

1 AN ACT concerning regulation.

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

4 Section 5. The Health Carrier External Review Act is
5 amended by changing Section 65 as follows:

6 (215 ILCS 180/65)

7 Sec. 65. External review reporting requirements.

8 (a) Each health carrier shall maintain written records in
9 the aggregate, by state, and for each type of health benefit
10 plan offered by the health carrier on all requests for external
11 review that the health carrier received notice from the
12 Director for each calendar year and submit a report to the
13 Director in the format specified by the Director by June 1
14 ~~March 1~~ of each year.

15 (a-5) An independent review organization assigned pursuant
16 to this Act to conduct an external review shall maintain
17 written records in the aggregate by state and by health carrier
18 on all requests for external review for which it conducted an
19 external review during a calendar year and submit a report in
20 the format specified by the Director by March 1 of each year.

21 (a-10) The report required by subsection (a-5) shall
22 include in the aggregate by state, and for each health carrier:

23 (1) the total number of requests for external review;

1 (2) the number of requests for external review resolved
2 and, of those resolved, the number resolved upholding the
3 adverse determination or final adverse determination and
4 the number resolved reversing the adverse determination or
5 final adverse determination;

6 (3) the average length of time for resolution;

7 (4) a summary of the types of coverages or cases for
8 which an external review was sought, as provided in the
9 format required by the Director;

10 (5) the number of external reviews that were terminated
11 as the result of a reconsideration by the health carrier of
12 its adverse determination or final adverse determination
13 after the receipt of additional information from the
14 covered person or the covered person's authorized
15 representative; and

16 (6) any other information the Director may request or
17 require.

18 (a-15) The independent review organization shall retain
19 the written records required pursuant to this Section for at
20 least 3 years.

21 (b) The report required under subsection (a) of this
22 Section shall include in the aggregate, by state, and by type
23 of health benefit plan:

24 (1) the total number of requests for external review;

25 (2) the total number of requests for expedited external
26 review;

1 (3) the total number of requests for external review
2 denied;

3 (4) the number of requests for external review
4 resolved, including:

5 (A) the number of requests for external review
6 resolved upholding the adverse determination or final
7 adverse determination;

8 (B) the number of requests for external review
9 resolved reversing the adverse determination or final
10 adverse determination;

11 (C) the number of requests for expedited external
12 review resolved upholding the adverse determination or
13 final adverse determination; and

14 (D) the number of requests for expedited external
15 review resolved reversing the adverse determination or
16 final adverse determination;

17 (5) the average length of time for resolution for an
18 external review;

19 (6) the average length of time for resolution for an
20 expedited external review;

21 (7) a summary of the types of coverages or cases for
22 which an external review was sought, as specified below:

23 (A) denial of care or treatment (dissatisfaction
24 regarding prospective non-authorization of a request
25 for care or treatment recommended by a provider
26 excluding diagnostic procedures and referral requests;

1 partial approvals and care terminations are also
2 considered to be denials);

3 (B) denial of diagnostic procedure
4 (dissatisfaction regarding prospective
5 non-authorization of a request for a diagnostic
6 procedure recommended by a provider; partial approvals
7 are also considered to be denials);

8 (C) denial of referral request (dissatisfaction
9 regarding non-authorization of a request for a
10 referral to another provider recommended by a PCP);

11 (D) claims and utilization review (dissatisfaction
12 regarding the concurrent or retrospective evaluation
13 of the coverage, medical necessity, efficiency or
14 appropriateness of health care services or treatment
15 plans; prospective "Denials of care or treatment",
16 "Denials of diagnostic procedures" and "Denials of
17 referral requests" should not be classified in this
18 category, but the appropriate one above);

19 (8) the number of external reviews that were terminated
20 as the result of a reconsideration by the health carrier of
21 its adverse determination or final adverse determination
22 after the receipt of additional information from the
23 covered person or the covered person's authorized
24 representative; and

25 (9) any other information the Director may request or
26 require.

1 (Source: P.A. 96-857, eff. 7-1-10; 97-574, eff. 8-26-11.)

2 Section 99. Effective date. This Act takes effect January
3 1, 2017.