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 Section 355.4 and by adding Section 355d as follows:

(215 ILCS 5/355.4)

Sec. 355.4. Provider notification of network plan changes.

(a) As used in this Section:

"Contracting entity" means any person or company that enters into direct contracts with providers for the delivery of dental services in the ordinary course of business, including a third-party administrator and a dental carrier.

"Dental carrier" means a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits, or a health insurance plan that includes coverage for dental services.

(b) No dental carrier may automatically enroll a provider in a leased network without allowing any provider that is part of the dental carrier's provider network to choose to not participate by opting out.

(c) Any contract entered into or renewed on or after the effective date of this amendatory Act of the 103rd General Assembly that allows the rights and obligations of the

contract to be assigned or leased to another insurer shall provide for notice that informs each provider in writing via ~~certified~~ mail 60 days before any scheduled assignment or lease of the network to which the provider is a contracted provider. To be in compliance with this Section, the notification must provide the specific URL address where the following are located: ~~include~~ all contract terms, a policy manual, a fee schedule, and a statement that the provider has the right to choose not to participate in third-party access. The notification must also provide instructions for how the provider may obtain a copy of those materials.

(d) A dental carrier that leases or assigns its network shall not cancel a network participating dentist's contractual relationship or otherwise penalize a network participating dentist in any way based on whether or not the dentist accepts the terms of the assignment or lease. Before accepting the terms of an assignment or lease agreement as described in this Section, any provider who receives notification of an impending assignment or lease must be given the option to contract directly with the entities proposing to gain access to the provider's network.

(e) The provisions of this Section do not apply:

(1) if access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity; or

(2) to a provider network contract for dental services provided to beneficiaries of the State employee group health insurance program or the medical assistance program under the Illinois Public Aid Code.

(Source: P.A. 103-24, eff. 1-1-24.)

(215 ILCS 5/355d new)

Sec. 355d. Denials of claims submitted after prior authorization.

(a) In this Section:

"Dental carrier" means an insurer, dental service corporation, insurance network leasing company, or any company that offers individual or group policies of accident and health insurance that provide coverage for dental services.

"Prior authorization" means any written communication that is verifiable, whether through issuance or letter, facsimile, email, or similar means, indicating that a specific procedure is, or multiple procedures are, covered under the patient's dental plan and reimbursable at a specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by a dentist using a format prescribed by the dental carrier.

(b) Beginning on the effective date of this amendatory Act of the 103rd General Assembly, a dental carrier shall not deny any claim subsequently submitted for procedures specifically included in a prior authorization unless at least one of the

following circumstances applies for each procedure denied:

(1) benefit limitations, such as annual maximums and frequency limitations, that were not applicable at the time of the prior authorization are reached due to utilization after issuance of the prior authorization;

(2) the documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

(3) if, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary based on the prevailing standard of care;

(4) if, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would, at that time, require disapproval pursuant to the terms and conditions for coverage under the plan for the patient in effect at the time the prior authorization was used; or

(5) the claim was denied by a dental carrier due to one of the following reasons:

(A) another payor is responsible for the payment;

(B) the dentist has already been paid for the procedures identified on the claim;

(C) the claim was submitted fraudulently or the prior authorization was based in whole or material part on erroneous information provided to the dental carrier; or

(D) the person receiving the procedure was not eligible for the procedure on the date of service and the dental carrier did not know, and with the exercise of reasonable care could not have known, that person's eligibility status.

A dental carrier shall not recoup a claim solely due to a loss of coverage of a patient or ineligibility if, at the time of treatment, the dental carrier erroneously confirmed coverage and eligibility, but had sufficient information available to the dental carrier indicating that the patient was no longer covered or was ineligible for coverage.

(c) The provisions of this Section may not be waived by contract. Any contractual agreement entered into or amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 103rd General Assembly that is in conflict with this Section or that purports to waive any requirement of this Section is null and void.

Section 10. The Limited Health Service Organization Act is amended by changing Section 4003 as follows:

(215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

Sec. 4003. Illinois Insurance Code provisions. Limited health service organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 155.49, 355.2, 355.3, 355b, 355d, 356q, 356v, 356z.4, 356z.4a, 356z.10, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.57, 356z.59, 356z.61, 356z.64, 356z.67, 356z.68, 364.3, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code. Nothing in this Section shall require a limited health care plan to cover any service that is not a limited health service. For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited health service organizations in the following categories are deemed to be domestic companies:

(1) a corporation under the laws of this State; or

(2) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a domestic company under Article VIII 1/2 of the Illinois Insurance Code.

(Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22;

102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; revised 8-29-23.)

Section 15. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b, 355d, 356g, 356g.5, 356g.5-1, 356q, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.40, 356z.41, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 364.01, 364.3, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 102-30, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)