HB5471

LRB09616762RPM32057b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB5471

Introduced 2/5/2010, by Rep. Mary E. Flowers

SYNOPSIS AS INTRODUCED:

215 ILCS 134/45
215 ILCS 180/20
215 ILCS 180/25
215 ILCS 180/45
215 ILCS 180/80 new

Amends the Managed Care Reform and Patient Rights Act and the Health Carrier External Review Act to provide that a determination by the Director of Insurance to uphold an external review decision that is adverse to an enrollee is subject to the process of administrative review pursuant to the Code of Civil Procedure. Further amends the Health Carrier External Review Act. Provides that when a health carrier sends any request for payment to a covered person, the health carrier shall include a written statement of the health care patient rights. Provides that the Office of Consumer Health Insurance within the Department of Insurance shall provide consultation and case management and shall establish a toll-free phone number for covered persons. Provides that every health carrier shall expend in the form of health care benefits no less than 85% of the aggregate dues, fees, and premiums received by the health carrier. Provides that a health carrier may average its total costs across all health benefit plans in compliance with the provision concerning minimum medical loss expenditures. Contains a nonacceleration clause. Makes other changes.

LRB096 16762 RPM 32057 b

A BILL FOR

AN ACT concerning insurance.

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

Section 5. The Managed Care Reform and Patient Rights Act is amended by changing Section 45 as follows:

(215 ILCS 134/45)

(Text of Section before amendment by P.A. 96-857)

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 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 under subsection (f) of the adverse determination.

(f) External independent review.

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

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

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

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

and the health care plan; and

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

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

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

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

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

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

(A) be a clinical peer;

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

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

(9) A determination by the Director to uphold an external review decision that is adverse to an enrollee is subject to the process of administrative review pursuant to Article III of the Code of Civil Procedure.

(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.)

(Text of Section after amendment by P.A. 96-857)

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.

(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.

(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 require the health carrier to pay for the health care service or treatment; such decision, if any, shall be made solely on the legal or medical merits of the claim. 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. A determination by the Director to uphold an external review decision that is adverse to an enrollee is subject to the process of administrative review pursuant to Article III of the Code of Civil Procedure.

(g) 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 health care services appeals, complaints, or external independent reviews under the Illinois Health Carrier External Review Act.

(h) 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. 96-857, eff. 7-1-10.)

Section 10. The Health Carrier External Review Act is amended by changing Sections 20, 25, and 45 and by adding Section 80 as follows:

(215 ILCS 180/20)

(This Section may contain text from a Public Act with a delayed effective date)

Sec. 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.

(e) In every billing instance when a health carrier sends any request for payment to a covered person, the health carrier shall include a written statement of the health care patient rights as set forth in Section 5 of the Managed Care Reform and Patient Rights Act.

(Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 180/25)

(This Section may contain text from a Public Act with a delayed effective date)

Sec. 25. Request for external review.

(a) 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.

(b) The Office of Consumer Health Insurance within the Department of Insurance shall provide consultation and case management for covered persons. The Office of Consumer Health

Insurance shall establish a toll-free phone number for covered persons who are engaged in an appeal or seeking external review of an adverse determination or final adverse determination. The Department shall adopt rules to implement this subsection (b).

(Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 180/45)

(This Section may contain text from a Public Act with a delayed effective date)

Sec. 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. A determination by the Director to uphold an external review decision that is adverse to an enrollee is subject to the process of administrative review pursuant to Article III of the Code of Civil Procedure.

(Source: P.A. 96-857, eff. 7-1-10.)

(215 ILCS 180/80 new)

Sec. 80. Minimum medical loss requirement.

(a) Every health carrier shall expend in the form of health care benefits no less than 85% of the aggregate dues, fees, premiums, or other periodic payments received by the health carrier. For purposes of this Section, the health carrier may deduct from the aggregate dues, fees, premiums, or other periodic payments received by the health carrier the amount of income taxes or other taxes that the health carrier expensed.

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

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

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

Section 95. 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.