SB1642

LRB09808861RPM38991b

98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

SB1642

Introduced 2/13/2013, by Sen. Mattie Hunter

SYNOPSIS AS INTRODUCED:

215 ILCS 5/143.31
215 ILCS 5/368c

Amends the Illinois Insurance Code. Makes changes to the provision concerning the required content in (1) explanation of benefits paid statements and (2) claims summary statements sent to an insured by their accident and health insurer. Makes changes to the provision concerning the remittance advice that is furnished to a health care professional or health care provider.

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A BILL FOR

AN ACT concerning regulation.

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 143.31 and 368c as follows:

(215 ILCS 5/143.31)

Sec. 143.31. Uniform medical claim and billing forms.

(a) The Director shall prescribe by rule, after consultation with providers of health care or treatment, insurers, hospital, medical, and dental service corporations, and other prepayment organizations, insurance claim and billing forms that the Director determines will provide for uniformity and simplicity in insurance claims handling. The claim forms shall include, but need not be limited to, information regarding the medical diagnosis, treatment, and prognosis of the patient, together with the details of charges incident to the providing of care, treatment, or services, sufficient for the purpose of meeting the proof requirements of an insurance policy or a hospital, medical, or dental service contract.

(b) An insurer or a provider of health care treatment may not refuse to accept a claim or bill submitted on duly promulgated uniform claim and billing forms. An insurer,

however, may accept claims and bills submitted on any other form.

(c) Accident and health insurer explanation of benefits paid statements or claims summary statements sent to an insured by the accident and health insurer shall be in a format and written in a manner that promotes understanding by the insured by setting forth all of the following:

(1) The total dollar amount submitted to the insurer for payment.

(2) Any reduction in the amount paid. For any reductions to the amount for which the claim was submitted, the explanation of benefits shall identify separately in clearly marked columns any and all withholds and the reason for any denial or reduction, including, but not limited to, deductibles, copayments, coinsurance, and administrative fees of any kind ~~due to the application of any co payment or deductible, along with an explanation of the amount of the co payment or deductible applied under the insured's policy~~.

(3) Any reduction in the amount paid due to the application of any other policy limitation or exclusion set forth in the insured's policy, along with an explanation thereof.

(4) The total dollar amount paid.

(5) The total dollar amount remaining unpaid.

The items and amounts shown on any health care explanation

of benefits must match and be consistent with the items and amounts on the corresponding remittance advice sent to a health care provider, such that the explanation of benefits clearly discloses to the patient all reductions in the actual amount paid to a provider.

No payer may issue an explanation of benefits stating payment has been made to a provider unless and until actual payment has been made. If actual payment will not be made promptly as provided in Section 368a of this Code, a payer shall issue a preliminary explanation of benefits stating that payment is anticipated in a specified amount and a second explanation of benefits when actual payment has been made.

(d) The Director may issue an order directing an accident and health insurer to comply with subsection (c).

(e) An accident and health insurer does not violate subsection (c) by using a document that the accident and health insurer is required to use by the federal government or the State.

(f) The adoption of uniform claim forms and uniform billing forms by the Director under this Section does not preclude an insurer, hospital, medical, or dental service corporation, or other prepayment organization from obtaining any necessary additional information regarding a claim from the claimant, provider of health care or treatment, or certifier of coverage, as may be required.

(g) On and after January 1, 1996 when billing insurers or

otherwise filing insurance claims with insurers subject to this Section, providers of health care or treatment, medical services, dental services, pharmaceutical services, or medical equipment must use the uniform claim and billing forms adopted by the Director under this Section.

(Source: P.A. 91-357, eff. 7-29-99.)

(215 ILCS 5/368c)

Sec. 368c. Remittance advice and procedures.

(a) Payors, including, but not limited to, insurers, health maintenance organizations, managed care plans, health care plans, preferred provider organizations, third party administrators, independent practice associations, and physician-hospital organizations, shall furnish a health care professional or health care provider with 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 separately any and all withholds in clearly marked columns ~~any withholds~~ and the reason for any denial or reduction, including, but not limited to, deductibles, copayments, coinsurance, and administrative fees of any kind.

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; provided, however, no such contract shall contain terms in violation of this Section. In the event of a conflict between a provider contract and this Section, this Section shall prevail.

(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 may pay for covered services either to a patient directly or to the non-participating health care professional or health care provider.

(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.

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