

1 AN ACT concerning insurance.

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

4 Section 5. The Managed Care Reform and Patient Rights Act
5 is amended by changing Sections 80 and 85 as follows:

6 (215 ILCS 134/80)

7 Sec. 80. Quality assessment program.

8 (a) A health care plan shall develop and implement a
9 quality assessment and improvement strategy designed to
10 identify and evaluate accessibility, continuity, and quality
11 of care. The health care plan shall have:

12 (1) an ongoing, written, internal quality assessment
13 program;

14 (2) specific written guidelines for monitoring and
15 evaluating the quality and appropriateness of care and
16 services provided to enrollees requiring the health care
17 plan to assess:

18 (A) the accessibility to health care providers;

19 (B) appropriateness of utilization;

20 (C) concerns identified by the health care plan's
21 medical or administrative staff and enrollees; and

22 (D) other aspects of care and service directly
23 related to the improvement of quality of care;

1 (3) a procedure for remedial action to correct quality
2 problems that have been verified in accordance with the
3 written plan's methodology and criteria, including written
4 procedures for taking appropriate corrective action;

5 (4) follow-up measures implemented to evaluate the
6 effectiveness of the action plan.

7 (b) The health care plan shall establish a committee that
8 oversees the quality assessment and improvement strategy which
9 includes physician and enrollee participation.

10 (c) Reports on quality assessment and improvement
11 activities shall be made to the governing body of the health
12 care plan not less than quarterly.

13 (d) The health care plan shall make available its written
14 description of the quality assessment program to the Department
15 of Public Health.

16 (e) With the exception of subsection (d), the Department of
17 Public Health shall accept evidence of accreditation with
18 regard to the health care network quality management and
19 performance improvement standards of:

20 (1) the National Commission on Quality Assurance
21 (NCQA);

22 (2) the American Accreditation Healthcare Commission
23 (URAC);

24 (3) the Joint Commission on Accreditation of
25 Healthcare Organizations (JCAHO); ~~or~~

26 (4) the Accreditation Association for Ambulatory

1 Health Care (AAAHC); or

2 (5) ~~(4)~~ any other entity that the Director of Public
3 Health deems has substantially similar or more stringent
4 standards than provided for in this Section.

5 (f) If the Department of Public Health determines that a
6 health care plan is not in compliance with the terms of this
7 Section, it shall certify the finding to the Department of
8 Insurance. The Department of Insurance shall subject a health
9 care plan to penalties, as provided in this Act, for such
10 non-compliance.

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

12 (215 ILCS 134/85)

13 Sec. 85. Utilization review program registration.

14 (a) No person may conduct a utilization review program in
15 this State unless once every 2 years the person registers the
16 utilization review program with the Department and certifies
17 compliance with the Health Utilization Management Standards of
18 the American Accreditation Healthcare Commission (URAC)
19 sufficient to achieve American Accreditation Healthcare
20 Commission (URAC) accreditation or submits evidence of
21 accreditation by the American Accreditation Healthcare
22 Commission (URAC) for its Health Utilization Management
23 Standards. Nothing in this Act shall be construed to require a
24 health care plan or its subcontractors to become American
25 Accreditation Healthcare Commission (URAC) accredited.

1 (b) In addition, the Director of the Department, in
2 consultation with the Director of the Department of Public
3 Health, may certify alternative utilization review standards
4 of national accreditation organizations or entities in order
5 for plans to comply with this Section. Any alternative
6 utilization review standards shall meet or exceed those
7 standards required under subsection (a).

8 (b-5) The Department shall recognize the Accreditation
9 Association for Ambulatory Health Care among the list of
10 accreditors from which utilization organizations may receive
11 accreditation and qualify for reduced registration and renewal
12 fees.

13 (c) The provisions of this Section do not apply to:

14 (1) persons providing utilization review program
15 services only to the federal government;

16 (2) self-insured health plans under the federal
17 Employee Retirement Income Security Act of 1974, however,
18 this Section does apply to persons conducting a utilization
19 review program on behalf of these health plans;

20 (3) hospitals and medical groups performing
21 utilization review activities for internal purposes unless
22 the utilization review program is conducted for another
23 person.

24 Nothing in this Act prohibits a health care plan or other
25 entity from contractually requiring an entity designated in
26 item (3) of this subsection to adhere to the utilization review

1 program requirements of this Act.

2 (d) This registration shall include submission of all of
3 the following information regarding utilization review program
4 activities:

5 (1) The name, address, and telephone number of the
6 utilization review programs.

7 (2) The organization and governing structure of the
8 utilization review programs.

9 (3) The number of lives for which utilization review is
10 conducted by each utilization review program.

11 (4) Hours of operation of each utilization review
12 program.

13 (5) Description of the grievance process for each
14 utilization review program.

15 (6) Number of covered lives for which utilization
16 review was conducted for the previous calendar year for
17 each utilization review program.

18 (7) Written policies and procedures for protecting
19 confidential information according to applicable State and
20 federal laws for each utilization review program.

21 (e) (1) A utilization review program shall have written
22 procedures for assuring that patient-specific information
23 obtained during the process of utilization review will be:

24 (A) kept confidential in accordance with applicable
25 State and federal laws; and

26 (B) shared only with the enrollee, the enrollee's

1 designee, the enrollee's health care provider, and those
2 who are authorized by law to receive the information.

3 Summary data shall not be considered confidential if it
4 does not provide information to allow identification of
5 individual patients or health care providers.

6 (2) Only a health care professional may make
7 determinations regarding the medical necessity of health
8 care services during the course of utilization review.

9 (3) When making retrospective reviews, utilization
10 review programs shall base reviews solely on the medical
11 information available to the attending physician or
12 ordering provider at the time the health care services were
13 provided.

14 (4) When making prospective, concurrent, and
15 retrospective determinations, utilization review programs
16 shall collect only information that is necessary to make
17 the determination and shall not routinely require health
18 care providers to numerically code diagnoses or procedures
19 to be considered for certification, unless required under
20 State or federal Medicare or Medicaid rules or regulations,
21 but may request such code if available, or routinely
22 request copies of medical records of all enrollees
23 reviewed. During prospective or concurrent review, copies
24 of medical records shall only be required when necessary to
25 verify that the health care services subject to review are
26 medically necessary. In these cases, only the necessary or

1 relevant sections of the medical record shall be required.

2 (f) If the Department finds that a utilization review
3 program is not in compliance with this Section, the Department
4 shall issue a corrective action plan and allow a reasonable
5 amount of time for compliance with the plan. If the utilization
6 review program does not come into compliance, the Department
7 may issue a cease and desist order. Before issuing a cease and
8 desist order under this Section, the Department shall provide
9 the utilization review program with a written notice of the
10 reasons for the order and allow a reasonable amount of time to
11 supply additional information demonstrating compliance with
12 requirements of this Section and to request a hearing. The
13 hearing notice shall be sent by certified mail, return receipt
14 requested, and the hearing shall be conducted in accordance
15 with the Illinois Administrative Procedure Act.

16 (g) A utilization review program subject to a corrective
17 action may continue to conduct business until a final decision
18 has been issued by the Department.

19 (h) Any adverse determination made by a health care plan or
20 its subcontractors may be appealed in accordance with
21 subsection (f) of Section 45.

22 (i) The Director may by rule establish a registration fee
23 for each person conducting a utilization review program. All
24 fees paid to and collected by the Director under this Section
25 shall be deposited into the Insurance Producer Administration
26 Fund.

1 (Source: P.A. 91-617, eff. 7-1-00.)