**Sen. Heather Steans**

# Filed: 5/27/2009



AMENDMENT TO HOUSE BILL 3923

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

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

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

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

"Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other

health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

"Authorized representative" means:

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

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

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

"Best evidence" means evidence based on:

(1) randomized clinical trials;

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

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

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

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

"Clinical review criteria" means the written screening

procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

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

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

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

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

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

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

(2) serious impairment to bodily functions; or

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

"Emergency services" means health care items and services

furnished or required to evaluate and treat an emergency medical condition.

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

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

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

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

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

"Health care provider" or "provider" means a physician, hospital facility, or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with State law, responsible for

recommending health care services on behalf of a covered person.

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

"Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, or any other entity providing a plan of health insurance, health benefits, or health care services. "Health carrier" also means Limited Health Service Organizations (LHSO) and Voluntary Health Service Plans.

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

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

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

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

"Independent review organization" means an entity that

conducts independent external reviews of adverse determinations and final adverse determinations.

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

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

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

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

(4) the following standard reference compendia:

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

(b) Drug Facts and Comparisons;

(c) The American Dental Association Accepted

Dental Therapeutics; and

(d) The United States Pharmacopoeia-Drug Information;

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

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

(b) the National Institutes of Health;

(c) the National Cancer Institute;

(d) the National Academy of Sciences;

(e) the Centers for Medicare & Medicaid Services;

(f) the federal Food and Drug Administration; and

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

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

"Protected health information" means health information (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.

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

Section 15. Applicability and scope.

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

(b) The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by Article XIXA of the Illinois Insurance Code, vision care, or any other limited supplemental benefit; a Medicare supplement policy of insurance as defined by the Director by regulation; coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program; any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage; any coverage issued as supplemental to liability insurance, workers' compensation, or similar insurance; automobile medical-payment insurance or any insurance under which benefits are payable

with or without regard to fault, whether written on a group blanket or individual basis.

Section 20. Notice of right to external review.

(a) At the same time the health carrier sends written notice of a covered person's right to appeal a coverage decision 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 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 the timeframe for completion of (A) an expedited internal review of a grievance involving an adverse determination, (B) a final adverse determination as set forth in the Managed Care Reform and Patient Rights Act, or (C) a standard external review as established in this Act, would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, then the covered person or the covered person's authorized representative may file a request for an expedited external review.

(2) The covered person or the covered person's authorized representative may file a request for an expedited external review at the same time the covered person or the covered person's authorized representative files a request for an expedited internal appeal involving an adverse determination as set forth in the Managed Care Reform and Patient Rights Act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's health care provider certifies in writing that the recommended or requested health care service or

treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated. The independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review.

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

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

(1) if the covered person has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's

ability to regain maximum function, then the covered person or the covered person's authorized representative may file a request for an expedited external review; or

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

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

(d) In addition to the information to be provided pursuant to subsections (a), (b), and (c) of this Section, the health carrier shall include a copy of the description of both the required standard and expedited external review procedures. The description shall highlight the external review procedures that give the covered person or the covered person's authorized

representative the opportunity to submit additional information, including any forms used to process an external review.

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

Section 30. Exhaustion of internal grievance process.

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

(1) the covered person or the covered person's authorized representative filed a request for an internal review of an adverse determination pursuant to the Managed

Care Reform and Patient Rights Act and has not received a written decision on the request from the health carrier within 15 days after receipt of the required information but not more than 30 days after the request was filed by the covered person or the covered person's authorized representative, except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay; however, a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination until the covered person has exhausted the health carrier's internal grievance process;

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

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

Section 35. Standard external review.

(a) Within 4 months after the date of receipt of a notice

of an adverse determination or final adverse determination, a covered person or the covered person's authorized representative may file a request for an external review with the health carrier.

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

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

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

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

(4) for appeals relating to a determination based on treatment being experimental or investigational, the requested health care service or treatment that is the subject of the adverse determination or final adverse

determination is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier and that the covered person's health care provider, who is a physician licensed to practice medicine in all its branches, has certified that one of the following situations is applicable:

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

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

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

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

(E) that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more

beneficial to the covered person than any available standard health care services or treatments; and

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

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

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

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

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

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

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

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

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

The health carrier shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may, within 5 business days following the date of receipt of the notice provided pursuant to item (2) of this subsection (d), submit in writing to the assigned independent review organization additional information that the independent review organization shall consider when conducting the external

review. The independent review organization is not required to, but may, accept and consider additional information submitted after 5 business days.

(e) The assignment of an approved independent review organization to conduct an external review in accordance with this Section shall be made from those approved independent 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 reverse the adverse determination.

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

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

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

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination shall

not delay or terminate the external review.

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

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

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

(i) In addition to the documents and information provided by the health carrier or its utilization review organization and the covered person and the covered person's authorized representative, if any, the independent review organization, to the extent the information or documents are available and the independent review organization considers them

appropriate, shall consider the following in reaching a decision:

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

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

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

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

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

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

(7) the opinion of the independent review organization's clinical reviewer or reviewers after considering items (1) through (6) of this subsection (i) to

the extent the information or documents are available and the clinical reviewer or reviewers considers the information or documents appropriate; and

(8) for a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether and 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 and, if applicable, the covered person's authorized representative. In reaching a decision, the assigned independent review organization is not bound by any claim determinations reached prior to the submission of information the independent review organization. In such cases, the following provisions shall apply:

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

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

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

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

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

(E) the date of its decision; and

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

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

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

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

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

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

(E) whether the recommended or requested health care service or treatment has been approved by the

federal Food and Drug Administration, for the condition;

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

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

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

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

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

(2) The notice of initial determination shall include a

statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the Director.

(3) The Director may determine that a request is eligible for expedited external review notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

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

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

(1) The assignment of an approved independent review organization to conduct an external review in accordance with this Section shall be made from those approved independent review organizations qualified to conduct

external review as required by Sections 50 and 55 of this Act.

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

(3) If the health carrier or its utilization review organization fails to provide the documents and information within the specified 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 (3) of this subsection (c), 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.

(d) 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.

(e) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than 2 business days 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.

(f) 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.

(g) 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.

(h) Within 48 hours after the date of providing the notice required in item (2) of subsection (e), 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.

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

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

Section 50. Approval of independent review organizations.

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

(b) In order to be eligible for approval by the Director

under this Section to conduct external reviews under this Act an independent review organization:

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

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

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

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

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

(2) by rule establish an application fee that

independent review organizations shall submit to the Director with an application for approval and renewing.

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

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

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

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

Section 55. Minimum qualifications for independent review organizations.

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

minimum:

(1) a quality assurance mechanism that ensures that:

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

(B) selection of qualified and impartial clinical 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, and records information related to external reviews and provides appropriate instructions; and

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

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

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

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

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

review; and

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

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

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

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

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

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

(4) the health care provider, the health care 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;

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

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

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

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

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

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

(A) denial of care or treatment (dissatisfaction regarding prospective non-authorization of a request for care or treatment recommended by a provider excluding diagnostic procedures and referral requests;

partial approvals and care terminations are also considered to be denials);

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

(C) denial of referral request (dissatisfaction regarding non-authorization of a request for a referral to another provider recommended by a 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 Department of Insurance.

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

(215 ILCS 5/155.36)

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

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

(215 ILCS 5/359b new)

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

(a) For the purposes of this Section:

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

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

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

(b) A committee is established in the Department consisting of 11 members, including the Director or the Director's designee, who are appointed by the Director. The Director shall appoint to the committee 5 representatives as recommended by the Illinois Insurance Association, Illinois Life Insurance Council, Professional Independent Insurance Agents of Illinois, Illinois Association of Health Underwriters, Illinois Chamber of Commerce, Illinois Manufacturers Association, Illinois Retail Merchants Association, and National Federation of Independent Businesses and 5 consumer representatives. The Director or the Director's designee shall serve as chairperson of the committee.

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

A uniform employee health-status questionnaire shall allow small employers that are required to provide information regarding their employees to a small employer carrier when applying for a small employer group health insurance policy to use a standardized questionnaire that small employer carriers shall be required to use. The development of the uniform

employee health-status questionnaire is intended to relieve small employers of the burden of completing separate application forms for each small employer carrier with which the employer applies for insurance or from which the employer seeks information regarding such matters as rates, coverage, and availability. The use of the uniform employee health-status questionnaire by small employer carriers and small employers shall be mandatory.

(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 shall 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 shall 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) On or before July 1, 2010, 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 individual health insurance coverage and consolidate the statements into a standard individual market health statement. The standard individual market health statement shall be designed to permit its use both as a written document and through electronic or other alternative delivery formats. For purposes of the individual market health statement, the Director may, but shall not be required to, establish a committee distinct from that formed to develop an application for small employers. In that event, the composition of the committee shall be as prescribed in subsection (b) of this Section, although individual participants may change.

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

(i) The Director, as needed, may reconvene the committee to consider whether changes are necessary to the standard individual market health statement. If the committee determines that changes to the statement are necessary, the Director may adopt revisions to the statement as recommended by the committee. All carriers who offer individual health insurance coverage shall use the revised statement beginning 90

days after the Director adopts any revision.

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

(k) Nothing in this Section shall be construed to limit or restrict a health carrier's ability to appropriately rate risk, refuse to issue or renew coverage, or otherwise rescind, terminate, or restrict coverage under a health benefit plan or a policy of individual health insurance coverage or conduct further review of the information submitted on the statement by contacting an individual, the individual's health care provider, or any other entity for additional health status related information.

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

(215 ILCS 5/359c new)

Sec. 359c. Accident and health expense reporting.

(a) Beginning January 1, 2011 and every 6 months thereafter, any carrier providing a group or individual major medical policy of accident or health insurance shall prepare and provide to the Department of Insurance a statement of the aggregate administrative expenses of the carrier, based on the premiums earned in the immediately preceding 6-month period on

the accident or health insurance business of the carrier. The semi-annual statements shall be filed on or before July 31 for the preceding 6-month period ending June 30 and on or before February 1 for the preceding 6-month period ending December 31. The statements shall itemize and separately detail all of the following information with respect to the carrier's accident or health insurance business:

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

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

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

(B) wellness and health education programs;

(C) fraud prevention;

(D) maintaining provider networks and provider credentialing;

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

(F) utilization review and utilization management;

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

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

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

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

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

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

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

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

(1) individually underwritten;

(2) groups of 2 to 25 members;

(3) groups of 26 to 50 members;

(4) groups of 51 or more members.

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

Section 95. The Managed Care Reform and Patient Rights Act

is amended by changing Sections 40 and 45 as follows:

(215 ILCS 134/40)

Sec. 40. Access to specialists.

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

(b) A health care plan shall establish a procedure by which an enrollee who has a condition that requires ongoing care from a specialist physician or other health care provider may apply for a standing referral to a specialist physician or other health care provider if a referral to a specialist physician or other health care provider is required for coverage. The application shall be made to the enrollee's primary care physician. This procedure for a standing referral must specify the necessary criteria and conditions that must be met in order for an enrollee to obtain a standing referral. A standing referral shall be effective for the period necessary to provide

the referred services or one year, except in the event of termination of a contract or policy in which case Section 25 on transition of services shall apply, if applicable. A primary care physician may renew and re-renew a standing referral.

(c) The enrollee may be required by the health care plan to select a specialist physician or other health care provider who has a referral arrangement with the enrollee's primary care physician or to select a new primary care physician who has a referral arrangement with the specialist physician or other health care provider chosen by the enrollee. If a health care plan requires an enrollee to select a new physician under this subsection, the health care plan must provide the enrollee with both options provided in this subsection. When a participating specialist with a referral arrangement is not available, the primary care physician, in consultation with the enrollee, shall arrange for the enrollee to have access to a qualified participating health care provider, and the enrollee shall be allowed to stay with his or her primary care physician. If a secondary referral is necessary, the specialist physician or other health care provider shall advise the primary care physician. The primary care physician shall be responsible for making the secondary referral. In addition, the health care plan shall require the specialist physician or other health care provider to provide regular updates to the enrollee's primary care physician.

(d) When the type of specialist physician or other health

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

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

(f) If an enrollee's application for any referral is denied, an enrollee may appeal the decision through the health care plan's external independent review process as provided by the Illinois Health Carrier External Review 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.)

(215 ILCS 134/45)

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

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

(b) When an appeal concerns a decision or action by a health care plan, its employees, or its subcontractors that relates to (i) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an

enrollee's health, or (ii) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, the health care plan must allow for the filing of an appeal either orally or in writing. Upon submission of the appeal, a health care plan must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 24 hours after receipt of the required information. The health care plan shall notify the party filing the appeal and the enrollee, enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal of its decision orally followed-up by a written notice of the determination.

(c) For all appeals related to health care services including, but not limited to, procedures or treatments for an enrollee and not covered by subsection (b) above, the health care plan shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection, a health care plan must notify the party filing an appeal, within 3 business days, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 15 business days after receipt of the required information. The health care plan shall notify the

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

(d) An appeal under subsection (b) or (c) may be filed by the enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health care provider. A health care plan shall designate a clinical peer to review appeals, because these appeals pertain to medical or clinical matters and such an appeal must be reviewed by an appropriate health care professional. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal. The written notice of determination required under subsections (b) and (c) shall include (i) clear and detailed reasons for the determination, (ii) the medical or clinical criteria for the determination, which shall be based upon sound clinical evidence and reviewed on a periodic basis, and (iii) in the case of an adverse determination, the procedures for requesting an external independent review as provided by the Illinois Health Carrier External Review 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) Until July 1, 2013, if an external independent review decision made pursuant to the Illinois Health Carrier External Review Act upholds a determination adverse to the covered person, the covered person has the right to appeal the final decision to the Department; if the external review decision is found by the Director to have been arbitrary and capricious, then the Director, with consultation from a licensed medical professional, may overturn the external review decision and assign a new independent review organization to reconsider the overturned decision. If an external review decision is overturned by the Director pursuant to this Section and the health carrier so requests, then the Director shall assign a new independent review organization to reconsider the overturned decision. The new independent review organization shall follow subsection (d) of Section 40 of the Health Carrier External Review Act in rendering a decision. ~~External independent review.~~

~~(1) The party seeking an external independent review shall so notify the health care plan. The health care plan shall seek to resolve all external independent reviews in the most expeditious manner and shall make a determination and provide notice of the determination no more than 24~~

~~hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health or when extended health care services for an enrollee undergoing a course of treatment prescribed by a health care provider are at issue.~~

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

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

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

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

~~(4) Within 5 days after receipt of all necessary~~

~~information, the independent reviewer shall evaluate and analyze the case and render a decision that is based on whether or not the health care service or claim for the health care service is medically appropriate. The decision by the independent reviewer is final. If the external independent reviewer determines the health care service to be medically appropriate, the health care plan shall pay for the health care service.~~

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

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

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

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

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

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

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

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

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

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

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

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