covered
4 person or would jeopardize the covered person's ability to
5 regain maximum function, then the covered person or the
6 covered person's authorized representative may file a
7 request for an expedited external review.

8 (2) The covered person or the covered person's
9 authorized representative may file a request for an
10 expedited external review at the same time the covered
11 person or the covered person's authorized representative
12 files a request for an expedited internal appeal involving
13 an adverse determination as set forth in the Managed Care
14 Reform and Patient Rights Act if the adverse determination
15 involves a denial of coverage based on a determination that
16 the recommended or requested health care service or
17 treatment is experimental or investigational and the
18 covered person's health care provider certifies in writing
19 that the recommended or requested health care service or
20 treatment that is the subject of the adverse determination
21 would be significantly less effective if not promptly
22 initiated. The independent review organization assigned to
23 conduct the expedited external review will determine
24 whether the covered person shall be required to complete
25 the expedited review of the grievance prior to conducting
26 the expedited external review.

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

11 (c) This subsection (c) shall apply to an expedited review
12 upon final adverse determination. In addition to the notice
13 required in subsection (a), the health carrier shall include a
14 notice related to a final adverse determination, a statement
15 informing the covered person all of the following:

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

23 (2) if a final adverse determination concerns an
24 admission, availability of care, continued stay, or health
25 care service for which the covered person received
26 emergency services, but has not been discharged from a

1 facility, then the covered person, or the covered person's
2 authorized representative, may request an expedited
3 external review; or

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

14 (d) In addition to the information to be provided pursuant
15 to subsections (a), (b), and (c) of this Section, the health
16 carrier shall include a copy of the description of both the
17 required standard and expedited external review procedures.
18 The description shall highlight the external review procedures
19 that give the covered person or the covered person's authorized
20 representative the opportunity to submit additional
21 information, including any forms used to process an external
22 review.

23 Section 25. Request for external review. A covered person
24 or the covered person's authorized representative may make a
25 request for a standard external or expedited external review of

1 an adverse determination or final adverse determination.
2 Requests under this Section shall be made directly to the
3 health carrier that made the adverse or final adverse
4 determination. All requests for external review shall be in
5 writing except for requests for expedited external reviews
6 which may be made orally. Health carriers must provide covered
7 persons with forms to request external reviews.

8 Section 30. Exhaustion of internal grievance process.

9 Except as provided in subsection (b) of Section 20, a
10 request for an external review shall not be made until the
11 covered person has exhausted the health carrier's internal
12 grievance process as set forth in the Managed Care Reform and
13 Patient Rights Act. A covered person shall also be considered
14 to have exhausted the health carrier's internal grievance
15 process for purposes of this Section if:

16 (1) the covered person or the covered person's
17 authorized representative filed a request for an internal
18 review of an adverse determination pursuant to the Managed
19 Care Reform and Patient Rights Act and has not received a
20 written decision on the request from the health carrier
21 within 15 days after receipt of the required information
22 but not more than 30 days after the request was filed by
23 the covered person or the covered person's authorized
24 representative, except to the extent the covered person or
25 the covered person's authorized representative requested

1 or agreed to a delay; however, a covered person or the
2 covered person's authorized representative may not make a
3 request for an external review of an adverse determination
4 involving a retrospective review determination until the
5 covered person has exhausted the health carrier's internal
6 grievance process;

7 (2) the covered person or the covered person's
8 authorized representative filed a request for an expedited
9 internal review of an adverse determination pursuant to the
10 Managed Care Reform and Patient Rights Act and has not
11 received a decision on request from the health carrier
12 within 48 hours, except to the extent the covered person or
13 the covered person's authorized representative requested
14 or agreed to a delay; or

15 (3) the health carrier agrees to waive the exhaustion
16 requirement.

17 Section 35. Standard external review.

18 (a) Within 4 months after the date of receipt of a notice
19 of an adverse determination or final adverse determination, a
20 covered person or the covered person's authorized
21 representative may file a request for an external review with
22 the health carrier.

23 (b) Within 5 business days following the date of receipt of
24 the external review request, the health carrier shall complete
25 a preliminary review of the request to determine whether:

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

5 (2) the health care service that is the subject of the
6 adverse determination or the final adverse determination
7 is a covered service under the covered person's health
8 benefit plan, but the health carrier has determined that
9 the health care service is not covered because it does not
10 meet the health carrier's requirements for medical
11 necessity, appropriateness, health care setting, level of
12 care, or effectiveness;

13 (3) the covered person has exhausted the health
14 carrier's internal grievance process as set forth in this
15 Act;

16 (4) for appeals relating to a determination based on
17 treatment being experimental or investigational, the
18 requested health care service or treatment that is the
19 subject of the adverse determination or final adverse
20 determination is a covered benefit under the covered
21 person's health benefit plan except for the health
22 carrier's determination that the service or treatment is
23 experimental or investigational for a particular medical
24 condition and is not explicitly listed as an excluded
25 benefit under the covered person's health benefit plan with
26 the health carrier and that the covered person's health

1 care provider, who is a physician licensed to practice
2 medicine in all its branches, has certified that one of the
3 following situations is applicable:

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

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

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

13 (D) the health care service or treatment is likely
14 to be more beneficial to the covered person, in the
15 health care provider's opinion, than any available
16 standard health care services or treatments; or

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

22 (5) the covered person has provided all the information
23 and forms required to process an external review, as
24 specified in this Act.

25 (c) Within one business day after completion of the
26 preliminary review, the health carrier shall notify the covered

1 person and, if applicable, the covered person's authorized
2 representative in writing whether the request is complete and
3 eligible for external review. If the request:

4 (1) is not complete, the health carrier shall inform
5 the covered person and, if applicable, the covered person's
6 authorized representative in writing and include in the
7 notice what information or materials are required by this
8 Act to make the request complete; or

9 (2) is not eligible for external review, the health
10 carrier shall inform the covered person and, if applicable,
11 the covered person's authorized representative in writing
12 and include in the notice the reasons for its
13 ineligibility.

14 The notice of initial determination of ineligibility shall
15 include a statement informing the covered person and, if
16 applicable, the covered person's authorized representative
17 that a health carrier's initial determination that the external
18 review request is ineligible for review may be appealed to the
19 Director by filing a complaint with the Director.

20 Notwithstanding a health carrier's initial determination
21 that the request is ineligible for external review, the
22 Director may determine that a request is eligible for external
23 review and require that it be referred for external review. In
24 making such determination, the Director's decision shall be in
25 accordance with the terms of the covered person's health
26 benefit plan and shall be subject to all applicable provisions

1 of this Act.

2 (d) Whenever a request is eligible for external review the
3 health carrier shall, within 5 business days:

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

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

11 The health carrier shall include in the notice provided to
12 the covered person and, if applicable, the covered person's
13 authorized representative a statement that the covered person
14 or the covered person's authorized representative may, within 5
15 business days following the date of receipt of the notice
16 provided pursuant to item (2) of this subsection (d), submit in
17 writing to the assigned independent review organization
18 additional information that the independent review
19 organization shall consider when conducting the external
20 review. The independent review organization is not required to,
21 but may, accept and consider additional information submitted
22 after 5 business days.

23 (e) The assignment of an approved independent review
24 organization to conduct an external review in accordance with
25 this Section shall be made from those approved independent
26 review organizations qualified to conduct external review as

1 required by Sections 50 and 55 of this Act.

2 (f) Upon assignment of an independent review organization,
3 the health carrier or its designee utilization review
4 organization shall, within 5 business days, provide to the
5 assigned independent review organization the documents and any
6 information considered in making the adverse determination or
7 final adverse determination; in such cases, the following
8 provisions shall apply:

9 (1) Except as provided in item (2) of this subsection
10 (f), failure by the health carrier or its utilization
11 review organization to provide the documents and
12 information within the specified time frame shall not delay
13 the conduct of the external review.

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

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

1 reverse the adverse determination.

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

9 (h) Upon receipt of any information submitted by the
10 covered person or the covered person's authorized
11 representative, the independent review organization shall
12 forward the information to the health carrier within 1 business
13 day.

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

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

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

1 In such cases, the following provisions shall apply:

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

9 (B) Upon notice from the health carrier that the
10 health carrier has made a decision to reverse its
11 adverse determination or final adverse determination,
12 the assigned independent review organization shall
13 terminate the external review.

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

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

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

25 (3) consulting reports from appropriate health care
26 providers and other documents submitted by the health

1 carrier, the covered person, the covered person's
2 authorized representative, or the covered person's
3 treating provider;

4 (4) the terms of coverage under the covered person's
5 health benefit plan with the health carrier to ensure that
6 the independent review organization's decision is not
7 contrary to the terms of coverage under the covered
8 person's health benefit plan with the health carrier;

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

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

17 (7) the opinion of the independent review
18 organization's clinical reviewer or reviewers after
19 considering items (1) through (6) of this subsection (i) to
20 the extent the information or documents are available and
21 the clinical reviewer or reviewers considers the
22 information or documents appropriate; and

23 (8) for a denial of coverage based on a determination
24 that the health care service or treatment recommended or
25 requested is experimental or investigational, whether and
26 to what extent:

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

5 (B) medical or scientific evidence or
6 evidence-based standards demonstrate that the expected
7 benefits of the recommended or requested health care
8 service or treatment is more likely than not to be
9 beneficial to the covered person than any available
10 standard health care service or treatment and the
11 adverse risks of the recommended or requested health
12 care service or treatment would not be substantially
13 increased over those of available standard health care
14 services or treatments; or

15 (C) the terms of coverage under the covered
16 person's health benefit plan with the health carrier to
17 ensure that the health care service or treatment that
18 is the subject of the opinion is experimental or
19 investigational would otherwise be covered under the
20 terms of coverage of the covered person's health
21 benefit plan with the health carrier.

22 (j) Within 5 days after the date of receipt of all
23 necessary information, the assigned independent review
24 organization shall provide written notice of its decision to
25 uphold or reverse the adverse determination or the final
26 adverse determination to the health carrier, the covered person

1 and, if applicable, the covered person's authorized
2 representative. In reaching a decision, the assigned
3 independent review organization is not bound by any claim
4 determinations reached prior to the submission of information
5 to the independent review organization. In such cases, the
6 following provisions shall apply:

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

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

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

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

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

19 (E) the date of its decision; and

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

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

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

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

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

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

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

22 (F) whether medical or scientific evidence or
23 evidence-based standards demonstrate that the expected
24 benefits of the recommended or requested health care
25 service or treatment is more likely than not to be more
26 beneficial to the covered person than any available

1 standard health care service or treatment and the
2 adverse risks of the recommended or requested health
3 care service or treatment would not be substantially
4 increased over those of available standard health care
5 services or treatments; and

6 (G) the written opinion of the clinical reviewer,
7 including the reviewer's recommendation as to whether
8 the recommended or requested health care service or
9 treatment should be covered and the rationale for the
10 reviewer's recommendation.

11 (3) In reaching a decision, the assigned independent
12 review organization is not bound by any decisions or
13 conclusions reached during the health carrier's
14 utilization review process or the health carrier's
15 internal grievance or appeals process.

16 (4) Upon receipt of a notice of a decision reversing
17 the adverse determination or final adverse determination,
18 the health carrier immediately shall approve the coverage
19 that was the subject of the adverse determination or final
20 adverse determination.

21 Section 40. Expedited external review.

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

25 (1) immediately after the date of receipt of a notice

1 prior to a final adverse determination as provided by
2 subsection (b) of Section 20 of this Act;

3 (2) immediately after the date of receipt of a notice a
4 final adverse determination as provided by subsection (c)
5 of Section 20 of this Act; or

6 (3) if a health carrier fails to provide a decision on
7 request for an expedited internal appeal within 48 hours as
8 provided by item (2) of Section 30 of this Act.

9 (b) Immediately upon receipt of the request for an
10 expedited external review as provided under subsections (b) and
11 (c) of Section 20, the health carrier shall determine whether
12 the request meets the reviewability requirements set forth in
13 items (1), (2), and (4) of subsection (b) of Section 35. In
14 such cases, the following provisions shall apply:

15 (1) The health carrier shall immediately notify the
16 covered person and, if applicable, the covered person's
17 authorized representative of its eligibility
18 determination.

19 (2) The notice of initial determination shall include a
20 statement informing the covered person and, if applicable,
21 the covered person's authorized representative that a
22 health carrier's initial determination that an external
23 review request is ineligible for review may be appealed to
24 the Director.

25 (3) The Director may determine that a request is
26 eligible for expedited external review notwithstanding a

1 health carrier's initial determination that the request is
2 ineligible and require that it be referred for external
3 review.

4 (4) In making a determination under item (3) of this
5 subsection (b), the Director's decision shall be made in
6 accordance with the terms of the covered person's health
7 benefit plan and shall be subject to all applicable
8 provisions of this Act.

9 (c) Upon determining that a request meets the requirements
10 of subsections (b) and (c) of Section 20, the health carrier
11 shall immediately assign an independent review organization
12 from the list of approved independent review organizations
13 compiled and maintained by the Director to conduct the
14 expedited review. In such cases, the following provisions shall
15 apply:

16 (1) The assignment of an approved independent review
17 organization to conduct an external review in accordance
18 with this Section shall be made from those approved
19 independent review organizations qualified to conduct
20 external review as required by Sections 50 and 55 of this
21 Act.

22 (2) Immediately upon assigning an independent review
23 organization to perform an expedited external review, but
24 in no case more than 24 hours after assigning the
25 independent review organization, the health carrier or its
26 designee utilization review organization shall provide or

1 transmit all necessary documents and information
2 considered in making the final adverse determination to the
3 assigned independent review organization electronically or
4 by telephone or facsimile or any other available
5 expeditious method.

6 (3) If the health carrier or its utilization review
7 organization fails to provide the documents and
8 information within the specified timeframe, the assigned
9 independent review organization may terminate the external
10 review and make a decision to reverse the adverse
11 determination or final adverse determination.

12 (4) Within one business day after making the decision
13 to terminate the external review and make a decision to
14 reverse the adverse determination or final adverse
15 determination under item (3) of this subsection (c), the
16 independent review organization shall notify the health
17 carrier, the covered person and, if applicable, the covered
18 person's authorized representative of its decision to
19 reverse the adverse determination.

20 (d) In addition to the documents and information provided
21 by the health carrier or its utilization review organization
22 and any documents and information provided by the covered
23 person and the covered person's authorized representative, the
24 independent review organization shall consider information as
25 required by subsection (i) of Section 35 of this Act in
26 reaching a decision.

1 (e) As expeditiously as the covered person's medical
2 condition or circumstances requires, but in no event more than
3 2 business days after the receipt of all pertinent information,
4 the assigned independent review organization shall:

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

7 (2) notify the health carrier, the covered person, the
8 covered person's health care provider, and if applicable,
9 the covered person's authorized representative, of the
10 decision.

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

16 (g) Upon receipt of notice of a decision reversing the
17 final adverse determination, the health carrier shall
18 immediately approve the coverage that was the subject of the
19 final adverse determination.

20 (h) Within 48 hours after the date of providing the notice
21 required in item (2) of subsection (e), the assigned
22 independent review organization shall provide written
23 confirmation of the decision to the health carrier, the covered
24 person, and if applicable, the covered person's authorized
25 representative including the information set forth in
26 subsection (j) of Section 35 of this Act as applicable.

1 (i) An expedited external review may not be provided for
2 retrospective adverse or final adverse determinations.

3 Section 45. Binding nature of external review decision. An
4 external review decision is binding on the health carrier. An
5 external review decision is binding on the covered person
6 except to the extent the covered person has other remedies
7 available under applicable federal or State law. A covered
8 person or the covered person's authorized representative may
9 not file a subsequent request for external review involving the
10 same adverse determination or final adverse determination for
11 which the covered person has already received an external
12 review decision pursuant to this Act.

13 Section 50. Approval of independent review organizations.

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

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

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

1 for independent review; and

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

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

7 (d) Any independent review organization wishing to be
8 approved to conduct external reviews under this Act shall
9 submit the application form and include with the form all
10 documentation and information necessary for the Director to
11 determine if the independent review organization satisfies the
12 minimum qualifications established under this Act. The
13 Director may:

14 (1) approve independent review organizations that are
15 not accredited by a nationally recognized private
16 accrediting entity if there are no acceptable nationally
17 recognized private accrediting entities providing
18 independent review organization accreditation; and

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

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

26 (f) Whenever the Director determines that an independent

1 review organization has lost its accreditation or no longer
2 satisfies the minimum requirements established under this Act,
3 the Director shall terminate the approval of the independent
4 review organization and remove the independent review
5 organization from the list of independent review organizations
6 approved to conduct external reviews under this Act that is
7 maintained by the Director.

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

10 (h) The Director may promulgate regulations to carry out
11 the provisions of this Section.

12 Section 55. Minimum qualifications for independent review
13 organizations.

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

20 (1) a quality assurance mechanism that ensures that:

21 (A) external reviews are conducted within the
22 specified timeframes and required notices are provided
23 in a timely manner;

24 (B) selection of qualified and impartial clinical
25 reviewers to conduct external reviews on behalf of the

1 independent review organization and suitable matching
2 of reviewers to specific cases and that the independent
3 review organization employs or contracts with an
4 adequate number of clinical reviewers to meet this
5 objective;

6 (C) for adverse determinations involving
7 experimental or investigational treatments, in
8 assigning clinical reviewers, the independent review
9 organization selects physicians or other health care
10 professionals who, through clinical experience in the
11 past 3 years, are experts in the treatment of the
12 covered person's condition and knowledgeable about the
13 recommended or requested health care service or
14 treatment;

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

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

22 (F) any person employed by or under contract with
23 the independent review organization adheres to the
24 requirements of this Act;

25 (2) a toll-free telephone service operating on a
26 24-hour-day, 7-day-a-week basis that accepts, receives,

1 and records information related to external reviews and
2 provides appropriate instructions; and

3 (3) an agreement to maintain and provide to the
4 Director the information set out in Section 70 of this Act.

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

9 (1) be an expert in the treatment of the covered
10 person's medical condition that is the subject of the
11 external review;

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

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

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

1 competence or moral character.

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

9 (d) Conflicts of interest prohibited. In addition to the
10 requirements set forth in subsections (a), (b), and (c) of this
11 Section, to be approved pursuant to this Act to conduct an
12 external review of a specified case, neither the independent
13 review organization selected to conduct the external review nor
14 any clinical reviewer assigned by the independent organization
15 to conduct the external review may have a material
16 professional, familial or financial conflict of interest with
17 any of the following:

18 (1) the health carrier that is the subject of the
19 external review;

20 (2) the covered person whose treatment is the subject
21 of the external review or the covered person's authorized
22 representative;

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

25 (4) the health care provider, the health care
26 provider's medical group or independent practice

1 association recommending the health care service or
2 treatment that is the subject of the external review;

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

5 (6) the developer or manufacturer of the principal
6 drug, device, procedure, or other therapy being
7 recommended for the covered person whose treatment is the
8 subject of the external review.

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

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

20 (g) Nothing in this Act precludes or shall be interpreted
21 to preclude a health carrier from contracting with approved
22 independent review organizations to conduct external reviews
23 assigned to it from such health carrier.

24 Section 60. Hold harmless for independent review
25 organizations. No independent review organization or clinical

1 reviewer working on behalf of an independent review
2 organization or an employee, agent or contractor of an
3 independent review organization shall be liable for damages to
4 any person for any opinions rendered or acts or omissions
5 performed within the scope of the organization's or person's
6 duties under the law during or upon completion of an external
7 review conducted pursuant to this Act, unless the opinion was
8 rendered or act or omission performed in bad faith or involved
9 gross negligence.

10 Section 65. External review reporting requirements.

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

15 (b) The report shall include in the aggregate:

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (C) denial of referral request (dissatisfaction
2 regarding non-authorization of a request for a
3 referral to another provider recommended by a PCP);

4 (D) claims and utilization review (dissatisfaction
5 regarding the concurrent or retrospective evaluation
6 of the coverage, medical necessity, efficiency or
7 appropriateness of health care services or treatment
8 plans; prospective "Denials of care or treatment",
9 "Denials of diagnostic procedures" and "Denials of
10 referral requests" should not be classified in this
11 category, but the appropriate one above);

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

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

20 Section 70. Funding of external review. The health carrier
21 shall be solely responsible for paying the cost of external
22 reviews conducted by independent review organizations.

23 Section 75. Disclosure requirements.

24 (a) Each health carrier shall include a description of the

1 external review procedures in, or attached to, the policy,
2 certificate, membership booklet, and outline of coverage or
3 other evidence of coverage it provides to covered persons.

4 (b) The description required under subsection (a) of this
5 Section shall include a statement that informs the covered
6 person of the right of the covered person to file a request for
7 an external review of an adverse determination or final adverse
8 determination with the health carrier. The statement shall
9 explain that external review is available when the adverse
10 determination or final adverse determination involves an issue
11 of medical necessity, appropriateness, health care setting,
12 level of care, or effectiveness. The statement shall include
13 the toll-free telephone number and address of the Office of
14 Consumer Health Insurance within the Department of Insurance.

15 Section 90. The Illinois Insurance Code is amended by
16 changing Section 155.36 and by adding Sections 359b and 359c as
17 follows:

18 (215 ILCS 5/155.36)

19 Sec. 155.36. Managed Care Reform and Patient Rights Act.
20 Insurance companies that transact the kinds of insurance
21 authorized under Class 1(b) or Class 2(a) of Section 4 of this
22 Code shall comply with Sections 45 and ~~Section~~ 85 and the
23 definition of the term "emergency medical condition" in Section
24 10 of the Managed Care Reform and Patient Rights Act.

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

2 (215 ILCS 5/359b new)

3 Sec. 359b. Committee to create a uniform small employer
4 group-health status questionnaire and individual health
5 statement.

6 (a) For the purposes of this Section:

7 "Employee health-status questionnaire" means a
8 questionnaire that poses questions about an individual
9 employee's or covered dependent's health history and that is to
10 be completed by the individual employee or covered dependent of
11 a small employer that seeks health insurance coverage from a
12 small employer carrier.

13 "Health benefit plan", "small employer", and "small
14 employer carrier" shall have the meaning given the terms in the
15 Small Employer Health Insurance Rating Act.

16 "Individual health insurance coverage" and "individual
17 market" shall have the meaning given the terms in the Illinois
18 Health Insurance Portability and Accountability Act.

19 (b) A committee is established in the Department consisting
20 of 11 members, including the Director or the Director's
21 designee, who are appointed by the Director. The Director shall
22 appoint to the committee 5 representatives as recommended by
23 the Illinois Insurance Association, Illinois Life Insurance
24 Council, Professional Independent Insurance Agents of
25 Illinois, Illinois Association of Health Underwriters,

1 Illinois Chamber of Commerce, Illinois Manufacturers
2 Association, Illinois Retail Merchants Association, and
3 National Federation of Independent Businesses and 5 consumer
4 representatives. The Director or the Director's designee shall
5 serve as chairperson of the committee.

6 (c) The committee shall develop a uniform employee
7 health-status questionnaire to simplify the health insurance
8 application process for small employers. The committee shall
9 study employee-health status questionnaires currently used by
10 major small employer carriers in this State and consolidate the
11 questionnaires into a uniform questionnaire. The questionnaire
12 shall be designed to permit its use both as a written document
13 and through electronic or other alternative delivery formats.

14 A uniform employee health-status questionnaire shall allow
15 small employers that are required to provide information
16 regarding their employees to a small employer carrier when
17 applying for a small employer group health insurance policy to
18 use a standardized questionnaire that small employer carriers
19 shall be required to use. The development of the uniform
20 employee health-status questionnaire is intended to relieve
21 small employers of the burden of completing separate
22 application forms for each small employer carrier with which
23 the employer applies for insurance or from which the employer
24 seeks information regarding such matters as rates, coverage,
25 and availability. The use of the uniform employee health-status
26 questionnaire by small employer carriers and small employers

1 shall be mandatory.

2 (d) On or before July 1, 2010, the committee shall develop
3 the uniform employee health-status questionnaire for adoption
4 by the Department. Beginning January 1, 2011, a small employer
5 carrier shall use the questionnaire for all small employer
6 groups for which it requires employees and their covered
7 dependents to complete questionnaires.

8 (e) The Director, as needed, may reconvene the committee to
9 consider whether changes are necessary to the uniform employee
10 health status questionnaire. If the committee determines that
11 changes to the questionnaire are necessary, then the Director
12 may adopt revisions to the questionnaire as recommended by the
13 committee. Small employer carriers shall use the revised
14 questionnaire beginning 90 days after the Director adopts any
15 revision.

16 (f) Nothing in this Section shall be construed to limit or
17 restrict a small employer carrier's ability to appropriately
18 rate risk under a small employer health benefit plan.

19 (g) On or before July 1, 2010, the committee shall develop
20 a standard individual market health statement to simplify the
21 health insurance application process for individuals. The
22 committee shall study health statements currently used by major
23 carriers in this State who offer individual health insurance
24 coverage and consolidate the statements into a standard
25 individual market health statement. The standard individual
26 market health statement shall be designed to permit its use

1 both as a written document and through electronic or other
2 alternative delivery formats. For purposes of the individual
3 market health statement, the Director may, but shall not be
4 required to, establish a committee distinct from that formed to
5 develop an application for small employers. In that event, the
6 composition of the committee shall be as prescribed in
7 subsection (b) of this Section, although individual
8 participants may change.

9 (h) Beginning January 1, 2011, all carriers who offer
10 individual health insurance coverage and evaluate the health
11 status of individuals shall use the standard individual market
12 health statement.

13 (i) The Director, as needed, may reconvene the committee to
14 consider whether changes are necessary to the standard
15 individual market health statement. If the committee
16 determines that changes to the statement are necessary, the
17 Director may adopt revisions to the statement as recommended by
18 the committee. All carriers who offer individual health
19 insurance coverage shall use the revised statement beginning 90
20 days after the Director adopts any revision.

21 (j) Nothing in this Section shall prevent a carrier from
22 using health information after enrollment for the purpose of
23 providing services or arranging for the provision of services
24 under a health benefit plan or a policy of individual health
25 insurance coverage.

26 (k) Nothing in this Section shall be construed to limit or

1 restrict a health carrier's ability to appropriately rate risk,
2 refuse to issue or renew coverage, or otherwise rescind,
3 terminate, or restrict coverage under a health benefit plan or
4 a policy of individual health insurance coverage or conduct
5 further review of the information submitted on the statement by
6 contacting an individual, the individual's health care
7 provider, or any other entity for additional health status
8 related information.

9 (1) Committee members are not eligible for compensation but
10 may receive reimbursement of expenses.

11 (215 ILCS 5/359c new)

12 Sec. 359c. Accident and health expense reporting.

13 (a) Beginning January 1, 2011 and every 6 months
14 thereafter, any carrier providing a group or individual major
15 medical policy of accident or health insurance shall prepare
16 and provide to the Department of Insurance a statement of the
17 aggregate administrative expenses of the carrier, based on the
18 premiums earned in the immediately preceding 6-month period on
19 the accident or health insurance business of the carrier. The
20 semi-annual statements shall be filed on or before July 31 for
21 the preceding 6-month period ending June 30 and on or before
22 February 1 for the preceding 6-month period ending December 31.
23 The statements shall itemize and separately detail all of the
24 following information with respect to the carrier's accident or
25 health insurance business:

1 (1) the amount of premiums earned by the carrier both
2 before and after any costs related to the carrier's
3 purchase of reinsurance coverage;

4 (2) the total amount of claims for losses paid by the
5 carrier both before and after any reimbursement from
6 reinsurance coverage including any costs incurred related
7 to:

8 (A) disease, case, or chronic care management
9 programs;

10 (B) wellness and health education programs;

11 (C) fraud prevention;

12 (D) maintaining provider networks and provider
13 credentialing;

14 (E) health information technology for personal
15 electronic health records; and

16 (F) utilization review and utilization management;

17 (3) the amount of any losses incurred by the carrier
18 but not reported to the carrier in the current or prior
19 reporting period;

20 (4) the amount of costs incurred by the carrier for
21 State fees and federal and State taxes including:

22 (A) any high risk pool and guaranty fund
23 assessments levied on the carrier by the State; and

24 (B) any regulatory compliance costs including
25 State fees for form and rate filings, licensures,
26 market conduct exams, and financial reports;

1 (5) the amount of costs incurred by the carrier for
2 reinsurance coverage;

3 (6) the amount of costs incurred by the carrier that
4 are related to the carrier's payment of marketing expenses
5 including commissions; and

6 (7) any other administrative expenses incurred by the
7 carrier.

8 (b) The information provided pursuant to subsection (a) of
9 this Section shall be separately aggregated for the following
10 lines of major medical insurance:

11 (1) individually underwritten;

12 (2) groups of 2 to 25 members;

13 (3) groups of 26 to 50 members;

14 (4) groups of 51 or more members.

15 (c) The Department shall make the submitted information
16 publicly available on the Department's website or such other
17 media as appropriate in a form useful for consumers.

18 Section 95. The Managed Care Reform and Patient Rights Act
19 is amended by changing Sections 40 and 45 as follows:

20 (215 ILCS 134/40)

21 Sec. 40. Access to specialists.

22 (a) All health care plans that require each enrollee to
23 select a health care provider for any purpose including
24 coordination of care shall permit an enrollee to choose any

1 available primary care physician licensed to practice medicine
2 in all its branches participating in the health care plan for
3 that purpose. The health care plan shall provide the enrollee
4 with a choice of licensed health care providers who are
5 accessible and qualified. Nothing in this Act shall be
6 construed to prohibit a health care plan from requiring a
7 health care provider to meet the health care plan's criteria in
8 order to coordinate access to health care.

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

24 (c) The enrollee may be required by the health care plan to
25 select a specialist physician or other health care provider who
26 has a referral arrangement with the enrollee's primary care

1 physician or to select a new primary care physician who has a
2 referral arrangement with the specialist physician or other
3 health care provider chosen by the enrollee. If a health care
4 plan requires an enrollee to select a new physician under this
5 subsection, the health care plan must provide the enrollee with
6 both options provided in this subsection. When a participating
7 specialist with a referral arrangement is not available, the
8 primary care physician, in consultation with the enrollee,
9 shall arrange for the enrollee to have access to a qualified
10 participating health care provider, and the enrollee shall be
11 allowed to stay with his or her primary care physician. If a
12 secondary referral is necessary, the specialist physician or
13 other health care provider shall advise the primary care
14 physician. The primary care physician shall be responsible for
15 making the secondary referral. In addition, the health care
16 plan shall require the specialist physician or other health
17 care provider to provide regular updates to the enrollee's
18 primary care physician.

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

1 physician shall notify the plan when a referral is made outside
2 the network.

3 (e) The enrollee's primary care physician shall remain
4 responsible for coordinating the care of an enrollee who has
5 received a standing referral to a specialist physician or other
6 health care provider. If a secondary referral is necessary, the
7 specialist physician or other health care provider shall advise
8 the primary care physician. The primary care physician shall be
9 responsible for making the secondary referral. In addition, the
10 health care plan shall require the specialist physician or
11 other health care provider to provide regular updates to the
12 enrollee's primary care physician.

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

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

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

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

2 (215 ILCS 134/45)

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

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

13 (b) When an appeal concerns a decision or action by a
14 health care plan, its employees, or its subcontractors that
15 relates to (i) health care services, including, but not limited
16 to, procedures or treatments, for an enrollee with an ongoing
17 course of treatment ordered by a health care provider, the
18 denial of which could significantly increase the risk to an
19 enrollee's health, or (ii) a treatment referral, service,
20 procedure, or other health care service, the denial of which
21 could significantly increase the risk to an enrollee's health,
22 the health care plan must allow for the filing of an appeal
23 either orally or in writing. Upon submission of the appeal, a
24 health care plan must notify the party filing the appeal, as
25 soon as possible, but in no event more than 24 hours after the

1 submission of the appeal, of all information that the plan
2 requires to evaluate the appeal. The health care plan shall
3 render a decision on the appeal within 24 hours after receipt
4 of the required information. The health care plan shall notify
5 the party filing the appeal and the enrollee, enrollee's
6 primary care physician, and any health care provider who
7 recommended the health care service involved in the appeal of
8 its decision orally followed-up by a written notice of the
9 determination.

10 (c) For all appeals related to health care services
11 including, but not limited to, procedures or treatments for an
12 enrollee and not covered by subsection (b) above, the health
13 care plan shall establish a procedure for the filing of such
14 appeals. Upon submission of an appeal under this subsection, a
15 health care plan must notify the party filing an appeal, within
16 3 business days, of all information that the plan requires to
17 evaluate the appeal. The health care plan shall render a
18 decision on the appeal within 15 business days after receipt of
19 the required information. The health care plan shall notify the
20 party filing the appeal, the enrollee, the enrollee's primary
21 care physician, and any health care provider who recommended
22 the health care service involved in the appeal orally of its
23 decision followed-up by a written notice of the determination.

24 (d) An appeal under subsection (b) or (c) may be filed by
25 the enrollee, the enrollee's designee or guardian, the
26 enrollee's primary care physician, or the enrollee's health

1 care provider. A health care plan shall designate a clinical
2 peer to review appeals, because these appeals pertain to
3 medical or clinical matters and such an appeal must be reviewed
4 by an appropriate health care professional. No one reviewing an
5 appeal may have had any involvement in the initial
6 determination that is the subject of the appeal. The written
7 notice of determination required under subsections (b) and (c)
8 shall include (i) clear and detailed reasons for the
9 determination, (ii) the medical or clinical criteria for the
10 determination, which shall be based upon sound clinical
11 evidence and reviewed on a periodic basis, and (iii) in the
12 case of an adverse determination, the procedures for requesting
13 an external independent review as provided by the Illinois
14 Health Carrier External Review Act ~~under subsection (f)~~.

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

24 (f) Until July 1, 2013, if an external independent review
25 decision made pursuant to the Illinois Health Carrier External
26 Review Act upholds a determination adverse to the covered

1 person, the covered person has the right to appeal the final
2 decision to the Department; if the external review decision is
3 found by the Director to have been arbitrary and capricious,
4 then the Director, with consultation from a licensed medical
5 professional, may overturn the external review decision and
6 require the health carrier to pay for the health care service
7 or treatment; such decision, if any, shall be made solely on
8 the legal or medical merits of the claim. If an external review
9 decision is overturned by the Director pursuant to this Section
10 and the health carrier so requests, then the Director shall
11 assign a new independent review organization to reconsider the
12 overturned decision. The new independent review organization
13 shall follow subsection (d) of Section 40 of the Health Carrier
14 External Review Act in rendering a decision. ~~External~~
15 ~~independent review.~~

16 ~~(1) The party seeking an external independent review~~
17 ~~shall so notify the health care plan. The health care plan~~
18 ~~shall seek to resolve all external independent reviews in~~
19 ~~the most expeditious manner and shall make a determination~~
20 ~~and provide notice of the determination no more than 24~~
21 ~~hours after the receipt of all necessary information when a~~
22 ~~delay would significantly increase the risk to an~~
23 ~~enrollee's health or when extended health care services for~~
24 ~~an enrollee undergoing a course of treatment prescribed by~~
25 ~~a health care provider are at issue.~~

26 ~~(2) Within 30 days after the enrollee receives written~~

1 ~~notice of an adverse determination, if the enrollee decides~~
2 ~~to initiate an external independent review, the enrollee~~
3 ~~shall send to the health care plan a written request for an~~
4 ~~external independent review, including any information or~~
5 ~~documentation to support the enrollee's request for the~~
6 ~~covered service or claim for a covered service.~~

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

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

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

20 ~~(4) Within 5 days after receipt of all necessary~~
21 ~~information, the independent reviewer shall evaluate and~~
22 ~~analyze the case and render a decision that is based on~~
23 ~~whether or not the health care service or claim for the~~
24 ~~health care service is medically appropriate. The decision~~
25 ~~by the independent reviewer is final. If the external~~
26 ~~independent reviewer determines the health care service to~~

1 ~~be medically appropriate, the health care plan shall pay~~
2 ~~for the health care service.~~

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

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

13 (g) ~~(7)~~ Future contractual or employment action by the
14 health care plan regarding the patient's physician or other
15 health care provider shall not be based solely on the
16 physician's or other health care provider's participation
17 in health care services appeals, complaints, or external
18 independent reviews under the Illinois Health Carrier
19 External Review Act ~~this procedure.~~

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

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

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

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

1 (h) ~~(g)~~ Nothing in this Section shall be construed to
2 require a health care plan to pay for a health care service not
3 covered under the enrollee's certificate of coverage or policy.
4 (Source: P.A. 91-617, eff. 1-1-00.)

5 Section 96. No acceleration or delay. Where this Act makes
6 changes in a statute that is represented in this Act by text
7 that is not yet or no longer in effect (for example, a Section
8 represented by multiple versions), the use of that text does
9 not accelerate or delay the taking effect of (i) the changes
10 made by this Act or (ii) provisions derived from any other
11 Public Act.

12 Section 97. Severability. The provisions of this Act are
13 severable under Section 1.31 of the Statute on Statutes.

14 Section 99. Effective date. This Act takes effect January
15 1, 2010, except that the changes to Section 155.36 of the
16 Illinois Insurance Code and Sections 40 and 45 of the Managed
17 Care Reform and Patient Rights Act and the Health Carrier
18 External Review Act take effect July 1, 2010.