HB3650

LRB09604626RPM14685b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB3650

Introduced 2/24/2009, by Rep. Mary E. Flowers

SYNOPSIS AS INTRODUCED:

5 ILCS 375/6.11	
55 ILCS 5/5-1069.3	
65 ILCS 5/10-4-2.3	
105 ILCS 5/10-22.3f	
215 ILCS 5/356f.1 new	
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2
215 ILCS 130/4003	from Ch. 73, par. 1504-3
215 ILCS 134/45	
215 ILCS 165/10	from Ch. 32, par. 604

Amends the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Illinois Insurance Code, the Health Maintenance Organization Act, the Limited Health Service Organization Act, and the Voluntary Health Services Plans Act. Provides that a policy of accident or health insurance or managed care plan shall establish and maintain an appeals procedure related to the denial of health care benefits. Sets forth guidelines for maintaining an appeals procedure, including an expedited process for an enrollee with (1) an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, (2) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, or (3) nonrenewal or termination of a plan. Provides that if an initial appeal is denied by the policy or plan, an enrollee is entitled to seek external independent review of the decision made by the policy or plan. Sets forth guidelines and requirements for the external independent review process. Provides that nothing in the provision shall be construed to require a policy or plan to pay for a health care service not covered under the enrollee's certificate of coverage or policy. Provides that a policy or plan shall provide each enrollee, prospective enrollee, and enrollee representative with written notification of the policy's or plan's appeal processes. Amends the Managed Care Reform and Patient Rights Act to provide that when an appeal concerns a decision or action by a health care plan, its employees, or its subcontractors that relates to the nonrenewal or termination of a plan, the health care plan must allow for the filing of an appeal either orally or in writing. Makes other changes.

LRB096 04626 RPM 14685 b

A BILL FOR

AN ACT concerning insurance.

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

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

(Text of Section before amendment by P.A. 95-958)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356f.1, 356g.5, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.9, 356z.10, 356z.13 ~~356z.11~~, and 356z.14 of the Illinois Insurance Code. The program of health benefits must comply with Section 155.37 of the Illinois Insurance Code.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

(Text of Section after amendment by P.A. 95-958)

Sec. 6.11. Required health benefits; Illinois Insurance

Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356f.1, 356g.5, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.9, 356z.10, 356z.11, ~~and~~ 356z.12, 356z.13 ~~356z.11~~, and 356z.14 of the Illinois Insurance Code. The program of health benefits must comply with Section 155.37 of the Illinois Insurance Code.
(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

Section 10. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

(Text of Section before amendment by P.A. 95-958)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356f.1, 356g.5, 356u, 356w, 356x, 356z.6,

356z.9, 356z.10, 356z.13 ~~356z.11~~, and 356z.14 of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.
(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

(Text of Section after amendment by P.A. 95-958)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356f.1, 356g.5, 356u, 356w, 356x, 356z.6, 356z.9, 356z.10, 356z.11, ~~and~~ 356z.12, 356z.13 ~~356z.11~~, and 356z.14 of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

Section 15. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

(Text of Section before amendment by P.A. 95-958)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356f.1, 356g.5, 356u, 356w, 356x, 356z.6, 356z.9, 356z.10, 356z.13 ~~356z.11~~, and 356z.14 of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-978, eff.

1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

(Text of Section after amendment by P.A. 95-958)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections <u>356f.1,</u> 356g.5, 356u, 356w, 356x, 356z.6, 356z.9, 356z.10, 356z.11, ~~and~~ 356z.12<u>,</u> <u>356z.13</u> ~~356z.11~~, and 356z.14 of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

Section 20. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

(Text of Section before amendment by P.A. 95-958)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356f.1, 356g.5, 356u, 356w, 356x, 356z.6, 356z.9, 356z.13 ~~and 356z.11~~, and 356z.14 of the Illinois Insurance Code.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-876, eff. 8-21-08; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

(Text of Section after amendment by P.A. 95-958)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356f.1, 356g.5, 356u, 356w, 356x, 356z.6, 356z.9, 356z.11, ~~and~~ 356z.12, 356z.13 ~~and 356z.11~~, and 356z.14 of the Illinois Insurance Code.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, 12-12-08; revised 12-15-08.)

Section 25. The Illinois Insurance Code is amended by

1 adding Section 356f.1 as follows:

2 (215 ILCS 5/356f.1 new)

3 Sec. 356f.1. Health care services appeals, complaints, and
4 external independent reviews.

5 (a) A policy of accident or health insurance or managed
6 care plan shall establish and maintain an appeals procedure as
7 outlined in this Section. Compliance with this Section's
8 appeals procedures shall satisfy a policy or plan's obligation
9 to provide appeal procedures under any other State law or
10 rules.

11 (b) When an appeal concerns a decision or action by a
12 policy of accident or health insurance or managed care plan,
13 its employees, or its subcontractors that relates to (i) health
14 care services, including, but not limited to, procedures or
15 treatments for an enrollee with an ongoing course of treatment
16 ordered by a health care provider, the denial of which could
17 significantly increase the risk to an enrollee's health, or
18 (ii) a treatment referral, service, procedure, or other health
19 care service, the denial of which could significantly increase
20 the risk to an enrollee's health, or (iii) the non-renewal or
21 termination of a plan, the policy or plan must allow for the
22 filing of an appeal either orally or in writing. Upon
23 submission of the appeal, a policy or plan must notify the
24 party filing the appeal, as soon as possible, but in no event
25 more than 24 hours after the submission of the appeal, of all

information that the plan requires to evaluate the appeal. The policy or plan shall render a decision on the appeal within 24 hours after receipt of the required information. The policy or plan shall notify the party filing the appeal and the enrollee, enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal of its decision orally followed-up by a written notice of the determination.

(c) For all appeals related to health care services including, but not limited to, procedures or treatments for an enrollee and not covered by subsection (b) above, the policy or plan shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection, a policy or plan must notify the party filing an appeal, within 3 business days, of all information that the policy or plan requires to evaluate the appeal. The policy or plan shall render a decision on the appeal within 15 business days after receipt of the required information. The policy or plan shall notify the party filing the appeal, the enrollee, the enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal orally of its decision followed-up by a written notice of the determination.

(d) An appeal under subsection (b) or (c) may be filed by the enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health

1 care provider. A policy or plan shall designate a clinical peer
2 to review appeals, because these appeals pertain to medical or
3 clinical matters and such an appeal must be reviewed by an
4 appropriate health care professional. No one reviewing an
5 appeal may have had any involvement in the initial
6 determination that is the subject of the appeal. The written
7 notice of determination required under subsections (b) and (c)
8 shall include (i) clear and detailed reasons for the
9 determination, (ii) the medical or clinical criteria for the
10 determination, which shall be based upon sound clinical
11 evidence and reviewed on a periodic basis, and (iii) in the
12 case of an adverse determination, the procedures for requesting
13 an external independent review under subsection (f).
14 (e) If an appeal filed under subsection (b) or (c) is
15 denied for a reason including, but not limited to, the service,
16 procedure, or treatment is not viewed as medically necessary,
17 denial of specific tests or procedures, denial of referral to
18 specialist physicians or denial of hospitalization requests or
19 length of stay requests, any involved party may request an
20 external independent review under subsection (f) of the adverse
21 determination.
22 (f) The party seeking an external independent review shall
23 so notify the policy or plan. The policy or plan shall seek to
24 resolve all external independent reviews in the most
25 expeditious manner and shall make a determination and provide
26 notice of the determination no more than 24 hours after the

receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health or when extended health care services for an enrollee undergoing a course of treatment prescribed by a health care provider are at issue.

(1) Within 30 days after the enrollee receives written notice of an adverse determination, if the enrollee decides to initiate an external independent review, the enrollee shall send to the policy or plan a written request for an external independent review, including any information or documentation to support the enrollee's request for the covered service or claim for a covered service.

(2) Within 30 days after the policy or plan receives a request for an external independent review from an enrollee or, within 24 hours after the receipt of a request if a delay would significantly increase the risk to the enrollee's health, the policy or plan shall:

(a) provide a mechanism for joint selection of an external independent reviewer by the enrollee, the enrollee's physician or other health care provider, and the policy or plan; and

(b) forward to the independent reviewer all medical records and supporting documentation pertaining to the case, a summary description of the applicable issues including a statement of the decision made by, the criteria used, and the medical

1 and clinical reasons for that decision.
2 (3) Within 5 days after receipt of all necessary
3 information or within 24 hours when a delay would
4 significantly increase the risk to an enrollee's health,
5 the independent reviewer shall evaluate and analyze the
6 case and render a decision that is based on whether or not
7 the health care service or claim for the health care
8 service is medically appropriate. The decision by the
9 independent reviewer is final. If the external independent
10 reviewer determines the health care service to be medically
11 appropriate, the policy or plan shall pay for the health
12 care service.
13 (4) The policy or plan shall be solely responsible for
14 paying the fees of the external independent reviewer who is
15 selected to perform the review.
16 (5) An external independent reviewer who acts in good
17 faith shall have immunity from any civil or criminal
18 liability or professional discipline as a result of acts or
19 omissions with respect to any external independent review,
20 unless the acts or omissions constitute wilful and wanton
21 misconduct. For purposes of any proceeding, the good faith
22 of the person participating shall be presumed.
23 (6) Future contractual or employment action by the
24 policy or plan regarding the patient's physician or other
25 health care provider shall not be based solely on the
26 physician's or other health care provider's participation

1 in this procedure.
2 (7) For the purposes of this Section, an external
3 independent reviewer shall:
4 (a) be a clinical peer;
5 (b) have no direct financial interest in
6 connection with the case; and
7 (c) have not been informed of the specific identity
8 of the enrollee.
9 (g) Nothing in this Section shall be construed to require a
10 policy or plan to pay for a health care service not covered
11 under the enrollee's certificate of coverage or policy.
12 (h) A policy of accident or health insurance or managed
13 care plan shall provide each enrollee, prospective enrollee,
14 and enrollee representative with written notification of the
15 policy's or plan's appeal process and any external review
16 appeals process that is available to the enrollee. This
17 notification shall be provided at the time the insured enrolls
18 in the health insurance or managed care plan, renews such
19 enrollment, or requests to reverse or modify an adverse
20 determination made by the insurer or managed care plan. The
21 notice outlined in this subsection (h) shall describe the
22 policy's or plan's appeals process, any applicable forms, and
23 the time frames for appeals, complaints, and external review
24 appeals and shall include a phone number to call for more
25 information from the policy or plan concerning the appeals
26 process.

Section 30. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

(Text of Section before amendment by P.A. 95-958)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 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, 355.2, 356f.1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.13 ~~356z.11~~, 356z.14, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

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

1 (3) a corporation organized under the laws of another
2 state, 30% or more of the enrollees of which are residents
3 of this State, except a corporation subject to
4 substantially the same requirements in its state of
5 organization as is a "domestic company" under Article VIII
6 1/2 of the Illinois Insurance Code.
7 (c) In considering the merger, consolidation, or other
8 acquisition of control of a Health Maintenance Organization
9 pursuant to Article VIII 1/2 of the Illinois Insurance Code,
10 (1) the Director shall give primary consideration to
11 the continuation of benefits to enrollees and the financial
12 conditions of the acquired Health Maintenance Organization
13 after the merger, consolidation, or other acquisition of
14 control takes effect;
15 (2)(i) the criteria specified in subsection (1)(b) of
16 Section 131.8 of the Illinois Insurance Code shall not
17 apply and (ii) the Director, in making his determination
18 with respect to the merger, consolidation, or other
19 acquisition of control, need not take into account the
20 effect on competition of the merger, consolidation, or
21 other acquisition of control;
22 (3) the Director shall have the power to require the
23 following information:
24 (A) certification by an independent actuary of the
25 adequacy of the reserves of the Health Maintenance
26 Organization sought to be acquired;

1 (B) pro forma financial statements reflecting the
2 combined balance sheets of the acquiring company and
3 the Health Maintenance Organization sought to be
4 acquired as of the end of the preceding year and as of
5 a date 90 days prior to the acquisition, as well as pro
6 forma financial statements reflecting projected
7 combined operation for a period of 2 years;
8 (C) a pro forma business plan detailing an
9 acquiring party's plans with respect to the operation
10 of the Health Maintenance Organization sought to be
11 acquired for a period of not less than 3 years; and
12 (D) such other information as the Director shall
13 require.
14 (d) The provisions of Article VIII 1/2 of the Illinois
15 Insurance Code and this Section 5-3 shall apply to the sale by
16 any health maintenance organization of greater than 10% of its
17 enrollee population (including without limitation the health
18 maintenance organization's right, title, and interest in and to
19 its health care certificates).
20 (e) In considering any management contract or service
21 agreement subject to Section 141.1 of the Illinois Insurance
22 Code, the Director (i) shall, in addition to the criteria
23 specified in Section 141.2 of the Illinois Insurance Code, take
24 into account the effect of the management contract or service
25 agreement on the continuation of benefits to enrollees and the
26 financial condition of the health maintenance organization to

1 be managed or serviced, and (ii) need not take into account the
2 effect of the management contract or service agreement on
3 competition.
4 (f) Except for small employer groups as defined in the
5 Small Employer Rating, Renewability and Portability Health
6 Insurance Act and except for medicare supplement policies as
7 defined in Section 363 of the Illinois Insurance Code, a Health
8 Maintenance Organization may by contract agree with a group or
9 other enrollment unit to effect refunds or charge additional
10 premiums under the following terms and conditions:
11 (i) the amount of, and other terms and conditions with
12 respect to, the refund or additional premium are set forth
13 in the group or enrollment unit contract agreed in advance
14 of the period for which a refund is to be paid or
15 additional premium is to be charged (which period shall not
16 be less than one year); and
17 (ii) the amount of the refund or additional premium
18 shall not exceed 20% of the Health Maintenance
19 Organization's profitable or unprofitable experience with
20 respect to the group or other enrollment unit for the
21 period (and, for purposes of a refund or additional
22 premium, the profitable or unprofitable experience shall
23 be calculated taking into account a pro rata share of the
24 Health Maintenance Organization's administrative and
25 marketing expenses, but shall not include any refund to be
26 made or additional premium to be paid pursuant to this

subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

(Text of Section after amendment by P.A. 95-958)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 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, 355.2, 356f.1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13 ~~356z.11~~, 356z.14, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

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

(3) 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.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro

1 forma financial statements reflecting projected
2 combined operation for a period of 2 years;
3 (C) a pro forma business plan detailing an
4 acquiring party's plans with respect to the operation
5 of the Health Maintenance Organization sought to be
6 acquired for a period of not less than 3 years; and
7 (D) such other information as the Director shall
8 require.
9 (d) The provisions of Article VIII 1/2 of the Illinois
10 Insurance Code and this Section 5-3 shall apply to the sale by
11 any health maintenance organization of greater than 10% of its
12 enrollee population (including without limitation the health
13 maintenance organization's right, title, and interest in and to
14 its health care certificates).
15 (e) In considering any management contract or service
16 agreement subject to Section 141.1 of the Illinois Insurance
17 Code, the Director (i) shall, in addition to the criteria
18 specified in Section 141.2 of the Illinois Insurance Code, take
19 into account the effect of the management contract or service
20 agreement on the continuation of benefits to enrollees and the
21 financial condition of the health maintenance organization to
22 be managed or serviced, and (ii) need not take into account the
23 effect of the management contract or service agreement on
24 competition.
25 (f) Except for small employer groups as defined in the
26 Small Employer Rating, Renewability and Portability Health

1 Insurance Act and except for medicare supplement policies as
2 defined in Section 363 of the Illinois Insurance Code, a Health
3 Maintenance Organization may by contract agree with a group or
4 other enrollment unit to effect refunds or charge additional
5 premiums under the following terms and conditions:
6 (i) the amount of, and other terms and conditions with
7 respect to, the refund or additional premium are set forth
8 in the group or enrollment unit contract agreed in advance
9 of the period for which a refund is to be paid or
10 additional premium is to be charged (which period shall not
11 be less than one year); and
12 (ii) the amount of the refund or additional premium
13 shall not exceed 20% of the Health Maintenance
14 Organization's profitable or unprofitable experience with
15 respect to the group or other enrollment unit for the
16 period (and, for purposes of a refund or additional
17 premium, the profitable or unprofitable experience shall
18 be calculated taking into account a pro rata share of the
19 Health Maintenance Organization's administrative and
20 marketing expenses, but shall not include any refund to be
21 made or additional premium to be paid pursuant to this
22 subsection (f)). The Health Maintenance Organization and
23 the group or enrollment unit may agree that the profitable
24 or unprofitable experience may be calculated taking into
25 account the refund period and the immediately preceding 2
26 plan years.

1 The Health Maintenance Organization shall include a
2 statement in the evidence of coverage issued to each enrollee
3 describing the possibility of a refund or additional premium,
4 and upon request of any group or enrollment unit, provide to
5 the group or enrollment unit a description of the method used
6 to calculate (1) the Health Maintenance Organization's
7 profitable experience with respect to the group or enrollment
8 unit and the resulting refund to the group or enrollment unit
9 or (2) the Health Maintenance Organization's unprofitable
10 experience with respect to the group or enrollment unit and the
11 resulting additional premium to be paid by the group or
12 enrollment unit.

13 In no event shall the Illinois Health Maintenance
14 Organization Guaranty Association be liable to pay any
15 contractual obligation of an insolvent organization to pay any
16 refund authorized under this Section.

17 (Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06;
18 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.
19 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005,
20 eff. 12-12-08; revised 12-15-08.)

21 Section 35. The Limited Health Service Organization Act is
22 amended by changing Section 4003 as follows:

23 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

24 Sec. 4003. Illinois Insurance Code provisions. Limited

1 health service organizations shall be subject to the provisions
2 of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c,
3 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8,
4 155.04, 155.37, 355.2, 356f.1, 356v, 356z.10, 368a, 401, 401.1,
5 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and
6 Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and
7 XXVI of the Illinois Insurance Code. For purposes of the
8 Illinois Insurance Code, except for Sections 444 and 444.1 and
9 Articles XIII and XIII 1/2, limited health service
10 organizations in the following categories are deemed to be
11 domestic companies:
12 (1) a corporation under the laws of this State; or
13 (2) a corporation organized under the laws of another
14 state, 30% of more of the enrollees of which are residents
15 of this State, except a corporation subject to
16 substantially the same requirements in its state of
17 organization as is a domestic company under Article VIII
18 1/2 of the Illinois Insurance Code.
19 (Source: P.A. 95-520, eff. 8-28-07; 95-876, eff. 8-21-08.)

20 Section 40. The Managed Care Reform and Patient Rights Act
21 is amended by changing Section 45 as follows:

22 (215 ILCS 134/45)
23 Sec. 45. Health care services appeals, complaints, and
24 external independent reviews.

(a) A health care plan shall establish and maintain an appeals procedure as outlined in this Act. Compliance with this Act's appeals procedures shall satisfy a health care plan's obligation to provide appeal procedures under any other State law or rules. All appeals of a health care plan's administrative determinations and complaints regarding its administrative decisions shall be handled as required under Section 50.

(b) When an appeal concerns a decision or action by a health care plan, its employees, or its subcontractors that relates to (i) health care services, including, but not limited to, procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, ~~or~~ (ii) a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, or (iii) the nonrenewal or termination of a plan, the health care plan must allow for the filing of an appeal either orally or in writing. Upon submission of the appeal, a health care plan must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 24 hours after receipt of the required information. The health care plan shall notify

1 the party filing the appeal and the enrollee, enrollee's
2 primary care physician, and any health care provider who
3 recommended the health care service involved in the appeal of
4 its decision orally followed-up by a written notice of the
5 determination.
6 (c) For all appeals related to health care services
7 including, but not limited to, procedures or treatments for an
8 enrollee and not covered by subsection (b) above, the health
9 care plan shall establish a procedure for the filing of such
10 appeals. Upon submission of an appeal under this subsection, a
11 health care plan must notify the party filing an appeal, within
12 3 business days, of all information that the plan requires to
13 evaluate the appeal. The health care plan shall render a
14 decision on the appeal within 15 business days after receipt of
15 the required information. The health care plan shall notify the
16 party filing the appeal, the enrollee, the enrollee's primary
17 care physician, and any health care provider who recommended
18 the health care service involved in the appeal orally of its
19 decision followed-up by a written notice of the determination.
20 (d) An appeal under subsection (b) or (c) may be filed by
21 the enrollee, the enrollee's designee or guardian, the
22 enrollee's primary care physician, or the enrollee's health
23 care provider. A health care plan shall designate a clinical
24 peer to review appeals, because these appeals pertain to
25 medical or clinical matters and such an appeal must be reviewed
26 by an appropriate health care professional. No one reviewing an

appeal may have had any involvement in the initial determination that is the subject of the appeal. The written notice of determination required under subsections (b) and (c) shall include (i) clear and detailed reasons for the determination, (ii) the medical or clinical criteria for the determination, which shall be based upon sound clinical evidence and reviewed on a periodic basis, and (iii) in the case of an adverse determination, the procedures for requesting an external independent review under subsection (f).

(e) If an appeal filed under subsection (b) or (c) is denied for a reason including, but not limited to, the service, procedure, or treatment is not viewed as medically necessary, denial of specific tests or procedures, denial of referral to specialist physicians or denial of hospitalization requests or length of stay requests, any involved party may request an external independent review under subsection (f) of the adverse determination.

(f) External independent review.

(1) The party seeking an external independent review shall so notify the health care plan. The health care plan shall seek to resolve all external independent reviews in the most expeditious manner and shall make a determination and provide notice of the determination no more than 24 hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health or when extended health care services for

an enrollee undergoing a course of treatment prescribed by a health care provider are at issue.

(2) Within 30 days after the enrollee receives written notice of an adverse determination, if the enrollee decides to initiate an external independent review, the enrollee shall send to the health care plan a written request for an external independent review, including any information or documentation to support the enrollee's request for the covered service or claim for a covered service.

(3) Within 30 days after the health care plan receives a request for an external independent review from an enrollee, the health care plan shall:

(A) provide a mechanism for joint selection of an external independent reviewer by the enrollee, the enrollee's physician or other health care provider, and the health care plan; and

(B) forward to the independent reviewer all medical records and supporting documentation pertaining to the case, a summary description of the applicable issues including a statement of the health care plan's decision, the criteria used, and the medical and clinical reasons for that decision.

(4) Within 5 days after receipt of all necessary information, the independent reviewer shall evaluate and analyze the case and render a decision that is based on whether or not the health care service or claim for the

1 health care service is medically appropriate. The decision
2 by the independent reviewer is final. If the external
3 independent reviewer determines the health care service to
4 be medically appropriate, the health care plan shall pay
5 for the health care service.
6 (5) The health care plan shall be solely responsible
7 for paying the fees of the external independent reviewer
8 who is selected to perform the review.
9 (6) An external independent reviewer who acts in good
10 faith shall have immunity from any civil or criminal
11 liability or professional discipline as a result of acts or
12 omissions with respect to any external independent review,
13 unless the acts or omissions constitute wilful and wanton
14 misconduct. For purposes of any proceeding, the good faith
15 of the person participating shall be presumed.
16 (7) Future contractual or employment action by the
17 health care plan regarding the patient's physician or other
18 health care provider shall not be based solely on the
19 physician's or other health care provider's participation
20 in this procedure.
21 (8) For the purposes of this Section, an external
22 independent reviewer shall:
23 (A) be a clinical peer;
24 (B) have no direct financial interest in
25 connection with the case; and
26 (C) have not been informed of the specific identity

1 of the enrollee.
2 (g) Nothing in this Section shall be construed to require a
3 health care plan to pay for a health care service not covered
4 under the enrollee's certificate of coverage or policy.
5 (Source: P.A. 91-617, eff. 1-1-00.)

6 Section 45. The Voluntary Health Services Plans Act is
7 amended by changing Section 10 as follows:

8 (215 ILCS 165/10) (from Ch. 32, par. 604)
9 (Text of Section before amendment by P.A. 95-958)
10 Sec. 10. Application of Insurance Code provisions. Health
11 services plan corporations and all persons interested therein
12 or dealing therewith shall be subject to the provisions of
13 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,
14 149, 155.37, 354, 355.2, 356f.1, 356g.5, 356r, 356t, 356u,
15 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6,
16 356z.8, 356z.9, 356z.10, 356z.13 ~~356z.11~~, 356z.14, 364.01,
17 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412,
18 and paragraphs (7) and (15) of Section 367 of the Illinois
19 Insurance Code.
20 (Source: P.A. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07;
21 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff.
22 8-28-07; 95-876, eff. 8-21-08; 95-978, eff. 1-1-09; 95-1005,
23 eff. 12-12-08; revised 12-15-08.)

1 (Text of Section after amendment by P.A. 95-958)
2 Sec. 10. Application of Insurance Code provisions. Health
3 services plan corporations and all persons interested therein
4 or dealing therewith shall be subject to the provisions of
5 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,
6 149, 155.37, 354, 355.2, 356f.1, 356g.5, 356r, 356t, 356u,
7 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6,
8 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13 ~~356z.11~~,
9 356z.14, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408,
10 408.2, and 412, and paragraphs (7) and (15) of Section 367 of
11 the Illinois Insurance Code.
12 (Source: P.A. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07;
13 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff.
14 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978,
15 eff. 1-1-09; 95-1005, eff. 12-12-08; revised 12-15-08.)

16 Section 95. No acceleration or delay. Where this Act makes
17 changes in a statute that is represented in this Act by text
18 that is not yet or no longer in effect (for example, a Section
19 represented by multiple versions), the use of that text does
20 not accelerate or delay the taking effect of (i) the changes
21 made by this Act or (ii) provisions derived from any other
22 Public Act.