Sen. William R. Haine

Filed: 5/18/2009

1 AMENDMENT TO HOUSE BILL 3923

2 AMENDMENT NO. ______. Amend House Bill 3923 by replacing
3 everything after the enacting clause with the following:

4 "Section 1. Short title. This Act may be cited as the
5 Health 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

1 health care service that is a covered benefit has been reviewed
2 and, based upon the information provided, does not meet the
3 health carrier's requirements for medical necessity,
4 appropriateness, health care setting, level of care, or
5 effectiveness, and the requested service or payment for the
6 service is therefore denied, reduced, or terminated.
7 "Authorized representative" means:
8 (1) a person to whom a covered person has given express
9 written consent to represent the covered person in an
10 external review;
11 (2) a person authorized by law to provide substituted
12 consent for a covered person; or
13 (3) the covered person's health care provider only when
14 the covered person is unable to provide consent.
15 "Best evidence" means evidence based on:
16 (1) randomized clinical trials;
17 (2) if randomized clinical trials are not available,
18 then cohort studies or case-control studies;
19 (3) if items (1) and (2) are not available, then
20 case-series; or
21 (4) if items (1), (2), and (3) are not available, then
22 expert opinion.
23 "Case-series" means an evaluation of a series of patients
24 with a particular outcome, without the use of a control group.
25 "Clinical review criteria" means the written screening
26 procedures, decision abstracts, clinical protocols, and

1 practice guidelines used by a health carrier to determine the
2 necessity and appropriateness of health care services.
3 "Cohort study" means a prospective evaluation of 2 groups
4 of patients with only one group of patients receiving specific
5 intervention.
6 "Covered benefits" or "benefits" means those health care
7 services to which a covered person is entitled under the terms
8 of a health benefit plan.
9 "Covered person" means a policyholder, subscriber,
10 enrollee, or other individual participating in a health benefit
11 plan.
12 "Director" means the Director of the Division of Insurance
13 within the Illinois Department of Financial and Professional
14 Regulation.
15 "Emergency medical condition" means the sudden onset of a
16 health condition or illness that requires immediate medical
17 attention, where failure to provide medical attention would
18 result in a serious impairment to bodily functions, serious
19 dysfunction of a bodily organ or part, or would place the
20 person's health in serious jeopardy.
21 "Emergency services" means health care items and services
22 furnished or required to evaluate and treat an emergency
23 medical condition.
24 "Evidence-based standard" means the conscientious,
25 explicit, and judicious use of the current best evidence based
26 on an overall systematic review of the research in making

1 decisions about the care of individual patients.

2 "Expert opinion" means a belief or an interpretation by
3 specialists with experience in a specific area about the
4 scientific evidence pertaining to a particular service,
5 intervention, or therapy.

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

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

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

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

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

26 "Health carrier" means an entity subject to the insurance

1 laws and regulations of this State, or subject to the
2 jurisdiction of the Director, that contracts or offers to
3 contract to provide, deliver, arrange for, pay for, or
4 reimburse any of the costs of health care services, including a
5 sickness and accident insurance company, a health maintenance
6 organization, a nonprofit hospital and health service
7 corporation, or any other entity providing a plan of health
8 insurance, health benefits, or health care services. "Health
9 carrier" also means Limited Health Service Organizations
10 (LHSO) and Voluntary Health Service Plans.
11 "Health information" means information or data, whether
12 oral or recorded in any form or medium, and personal facts or
13 information about events or relationships that relate to:
14 (1) the past, present, or future physical, mental, or
15 behavioral health or condition of an individual or a member
16 of the individual's family;
17 (2) the provision of health care services to an
18 individual; or
19 (3) payment for the provision of health care services
20 to an individual.
21 "Independent review organization" means an entity that
22 conducts independent external reviews of adverse
23 determinations and final adverse determinations.
24 "Medical or scientific evidence" means evidence found in
25 the following sources:
26 (1) peer-reviewed scientific studies published in or

1 accepted for publication by medical journals that meet
2 nationally recognized requirements for scientific
3 manuscripts and that submit most of their published
4 articles for review by experts who are not part of the
5 editorial staff;
6 (2) peer-reviewed medical literature, including
7 literature relating to therapies reviewed and approved by a
8 qualified institutional review board, biomedical
9 compendia, and other medical literature that meet the
10 criteria of the National Institutes of Health's Library of
11 Medicine for indexing in Index Medicus (Medline) and
12 Elsevier Science Ltd. for indexing in Excerpta Medicus
13 (EMBASE);
14 (3) medical journals recognized by the Secretary of
15 Health and Human Services under Section 1861(t)(2) of the
16 federal Social Security Act;
17 (4) the following standard reference compendia:
18 (a) The American Hospital Formulary Service-Drug
19 Information;
20 (b) Drug Facts and Comparisons;
21 (c) The American Dental Association Accepted
22 Dental Therapeutics; and
23 (d) The United States Pharmacopoeia-Drug
24 Information;
25 (5) findings, studies, or research conducted by or
26 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 (i) that identifies an individual who is the subject of the information; or (ii) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

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

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

1 "Utilization review organization" means a utilization
2 review program as defined in the Managed Care Reform and
3 Patient Rights Act.

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

23 Section 20. Notice of right to external review.
24 (a) At the same time the health carrier sends written

notice of a covered person's right to appeal a coverage decision upon an adverse determination or a final adverse determination 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 Act. 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.".

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

(1) If the covered person has a medical condition where

1 the timeframe for completion of (A) an expedited internal
2 review of a grievance involving an adverse determination,
3 (B) a final adverse determination as set forth in the
4 Managed Care Reform and Patient Rights Act, or (C) a
5 standard external review as established in this Act, would
6 seriously jeopardize the life or health of the covered
7 person or would jeopardize the covered person's ability to
8 regain maximum function, then the covered person or the
9 covered person's authorized representative may file a
10 request for an expedited external review.

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

1 whether the covered person shall be required to complete
2 the expedited review of the grievance prior to conducting
3 the expedited external review.
4 (3) If an adverse determination concerns a denial of
5 coverage based on a determination that the recommended or
6 requested health care service or treatment is experimental
7 or investigational and the covered person's health care
8 provider certifies in writing that the recommended or
9 requested health care service or treatment that is the
10 subject of the request would be significantly less
11 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 (c) This subsection (c) shall apply to an expedited review
15 upon final adverse determination. In addition to the notice
16 required in subsection (a), the health carrier shall include a
17 notice related to a final adverse determination, a statement
18 informing the covered person all of the following:
19 (1) if the covered person has a medical condition where
20 the timeframe for completion of a standard external review
21 would seriously jeopardize the life or health of the
22 covered person or would jeopardize the covered person's
23 ability to regain maximum function, then the covered person
24 or the covered person's authorized representative may file
25 a request for an expedited external review; or
26 (2) if a final adverse determination concerns an

1 admission, availability of care, continued stay, or health
2 care service for which the covered person received
3 emergency services, but has not been discharged from a
4 facility, then the covered person, or the covered person's
5 authorized representative, may request an expedited
6 external review; or
7 (3) if a final adverse determination concerns a denial
8 of coverage based on a determination that the recommended
9 or requested health care service or treatment is
10 experimental or investigational, and the covered person's
11 health care provider certifies in writing that the
12 recommended or requested health care service or treatment
13 that is the subject of the request would be significantly
14 less effective if not promptly initiated, then the covered
15 person or the covered person's authorized representative
16 may request an expedited external review.
17 (d) In addition to the information to be provided pursuant
18 to subsections (a), (b), and (c) of this Section, the health
19 carrier shall include a copy of the description of both the
20 required standard and expedited external review procedures.
21 The description shall highlight the external review procedures
22 that give the covered person or the covered person's authorized
23 representative the opportunity to submit additional
24 information, including any forms used to process an external
25 review.

1 Section 25. Request for external review. A covered person
2 or the covered person's authorized representative may make a
3 request for a standard external or expedited external review of
4 an adverse determination or final adverse determination.
5 Requests under this Section shall be made directly to the
6 health carrier that made the adverse or final adverse
7 determination. All requests for external review shall be in
8 writing except for requests for expedited external reviews
9 which may me made orally. Health carriers must provide covered
10 persons with forms to request external reviews.

11 Section 30. Exhaustion of internal grievance process.
12 Except as provided in subsection (b) of Section 20, a
13 request for an external review shall not be made until the
14 covered person has exhausted the health carrier's internal
15 grievance process as set forth in the Managed Care Reform and
16 Patient Rights Act. A covered person shall also be considered
17 to have exhausted the health carrier's internal grievance
18 process for purposes of this section if:
19 (1) the covered person or the covered person's
20 authorized representative filed a request for an internal
21 review of an adverse determination pursuant to the Managed
22 Care Reform and Patient Rights Act and has not received a
23 written decision on the request from the health carrier
24 within 30 days, 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

required by Sections 50 and 55 of this Act.

(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; in such cases, the following provisions shall apply:

(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 and, if applicable, the covered 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:

(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;

(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; or

(C) 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.

(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

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 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:

(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;

(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; and

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

(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 or appeals process.

(4) 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.

Section 40. 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

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 less than 24 hours after assigning the
25 independent review organization, the health carrier or its
26 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 timeframe, 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 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 information as required by subsection (i) of Section 35 of this Act in reaching a decision.

(d) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than 72 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; and

(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.

(e) 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.

(f) 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.

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

1 (h) 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

independent review organization and 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) for adverse determinations involving experimental or investigational treatments, 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 Act;

(2) a toll-free telephone service operating on a 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

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

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

(6) 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 this Act.

(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.

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

Section 60. 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 for 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 Act, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

Section 65. 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;

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);

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

(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" should 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.

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

Section 75. 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.

Section 90. The Illinois Insurance Code is amended by changing Sections 155.36 and 370c and by adding Sections 359b, 359c, and 359d 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.

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 or covered dependent's health history and that is
10 to be completed by the individual employee or covered
11 dependent of a small employer that seeks health insurance
12 coverage from a small employer carrier.
13 "Health benefit plan", "small employer", and "small
14 employer carrier" shall have the meaning given those terms
15 in the Small Employer Health Insurance Rating Act.
16 "Individual market" shall have the meaning given the
17 term in the Illinois Health Insurance Portability and
18 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 2 representatives each from the
23 Illinois Insurance Association and the Illinois Life Insurance
24 Council, one representative each from the Professional
25 Independent Insurance Agents of Illinois and the Illinois

1 Association of Health Underwriters, and one representative
2 each from the Illinois Chamber of Commerce, Illinois
3 Manufacturers Association, Illinois Retail Merchants
4 Association, and National Federation of Independent
5 Businesses. The Director or the Director's designee shall serve
6 as chairperson of the committee.
7 (c) The committee shall develop a uniform employee
8 health-status questionnaire to simplify the health insurance
9 application process for small employers. The committee shall
10 study employee health status questionnaires currently used by
11 major small employer carriers in this State and consolidate the
12 questionnaires into a uniform questionnaire. The questionnaire
13 shall be designed to permit its use both as a written document
14 and through electronic or other alternative delivery formats.
15 A uniform employee health-status questionnaire shall allow
16 small employers that are required to provide information
17 regarding their employees to a small employer carrier when
18 applying for a small employer group health insurance policy to
19 use a standardized questionnaire that small employer carriers
20 may elect to accept. The development of the uniform employee
21 health-status questionnaire is intended to relieve small
22 employers of the burden of completing separate application
23 forms for each small employer carrier with which the employer
24 applies for insurance or from which the employer seeks
25 information regarding such matters as rates, coverage, and
26 availability. The use of the uniform employee health-status

questionnaire by small employer carriers and small employers shall be voluntary.

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

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

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

(g) The committee shall develop a standard individual market health statement to simplify the health insurance application process for individuals. The committee shall study health statements currently used by major carriers in this State who offer health benefit plans in the individual market and consolidate the statements into a standard individual market health statement. The standard individual market health

1 statement shall be designed to permit its use both as a written
2 document and through electronic or other alternative delivery
3 formats.
4 (h) All carriers who offer health benefit plans in the
5 individual market and evaluate the health status of individuals
6 may use the standard individual market health statement on a
7 voluntary basis not less than 6 months after the statement
8 becomes effective.
9 (i) The Director, as needed, may reconvene the committee to
10 consider whether changes are necessary to the standard
11 individual market health statement. If the committee
12 determines that changes to the statement are necessary, the
13 Director may adopt revisions to the statement as recommended by
14 the committee. Individual market carriers may use the revised
15 statement beginning 90 days after the Director adopts any
16 revision.
17 (j) Nothing in this Section shall prevent a carrier from
18 using health information after enrollment for the purpose of
19 providing services or arranging for the provision of services
20 under a health benefit plan.
21 (k) Nothing in this Section shall be construed to limit or
22 restrict a health carrier's ability to appropriately rate risk,
23 refuse to issue or renew coverage, or otherwise rescind,
24 terminate, restrict coverage under a policy of accident and
25 health insurance or managed care plan, or conduct further
26 review of the information submitted on the statement by

1 contacting an individual, the individual's health care
2 provider, or other entity for additional health status related
3 information.
4 (l) Committee members serve at the pleasure of the Director
5 and are not eligible to receive compensation or reimbursement
6 of expenses.

7 (215 ILCS 5/359c new)
8 Sec. 359c. Accident and health expense reporting. An
9 insurer or managed care plan providing group or individual
10 major medical policy of accident or health insurance shall,
11 beginning on the first day of January or within 60 days
12 thereafter, annually prepare and provide to the Department of
13 Insurance a statement of the aggregate administrative expenses
14 of the insurer or managed care plan, based on the premiums
15 earned in the immediately preceding calendar year on the
16 accident or health insurance business of the insurer or managed
17 care plan. The statement shall itemize and separately detail
18 all of the following information with respect to the insurer's
19 or managed care plan's accident or health insurance business:
20 (1) the amount of premiums earned by the insurer or
21 managed care plan both before and after any costs related
22 to the insurer's purchase of reinsurance coverage;
23 (2) the total amount of claims for losses paid by the
24 insurer or managed care plan both before and after any
25 reimbursement from reinsurance coverage including any

1 costs incurred related to:
2 (A) disease, case, or chronic care management
3 programs;
4 (B) wellness and health education programs;
5 (C) fraud prevention;
6 (D) maintaining provider networks and provider
7 credentialing;
8 (E) health information technology for personal
9 electronic health records; and
10 (F) utilization review and utilization management;
11 (3) the amount of any losses incurred by the insurer or
12 managed care plan but not reported to the insurer or
13 managed care plan in the current or prior year;
14 (4) the amount of costs incurred by the insurer or
15 managed care plan for State fees and federal and State
16 taxes including:
17 (A) any high risk pool and guaranty fund
18 assessments levied on the insurer or managed care plan
19 by the State; and
20 (B) any regulatory compliance costs including
21 State fees for form and rate filings, licensures,
22 market conduct exams, and financial reports;
23 (5) the amount of costs incurred by the insurer or
24 managed care plan for reinsurance coverage;
25 (6) the amount of costs incurred by the insurer that
26 are related to the insurer's payment of marketing expenses

1 including commissions; and
2 (7) any other administrative expenses incurred by the
3 insurer.

4 (215 ILCS 5/359d new)
5 Sec. 359d. State-mandated health benefits; actuarial cost
6 analysis; moratorium on additional mandates.
7 (a) For purposes of this Section:
8 "Actuarial cost analysis" means an analysis conducted
9 by the Department of Insurance of the costs associated with
10 the State-mandated health benefit, including, but not
11 limited to, the actual premium cost of the specific mandate
12 and the effect of the mandate on insurance premiums charged
13 to the citizens of this State.
14 "State-mandated health benefits" means coverage
15 required under the laws of this State to be provided in a
16 group major medical policy for accident and health
17 insurance or a contract for a health-related condition
18 that: (i) includes coverage for specific health care
19 services or benefits; (ii) places limitations or
20 restrictions on deductibles, coinsurance, co-payments, or
21 any annual or lifetime maximum benefit amounts; or (iii)
22 includes coverage for a specific category of licensed
23 health practitioner from whom an insured is entitled to
24 receive care. State-mandated health benefits shall not
25 include any federally mandated benefit or mandated option.

(b) Any State-mandated health benefit introduced into the General Assembly after January 1, 2010, shall undergo an actuarial cost analysis, the results of which shall be reported to the House and Senate Committees on Insurance prior to any State-mandated health benefit legislation being considered by either the House or Senate.

(c) Notwithstanding any other provision of law to the contrary, a health insurance issuer shall not be required to deliver, issue, or renew a health benefit plan on or after January 1, 2010, and before December 31, 2013, that includes any additional State-mandated health benefit or mandated option beyond those statutory requirements in effect for health benefit plans on July 1, 2009. This subsection (c) shall apply to any health benefit plan delivered or issued for delivery in this State, including any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare plan, health and accident insurance policy, or any policy of group, family group, blanket, or franchise health and accident insurance, health maintenance organization, or preferred provider organization.

Nothing in this subsection (c) shall be construed to prohibit an employer from electing to expand coverage on any group or individual health benefit plan or policy covering the employer and the employees of the employer.

Nothing in this subsection (c) shall be construed to prohibit a health insurance issuer from electing to expand

1 coverage on any group or individual health benefit plan.
2 (d) Nothing in this Section shall be construed to allow a
3 health benefit plan policy delivered, issued, or renewed after
4 January 1, 2010, to suspend, limit, or modify any mandates in
5 effect prior to July 1, 2009.

6 (215 ILCS 5/370c) (from Ch. 73, par. 982c)
7 (Text of Section before amendment by P.A. 95-1049)
8 Sec. 370c. Mental and emotional disorders.
9 (a) (1) On and after the effective date of this Section,
10 every insurer which delivers, issues for delivery or renews or
11 modifies group A&H policies providing coverage for hospital or
12 medical treatment or services for illness on an
13 expense-incurred basis shall offer to the applicant or group
14 policyholder subject to the insurers standards of
15 insurability, coverage for reasonable and necessary treatment
16 and services for mental, emotional or nervous disorders or
17 conditions, other than serious mental illnesses as defined in
18 item (2) of subsection (b), up to the limits provided in the
19 policy for other disorders or conditions, except (i) the
20 insured may be required to pay up to 50% of expenses incurred
21 as a result of the treatment or services, and (ii) the annual
22 benefit limit may be limited to the lesser of $10,000 or 25% of
23 the lifetime policy limit.
24 (2) Each insured that is covered for mental, emotional or
25 nervous disorders or conditions shall be free to select the

1 physician licensed to practice medicine in all its branches,
2 licensed clinical psychologist, licensed clinical social
3 worker, licensed clinical professional counselor, or licensed
4 marriage and family therapist of his choice to treat such
5 disorders, and the insurer shall pay the covered charges of
6 such physician licensed to practice medicine in all its
7 branches, licensed clinical psychologist, licensed clinical
8 social worker, licensed clinical professional counselor, or
9 licensed marriage and family therapist up to the limits of
10 coverage, provided (i) the disorder or condition treated is
11 covered by the policy, and (ii) the physician, licensed
12 psychologist, licensed clinical social worker, licensed
13 clinical professional counselor, or licensed marriage and
14 family therapist is authorized to provide said services under
15 the statutes of this State and in accordance with accepted
16 principles of his profession.

17 (3) Insofar as this Section applies solely to licensed
18 clinical social workers, licensed clinical professional
19 counselors, and licensed marriage and family therapists, those
20 persons who may provide services to individuals shall do so
21 after the licensed clinical social worker, licensed clinical
22 professional counselor, or licensed marriage and family
23 therapist has informed the patient of the desirability of the
24 patient conferring with the patient's primary care physician
25 and the licensed clinical social worker, licensed clinical
26 professional counselor, or licensed marriage and family

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

8 (b) (1) An insurer that provides coverage for hospital or
9 medical expenses under a group policy of accident and health
10 insurance or health care plan amended, delivered, issued, or
11 renewed after the effective date of this amendatory Act of the
12 92nd General Assembly shall provide coverage under the policy
13 for treatment of serious mental illness under the same terms
14 and conditions as coverage for hospital or medical expenses
15 related to other illnesses and diseases. The coverage required
16 under this Section must provide for same durational limits,
17 amount limits, deductibles, and co-insurance requirements for
18 serious mental illness as are provided for other illnesses and
19 diseases. This subsection does not apply to coverage provided
20 to employees by employers who have 50 or fewer employees.

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

25 (A) schizophrenia;

26 (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) A qualifying group health benefit plan, in accordance with the Emergency Economic Stabilization Act of 2008, specifically, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, providing coverage for mental health and substance use disorders benefits, including those mental and emotional disorders required in subsection (a) and (b), must have the same treatment and financial levels as the predominant medical and surgical benefits provided in the benefit plan. Group health benefit plans are not restricted from applying utilization review, medical necessity determinations or other tools to encourage appropriate and effective care. Utilization review, medical necessity determinations or other tools to encourage appropriate and effective care shall be administered for mental

illness in a manner consistent with those for medical and surgical benefits offered in the plan. ~~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

1 medication management and shall cover the outpatient visits
2 under the same terms and conditions as it covers outpatient
3 visits for the treatment of physical illness.
4 (6) An issuer of a group health benefit plan may provide or
5 offer coverage required under this Section through a managed
6 care plan.
7 (7) This Section shall not be interpreted to require a
8 group health benefit plan to provide coverage for treatment of:
9 (A) an addiction to a controlled substance or cannabis
10 that is used in violation of law; or
11 (B) mental illness resulting from the use of a
12 controlled substance or cannabis in violation of law.
13 (8) (Blank).
14 (9) On and after June 1, 2010, coverage for the treatment
15 of mental and emotional disorders as provided by subsections
16 (a) and (b) of this Section shall not be denied under the
17 policy, provided that services are medically necessary as
18 determined by the insurer.
19 (Source: P.A. 94-402, eff. 8-2-05; 94-584, eff. 8-15-05;
20 94-906, eff. 1-1-07; 94-921, eff. 6-26-06; 95-331, eff.
21 8-21-07; 95-972, eff. 9-22-08; 95-973, eff. 1-1-09; revised
22 10-14-08.)

23 (Text of Section after amendment by P.A. 95-1049)
24 Sec. 370c. Mental and emotional disorders.
25 (a) (1) On and after the effective date of this Section,

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

15 (2) Each insured that is covered for mental, emotional or
16 nervous disorders or conditions shall be free to select the
17 physician licensed to practice medicine in all its branches,
18 licensed clinical psychologist, licensed clinical social
19 worker, licensed clinical professional counselor, or licensed
20 marriage and family therapist of his choice to treat such
21 disorders, and the insurer shall pay the covered charges of
22 such physician licensed to practice medicine in all its
23 branches, licensed clinical psychologist, licensed clinical
24 social worker, licensed clinical professional counselor, or
25 licensed marriage and family therapist up to the limits of
26 coverage, provided (i) the disorder or condition treated is

1 covered by the policy, and (ii) the physician, licensed
2 psychologist, licensed clinical social worker, licensed
3 clinical professional counselor, or licensed marriage and
4 family therapist is authorized to provide said services under
5 the statutes of this State and in accordance with accepted
6 principles of his profession.

7 (3) Insofar as this Section applies solely to licensed
8 clinical social workers, licensed clinical professional
9 counselors, and licensed marriage and family therapists, those
10 persons who may provide services to individuals shall do so
11 after the licensed clinical social worker, licensed clinical
12 professional counselor, or licensed marriage and family
13 therapist has informed the patient of the desirability of the
14 patient conferring with the patient's primary care physician
15 and the licensed clinical social worker, licensed clinical
16 professional counselor, or licensed marriage and family
17 therapist has provided written notification to the patient's
18 primary care physician, if any, that services are being
19 provided to the patient. That notification may, however, be
20 waived by the patient on a written form. Those forms shall be
21 retained by the licensed clinical social worker, licensed
22 clinical professional counselor, or licensed marriage and
23 family therapist for a period of not less than 5 years.

24 (b) (1) An insurer that provides coverage for hospital or
25 medical expenses under a group policy of accident and health
26 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) A qualifying group health benefit plan, in accordance with the Emergency Economic Stabilization Act of 2008, specifically, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, providing coverage for mental health and substance use disorders benefits, including those mental and emotional disorders required in subsection (a) and (b), must have the same treatment and financial levels as the predominant medical and surgical benefits provided in the benefit plan. Group health benefit plans are not restricted from applying utilization review, medical necessity determinations or other tools to encourage appropriate and effective care. Utilization review, medical necessity determinations or other tools to encourage appropriate and effective care shall be administered for mental illness in a manner consistent with those for medical and surgical benefits offered in the plan. ~~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 insurer.

(c) This Section shall not be interpreted to require coverage for speech therapy or other habilitative services for those individuals covered under Section 356z.15 ~~356z.14~~ of this Code.

(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; 95-1049, eff. 1-1-10; revised 4-10-09.)

Section 95. The Managed Care Reform and Patient Rights Act is amended by changing Sections 40, 45, and 90 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

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

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

1 (215 ILCS 134/45)
2 Sec. 45. Health care services appeals, complaints, and
3 external independent reviews.
4 (a) A health care plan shall establish and maintain an
5 appeals procedure as outlined in this Act. Compliance with this
6 Act's appeals procedures shall satisfy a health care plan's
7 obligation to provide appeal procedures under any other State
8 law or rules. All appeals of a health care plan's
9 administrative determinations and complaints regarding its
10 administrative decisions shall be handled as required under
11 Section 50.
12 (b) When an appeal concerns a decision or action by a
13 health care plan, its employees, or its subcontractors that
14 relates to (i) health care services, including, but not limited
15 to, procedures or treatments, for an enrollee with an ongoing
16 course of treatment ordered by a health care provider, the
17 denial of which could significantly increase the risk to an
18 enrollee's health, or (ii) a treatment referral, service,
19 procedure, or other health care service, the denial of which
20 could significantly increase the risk to an enrollee's health,
21 the health care plan must allow for the filing of an appeal
22 either orally or in writing. Upon submission of the appeal, a
23 health care plan must notify the party filing the appeal, as
24 soon as possible, but in no event more than 24 hours after the
25 submission of the appeal, of all information that the plan

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

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

23 (d) An appeal under subsection (b) or (c) may be filed by
24 the enrollee, the enrollee's designee or guardian, the
25 enrollee's primary care physician, or the enrollee's health
26 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 Act ~~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 Act ~~under subsection (f) of the adverse determination~~.

(f) (Blank). ~~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~~

1 the most expeditious manner and shall make a determination
2 and provide notice of the determination no more than 24
3 hours after the receipt of all necessary information when a
4 delay would significantly increase the risk to an
5 enrollee's health or when extended health care services for
6 an enrollee undergoing a course of treatment prescribed by
7 a health care provider are at issue.

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

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

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

22 (B) forward to the independent reviewer all
23 medical records and supporting documentation
24 pertaining to the case, a summary description of the
25 applicable issues including a statement of the health
26 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~~

1 ~~independent reviewer shall:~~
2 ~~(A) be a clinical peer;~~
3 ~~(B) have no direct financial interest in~~
4 ~~connection with the case; and~~
5 ~~(C) have not been informed of the specific identity~~
6 ~~of the enrollee.~~
7 ~~(g)~~ Nothing in this Section shall be construed to require a
8 health care plan to pay for a health care service not covered
9 under the enrollee's certificate of coverage or policy.
10 (Source: P.A. 91-617, eff. 1-1-00.)

11 (215 ILCS 134/90)
12 Sec. 90. Office of Consumer Health Insurance.
13 (a) The Director of Insurance shall establish the Office of
14 Consumer Health Insurance within the Department of Insurance to
15 provide assistance and information to all health care consumers
16 within the State. Within the appropriation allocated, the
17 Office shall provide information and assistance to all health
18 care consumers by:
19 (1) assisting consumers in understanding health
20 insurance marketing materials and the coverage provisions
21 of individual plans;
22 (2) educating enrollees about their rights within
23 individual plans;
24 (3) assisting enrollees with the process of filing
25 formal grievances and appeals;

1 (4) establishing and operating a toll-free "800"
2 telephone number line to handle consumer inquiries;
3 (5) making related information available in languages
4 other than English that are spoken as a primary language by
5 a significant portion of the State's population, as
6 determined by the Department;
7 (6) analyzing, commenting on, monitoring, and making
8 publicly available reports on the development and
9 implementation of federal, State, and local laws,
10 regulations, and other governmental policies and actions
11 that pertain to the adequacy of health care plans,
12 facilities, and services in the State;
13 (7) filing an annual report with the Governor, the
14 Director, and the General Assembly, which shall contain
15 recommendations for improvement of the regulation of
16 health insurance plans, including recommendations on
17 improving health care consumer assistance and patterns,
18 abuses, and progress that it has identified from its
19 interaction with health care consumers; and
20 (8) performing all duties assigned to the Office by the
21 Director.
22 (b) The report required under subsection (a)(7) shall be
23 filed by January 31, 2001 and each January 31 thereafter.
24 (c) Nothing in this Section shall be interpreted to
25 authorize access to or disclosure of individual patient or
26 health care professional or provider records.

1 (d) The Office of Consumer Health Insurance shall do all of the
2 following:
3 (1) Develop and implement a health coverage public
4 awareness and education program by:
5 (A) increasing public awareness of health coverage
6 options available in this State;
7 (B) educating the public on the value of health
8 insurance coverage; and
9 (C) providing information on health insurance
10 coverage options, including explanations of
11 deductibles and copayments and the differences between
12 health maintenance organizations, preferred provider
13 organizations, point of service plans, health savings
14 accounts and compatible high deductible health benefit
15 plans, and other forms of health insurance coverage.
16 (2) Provide information, including financial ratings
17 about specific health insurance coverage insurers, but the
18 Office may not favor or endorse one particular insurer over
19 another.
20 (3) Develop and release public service announcements
21 to educate consumers and employers about the types of
22 policies and availability of health coverage in this State,
23 including providing of information as to availability and
24 eligibility for health plans provided by the State.
25 (4) Provide other appropriate education to the public
26 regarding the value of health insurance coverage.

1 (5) Provide information and guidance regarding a
2 consumers rights to an internal and external review process
3 as provided in the Health Carrier External Review Act.
4 (Source: P.A. 91-617, eff. 1-1-00.)

5 Section 95. 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.".