Rep. Lou Lang

Filed: 5/27/2013

AMENDMENT TO SENATE BILL 1547

AMENDMENT NO. _____. Amend Senate Bill 1547 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Sections 370g and 370h and by adding Sections 370d.1 and 370u as follows:

(215 ILCS 5/370d.1 new)

Sec. 370d.1. Exclusive provider organization plans.

(a) For the purpose of this Section:

"Exclusive provider organization plan" or "EPO" means a benefit plan that utilizes a network of contracted health care providers and that excludes benefits for services provided by non-contracted health care providers, except for emergency services or when services are not available to an insured from a contracted provider within a designated service area.

"Designated service area" means a geographic area as specified in a health insurance policy for an EPO.

(b) An insurer that is licensed to write accident and health insurance under the provisions of this Code shall be authorized to issue policies for exclusive provider organization plans for either group or individual policies, provided such policies otherwise conform to the terms of this Section, and to the extent applicable to insurers, the Uniform Health Care Service Benefits Information Card Act, and the Health Carrier External Review Act. An insurer issuing exclusive provider organization plans under this Section shall not be required to be licensed as a health maintenance organization under the Health Maintenance Organization Act in order to issue a policy under this Section.

(c) An insurer writing policies for an EPO may limit enrollment in such a plan solely to those individuals who either live, work, or reside in the designated service area.

(d) Except as otherwise stated in this Section, an EPO shall comply with all other provisions of this Code, and regulations issued hereunder, relating to accident and health insurance policies that utilize a contracted health care provider network to provide the benefits under such policies. To the extent of any conflict between this Section and any other statutory provision, this Section prevails over the conflicting provision.

(e) This Section does not apply to:

(1) the Children's Health Insurance Program issued under the Children's Health Insurance Program Act;

(2) a Medicaid managed care program issued under Article V of the Illinois Public Aid Code; or

(3) the State Employees' Group Insurance Act.

(f) An insurer writing policies for an EPO shall provide within the contract and evidence of coverage a description of benefits and services available out of the EPO's designated service area, including any limitations and exclusions.

(g) An insurer shall not require a health care professional or health care provider, as a condition of participating in the EPO, to sign a contract requiring the health care professional or health care provider to provide services under another of the company's networks or plans.

(h) An insurer shall not require a health care professional or health care provider, as a condition of participating in any of the company's networks or plans, to sign a contract requiring the health care professional or health care provider to provide services under the insurer's EPO.

(i) An EPO issued or renewed in this State must prominently display on the cover page of the policy, evidence of coverage, and any marketing materials, that it is an exclusive provider organization benefit plan and that services, other than emergency services, provided by non-contracted health care providers may not be covered under the plan.

(j) An EPO must clearly state on the health care benefit

information card that it is an EPO.

(k) An insurer that issues, delivers, amends, or renews an individual or group EPO in this State after the effective date of this amendatory Act of the 98th General Assembly must include the following disclosure on its contracts and evidences of coverage: "WARNING, NO BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, there will be NO benefit payments to such non-participating providers. YOU WILL HAVE TO PAY FOR ANY SERVICE OR TREATMENT OUTSIDE OF THE EXCLUSIVE PROVIDER ORGANIZATION PLAN NETWORK. Non-participating providers may bill members for any treatments and services provided to the patient. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than copayments, co-insurance, and deductible amounts. You may obtain further information about the participating status of professional providers by calling the toll-free telephone number on your identification card.".

(l) Any insurer that issues, delivers, amends, or renews an individual or group EPO in this State after the effective date of this amendatory Act of the 98th General Assembly must comply with Sections 20, 25, 30, 35, 65, 70, 85, 95, and 100 of the Managed Care Reform and Patient Rights Act.

(m) Any insurer that issues, delivers, amends, or renews an

individual or group EPO in this State after the effective date of this amendatory Act of the 98th General Assembly must comply with the following provisions:

(1) An EPO shall provide annually to enrollees and prospective enrollees, upon request, a complete list of participating health care providers in the health care plan's service area and a description of the following terms of coverage:

(A) the service area;

(B) the covered benefits and services with all exclusions, exceptions, and limitations;

(C) the pre-certification and other utilization review procedures and requirements;

(D) the emergency coverage and benefits, including any restrictions on emergency care services;

(E) the out-of-area coverage and benefits, if any;

(F) the enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses;

(G) the provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by that provider; and

(H) the appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and

utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process.

(2) An EPO shall provide the information required to be disclosed under this Section upon enrollment and annually thereafter in a legible and understandable format.

(3) The written disclosure requirements of this Section may be met by disclosure to one enrollee in a household.

(n) The following provisions shall apply concerning EPO restrictions on primary care physicians.

(1) An EPO is prohibited from requiring enrollees to choose a primary care physician for the coordination of care.

(2) Enrollees may at any time select any physician from within the EPO network to provide care.

(3) An EPO is prohibited from requiring enrollees to obtain prior authorization from any participating physician in the network before seeing an EPO network provider of their choice.

(o) An insurer that issues, delivers, amends, or renews an individual or group EPO shall provide an internal claims and appeals process that incorporates the claims and appeals procedures set forth in Section 2719 of the Patient Protection and Affordable Care Act and Section 300gg-19 of the Public Health Service Act (42 USC 300gg-19) and any regulations issued

thereunder by the Secretary of Labor or by the Secretary of Health and Human Services for such plans and issuers.

(p) The Director of Insurance may adopt rules necessary to implement this Section.

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

Sec. 370g. Definitions. As used in this Article, the following definitions apply:

(a) "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization. The term includes, but is not limited to, hospital, medical, surgical, dental, vision and pharmaceutical services or products.

(b) "Insurer" means an insurance company or a health service corporation authorized in this State to issue policies or subscriber contracts which reimburse for expenses of health care services.

(c) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.

(d) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services.

(e) "Noninstitutional provider" means any person licensed under the Medical Practice Act of 1987, as now or hereafter amended.

(f) "Beneficiary" means an individual entitled to reimbursement for expenses of or the discount of provider fees for health care services under a program where the beneficiary has an incentive to utilize the services of a provider which has entered into an agreement or arrangement with an administrator.

(g) "Administrator" means any person, partnership or corporation, other than an insurer or health maintenance organization holding a certificate of authority under the "Health Maintenance Organization Act", as now or hereafter amended, that arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider.

(h) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including 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.

(i) "Exclusive provider organization plan" or "EPO" means a benefit plan that utilizes a network of contracted health care

providers and that excludes benefits for services provided by non-contracted health care providers, except for emergency services or when services are not available to an insured from a contracted provider within a Designated Service Area.

(j) "Designated service area" means a geographic area as specified in a health insurance policy for an EPO.

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

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

Sec. 370h. Noninstitutional providers.

(a) Before entering into any agreement under this Article an insurer or administrator shall establish terms and conditions that must be met by noninstitutional providers wishing to enter into an agreement with the insurer or administrator. These terms and conditions may not discriminate unreasonably against or among noninstitutional providers. Neither difference in prices among noninstitutional providers produced by a process of individual negotiation nor price differences among other noninstitutional providers in different geographical areas or different specialties constitutes unreasonable discrimination.

(b) An insurer or administrator shall not refuse to contract with any noninstitutional provider who meets the terms and conditions established by the insurer or administrator.

(c) Any insurer that issues, delivers, amends, or renews an individual or group EPO in this State after the effective date

of this amendatory Act of the 98th General Assembly shall not be obligated to comply with this Section solely with respect to the EPO product.

(Source: P.A. 90-655, eff. 7-30-98.)

(215 ILCS 5/370u new)

Sec. 370u. Exclusive provider organization plans permitted. An administrator, or an insurer as applicable under this Code, may offer an EPO, provided that the administrator meets the requirements of this Code and the Director determines that:

(1) the level of coverage, including deductibles, copayments, coinsurance, or other cost-sharing provisions to beneficiaries, or insured individuals does not operate unreasonably to restrict the access and availability of health care services for the insured; or

(2) the EPO has established an exclusive network that is adequate to provide health care services as required by this Code.".