HB1475

LRB09706647RPM46733b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB1475

by Rep. Mary E. Flowers

SYNOPSIS AS INTRODUCED:

215 ILCS 5/368b	
215 ILCS 5/368c	
215 ILCS 5/368d	
215 ILCS 5/368e	
215 ILCS 5/370	from Ch. 73, par. 982
215 ILCS 5/370a	from Ch. 73, par. 982a
215 ILCS 5/370b	from Ch. 73, par. 982b

Amends the Illinois Insurance Code. In the provisions concerning remittance advice and procedures and recoupment, provides that no recoupment or offset may be requested or withheld from future payments 60 or more days after the original payment was made. Provides that the provisions concerning administration and enforcement are deemed incorporated into health care professional and health care provider service contracts entered into on or before the effective date of the amendatory Act. Provides that the Director may require an insurance company that issues a policy in wilful violation of the Act to pay a penalty in a sum not exceeding $5,000 (instead of $1,000). Makes other changes.

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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 Illinois Insurance Code is amended by changing Sections 368b, 368c, 368d, 368e, 370, 370a, and 370b as follows:

(215 ILCS 5/368b)

Sec. 368b. Contracting procedures.

(a) A health care professional or health care provider offered a contract by an insurer, health maintenance organization, independent practice association, or physician hospital organization for signature after the effective date of this amendatory Act of the 93rd General Assembly shall be provided with a proposed health care professional or health care provider services contract including, if any, exhibits and attachments that the contract indicates are to be attached. Within 35 days after a written request, the health care professional or health care provider offered a contract shall be given the opportunity to review and obtain a copy of the following: a specialty-specific fee schedule sample based on a minimum of the 50 highest volume fee schedule codes with the rates applicable to the health care professional or health care provider to whom the contract is offered, the network provider

administration manual, and a summary capitation schedule, if payment is made on a capitation basis. If 50 codes do not exist for a particular specialty, the health care professional or health care provider offered a contract shall be given the opportunity to review or obtain a copy of a fee schedule sample with the codes applicable to that particular specialty. This information may be provided electronically. An insurer, health maintenance organization, independent practice association, or physician hospital organization may substitute the fee schedule sample with a document providing reference to the information needed to calculate the fee schedule that is available to the public at no charge and the percentage or conversion factor at which the insurer, health maintenance organization, preferred provider organization, independent practice association, or physician hospital organization sets its rates.

(b) The fee schedule, the capitation schedule, and the network provider administration manual constitute confidential, proprietary, and trade secret information and are subject to the provisions of the Illinois Trade Secrets Act. The health care professional or health care provider receiving such protected information may disclose the information on a need to know basis and only to individuals and entities that provide services directly related to the health care professional's or health care provider's decision to enter into the contract or keep the contract in force. Any person or

entity receiving or reviewing such protected information pursuant to this Section shall not disclose the information to any other person, organization, or entity, unless the disclosure is requested pursuant to a valid court order or required by a state or federal government agency. Individuals or entities receiving such information from a health care professional or health care provider as delineated in this subsection are subject to the provisions of the Illinois Trade Secrets Act.

(c) The health care professional or health care provider shall be allowed at least 30 days to review the health care professional or health care provider services contract, including exhibits and attachments, if any, before signing. The 30-day review period begins upon receipt of the health care professional or health care provider services contract, unless the information available upon request in subsection (a) is not included. If information is not included in the professional services contract and is requested pursuant to subsection (a), the 30-day review period begins on the date of receipt of the information. Nothing in this subsection shall prohibit a health care professional or health care provider from signing a contract prior to the expiration of the 30-day review period.

(d) The insurer, health maintenance organization, independent practice association, or physician hospital organization shall provide all contracted health care professionals or health care providers with any changes to the

fee schedule provided under subsection (a) not later than 35 days after the effective date of the changes, unless such changes are specified in the contract and the health care professional or health care provider is able to calculate the changed rates based on information in the contract and information available to the public at no charge. For the purposes of this subsection, "changes" means an increase or decrease in the fee schedule referred to in subsection (a). This information may be made available by mail, e-mail, newsletter, website listing, or other reasonable method. Upon request, a health care professional or health care provider may request an updated copy of the fee schedule referred to in subsection (a) every calendar quarter.

(e) Upon termination of a contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization and at the request of the patient, a health care professional or health care provider shall provide ~~transfer~~ copies of the patient's medical records. Any other provision of law notwithstanding, the costs for copying and transferring copies of medical records shall be assigned per the arrangements agreed upon, if any, in the health care professional or health care provider services contract.

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

(215 ILCS 5/368c)

Sec. 368c. Remittance advice and procedures.

(a) A remittance advice shall be furnished to a health care professional or health care provider that identifies the disposition of each claim. The remittance advice shall identify the services billed; the patient responsibility, if any; the actual payment, if any, for the services billed; and the reason for any reduction to the amount for which the claim was submitted. For any reductions to the amount for which the claim was submitted, the remittance shall identify any withholds and the reason for any denial or reduction.

A remittance advice for capitation or prospective payment arrangements shall be furnished to a health care professional or health care provider pursuant to a contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization in accordance with the terms of the contract.

(b) When health care services are provided by a non-participating health care professional or health care provider, an insurer, health maintenance organization, independent practice association, or physician hospital organization shall ~~may~~ pay for covered services ~~either to a patient~~ directly ~~or~~ to the non-participating health care professional or health care provider, if the benefits have been assigned by the patient.

(c) When a person presents a benefits information card, a health care professional or health care provider shall make a

good faith effort to inform the person if the health care professional or health care provider has a participation contract with the insurer, health maintenance organization, or other entity identified on the card.

(d) No recoupment or offset may be requested or withheld from future payments 60 or more days after the original payment was made.

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

(215 ILCS 5/368d)

Sec. 368d. Recoupments.

(a) A health care professional or health care provider shall be provided a remittance advice, which must include an explanation of a recoupment or offset taken by an insurer, health maintenance organization, independent practice association, or physician hospital organization, if any. The recoupment explanation shall, at a minimum, include the name of the patient; the date of service; the service code or if no service code is available a service description; the recoupment amount; and the reason for the recoupment or offset. In addition, an insurer, health maintenance organization, independent practice association, or physician hospital organization shall provide with the remittance advice a telephone number or mailing address to initiate an appeal of the recoupment or offset.

(b) It is not a recoupment when a health care professional

or health care provider is paid an amount prospectively or concurrently under a contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization that requires a retrospective reconciliation based upon specific conditions outlined in the contract.

(c) No recoupment or offset may be requested or withheld from future payments 60 or more days after the original payment was made.

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

(215 ILCS 5/368e)

Sec. 368e. Administration and enforcement.

(a) Other than the duties specifically created in Sections 368b, 368c, and 368d, nothing in those Sections is intended to preclude, prevent, or require the adoption, modification, or termination of any utilization management, quality management, or claims processing methodologies or other provisions of a contract applicable to services provided under a contract between an insurer, health maintenance organization, independent practice association, or physician hospital organization and a health care professional or health care provider.

(b) Nothing in Sections 368b, 368c, and 368d precludes, prevents, or requires the adoption, modification, or termination of any health plan term, benefit, coverage or

eligibility provision, or payment methodology.

(c) The provisions of Sections 368b, 368c, and 368d are deemed incorporated into health care professional and health care provider service contracts entered into on or before January 1, 2004 (the effective date of Public Act 93-261) ~~this amendatory Act of the 93rd General Assembly~~ and do not require an insurer, health maintenance organization, independent practice association, or physician hospital organization to renew or renegotiate the contracts with a health care professional or health care provider.

(c-5) The amendatory provisions of Sections 368b, 368c, 368d, 370a, and 370b are deemed incorporated into health care professional and health care provider service contracts entered into on or before the effective date of this amendatory Act of the 97th General Assembly and do not require an insurer, health maintenance organization, independent practice association, or physician hospital organization to renew or renegotiate the contracts with a health care professional or health care provider.

(d) The Department shall enforce the provisions of this Section and Sections 368b, 368c, and 368d pursuant to the enforcement powers granted to it by law.

(e) The Department is hereby granted specific authority to issue a cease and desist order against, fine, or otherwise penalize independent practice associations and physician-hospital organizations for violations.

(f) The Department shall adopt reasonable rules to enforce compliance with this Section and Sections 368b, 368c, and 368d.
(Source: P.A. 93-261, eff. 1-1-04.)

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

Sec. 370. Policies issued in violation of article-Penalty.

(1) Any company, or any officer or agent thereof, issuing or delivering to any person in this State any policy in wilful violation of the provision of this article shall be guilty of a petty offense.

(2) The Director may revoke the license of any foreign or alien company, or of the agent thereof wilfully violating any provision of this article or suspend such license for any period of time up to, but not to exceed, two years; or may by order require such insurance company or agent to pay to the people of the State of Illinois a penalty in a sum not exceeding $5,000 ~~$1,000~~, and upon the failure of such insurance company or agent to pay such penalty within twenty days after the mailing of such order, postage prepaid, registered, and addressed to the last known place of business of such insurance company or agent, unless such order is stayed by an order of a court of competent jurisdiction, the Director of Insurance may revoke or suspend the license of such insurance company or agent for any period of time up to, but not exceeding a period of, two years.
(Source: P.A. 93-32, eff. 7-1-03.)

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

Sec. 370a. Assignability of Accident and Health Insurance.

(a) No provision of the Illinois Insurance Code, or any other law, prohibits an insured under any policy of accident and health insurance or any other person who may be the owner of any rights under such policy from making an assignment of all or any part of his rights and privileges under the policy including but not limited to the right to designate a beneficiary and to have an individual policy issued in accordance with its terms. Subject to the terms of the policy or any contract relating thereto, an assignment by an insured or by any other owner of rights under the policy, made before or after the effective date of this amendatory Act of 1969 is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is effective, all rights and privileges so assigned. However, such assignment is without prejudice to the company on account of any payment it makes or individual policy it issues before receipt of notice of the assignment. This amendatory Act of 1969 acknowledges, declares and codifies the existing right of assignment of interests under accident and health insurance policies.

(b) For the purposes of payment for covered services, if ~~If~~ an enrollee or insured of an insurer, health maintenance organization, managed care plan, health care plan, preferred

provider organization, or third party administrator assigns a claim to a health care professional or health care facility, then payment shall be made directly to the health care professional or health care facility regardless of whether the professional is a participating or non-participating provider, including any interest required under Section 368a, of this Code for failure to pay claims within 30 days after receipt by the insurer of due proof of loss. Nothing in this Section shall be construed to prevent any parties from reconciling duplicate payments.

(Source: P.A. 91-605, eff. 12-14-99; 91-788, eff. 6-9-00.)

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

Sec. 370b. Reimbursement on equal basis. Notwithstanding any provision of any individual or group policy of accident and health insurance, or any provision of a policy, contract, plan or agreement for hospital or medical service or indemnity, wherever such policy, contract, plan or agreement provides for reimbursement for any service provided by persons licensed under the Medical Practice Act of 1987 or the Podiatric Medical Practice Act of 1987, the person entitled to benefits or person performing services under such policy, contract, plan or agreement is entitled to reimbursement on an equal basis for such service, when the service is performed by a person licensed under the Medical Practice Act of 1987 or the Podiatric Medical Practice Act of 1987 whether the person is a

participating or non-participating provider. The provisions of this Section do not apply to any policy, contract, plan or agreement in effect prior to September 19, 1969 or to preferred provider arrangements or benefit agreements.

(Source: P.A. 90-14, eff. 7-1-97.)