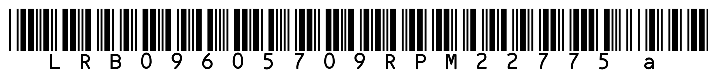
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Health Care Availability and Accessibility Committee

Filed: 3/10/2009

1 AMENDMENT TO HOUSE BILL 3749

2 AMENDMENT NO. ______. Amend House Bill 3749 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Illinois Insurance Code is amended by
5 changing Sections 357.9 357.9a, 368b, 368c, 368d, 368e, 368g,
6 370, 370a, and 370b as follows:

7 (215 ILCS 5/357.9) (from Ch. 73, par. 969.9)
8 Sec. 357.9. "TIME OF PAYMENT OF CLAIMS: Indemnities payable
9 under this policy for any loss other than loss for which this
10 policy provides any periodic payment will be paid immediately
11 upon receipt of due written proof of such loss. Subject to due
12 written proof of loss, all accrued indemnities for loss for
13 which this policy provides periodic payment will be paid ....
14 (insert period for payment which must not be less frequently
15 than monthly) and any balance remaining unpaid upon the
16 termination of liability, will be paid immediately upon receipt

1 of due written proof."
2 All claims and indemnities payable under the terms of a
3 policy of accident and health insurance shall be paid within 30
4 days following receipt by the insurer of due proof of loss.
5 Failure to pay within such period shall entitle the insured to
6 interest at the rate of 10% ~~9 per cent~~ per annum from the 30th
7 day after receipt of such proof of loss to the date of late
8 payment, provided that interest amounting to less than one
9 dollar need not be paid. An insured or an insured's assignee
10 shall be notified by the insurer, health maintenance
11 organization, managed care plan, health care plan, preferred
12 provider organization, or third party administrator of any
13 known failure to provide sufficient documentation for a due
14 proof of loss within 30 days after receipt of the claim. Any
15 required interest payments shall be made within 30 days after
16 the payment.
17 The requirements of this Section shall apply to any policy
18 of accident and health insurance delivered, issued for
19 delivery, renewed or amended on or after 180 days following the
20 effective date of this amendatory Act of 1985. The requirements
21 of this Section also shall specifically apply to any group
22 policy of dental insurance only, delivered, issued for
23 delivery, renewed or amended on or after 180 days following the
24 effective date of this amendatory Act of 1987.
25 (Source: P.A. 91-605, eff. 12-14-99.)

(215 ILCS 5/357.9a) (from Ch. 73, par. 969.9a)

Sec. 357.9a. Delay in payment of claims. Periodic payments of accrued indemnities for loss-of-time coverage under accident and health policies shall commence not later than 30 days after the receipt by the company of the required written proofs of loss. An insurer which violates this Section if liable under said policy, shall pay to the insured, in addition to any other penalty provided for in this Code, interest at the rate of 10% ~~9%~~ per annum from the 30th day after receipt of such proofs of loss to the date of late payment of the accrued indemnities, provided that interest amounting to less than one dollar need not be paid.

(Source: P.A. 92-139, eff. 7-24-01.)

(215 ILCS 5/368c)

Sec. 368c. Remittance advice and procedures.

(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 any withholds and the reason for any denial or reduction. An insurer, health maintenance organization, independent practice association, or

1 physician hospital organization may not reduce the amount for
2 which a claim is submitted other than pursuant to the terms of
3 a contract signed by the health care professional or health
4 care provider. If no contract exists, then the health care
5 professional's or health care provider's charges shall be paid
6 with the patient's responsibility being no more than 30% of the
7 charges, not including any applicable deductible.

8 A remittance advice for capitation or prospective payment
9 arrangements shall be furnished to a health care professional
10 or health care provider pursuant to a contract with an insurer,
11 health maintenance organization, independent practice
12 association, or physician hospital organization in accordance
13 with the terms of the contract.

14 (b) When health care services are provided by a
15 non-participating health care professional or health care
16 provider, an insurer, health maintenance organization,
17 independent practice association, or physician hospital
18 organization may pay for covered services either to a patient
19 directly or to the non-participating health care professional
20 or health care provider.

21 (c) When a person presents a benefits information card, a
22 health care professional or health care provider shall make a
23 good faith effort to inform the person if the health care
24 professional or health care provider has a participation
25 contract with the insurer, health maintenance organization, or
26 other entity identified on the card.

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

(215 ILCS 5/368d)

Sec. 368d. Recoupments.

(a) A health care professional or health care provider shall be provided a remittance advice, which must include an explanation of a recoupment or offset taken by an insurer, health maintenance organization, independent practice association, or physician hospital organization, if any. The recoupment explanation shall, at a minimum, include the name of the patient; the date of service; the service code or if no service code is available a service description; the recoupment amount; and the reason for the recoupment or offset. In addition, an insurer, health maintenance organization, independent practice association, or physician hospital organization shall provide with the remittance advice a telephone number or mailing address to initiate an appeal of the recoupment ~~or offset~~. An insurer, health maintenance organization, independent practice association, or physician hospital organization may not recoup any amount unless the recoupment request is submitted within 60 days after the payment of the claim. Offsets are prohibited.

(b) It is not a recoupment when a health care professional or health care provider is paid an amount prospectively or concurrently under a contract with an insurer, health maintenance organization, independent practice association, or

1 physician hospital organization that requires a retrospective
2 reconciliation based upon specific conditions outlined in the
3 contract.
4 (Source: P.A. 93-261, eff. 1-1-04.)

5 (215 ILCS 5/368g new)
6 Sec. 368g. Coverage and rates.
7 (a) No policy of accident and health or managed care plan
8 amended, delivered, issued, or renewed in this State may deny,
9 discontinue, or alter coverage of a treatment method that
10 follows a prescribed standard of care for any illness,
11 condition, injury, disease, or disability during a benefit
12 period if the illness, condition, injury, disease, or
13 disability was covered at any time during the benefit period or
14 if a claim regarding the treatment method is paid during the
15 benefit period. If a treatment method is covered by the policy
16 or plan during the benefit period or if a claim regarding the
17 treatment method is paid, then the policy or plan must continue
18 coverage of the treatment method at the payment rate set by a
19 contract signed by the health care professional or provider or
20 the health care professional's or health care provider's
21 charges for the remainder of the benefit period.
22 (b) No company that issues, delivers, amends, or renews an
23 individual or group policy of accident and health or managed
24 care plan in this State may alter its definition of "eligible
25 expense" or "maximum allowable expense" for a policy or plan

1 after the policy's or plan's benefit period has started.
2 (c) The Director is hereby granted specific authority to
3 issue a cease and desist order against, fine, or otherwise
4 penalize any company doing business in this State that violates
5 the provisions of this Section.

6 (215 ILCS 5/370a) (from Ch. 73, par. 982a)
7 Sec. 370a. Assignability of Accident and Health Insurance.
8 (a) No provision of the Illinois Insurance Code, or any
9 other law, prohibits an insured under any policy of accident
10 and health insurance or any other person who may be the owner
11 of any rights under such policy from making an assignment of
12 all or any part of his rights and privileges under the policy
13 including but not limited to the right to designate a
14 beneficiary and to have an individual policy issued in
15 accordance with its terms. Subject to the terms of the policy
16 or any contract relating thereto, an assignment by an insured
17 or by any other owner of rights under the policy, made before
18 or after the effective date of this amendatory Act of 1969 is
19 valid for the purpose of vesting in the assignee, in accordance
20 with any provisions included therein as to the time at which it
21 is effective, all rights and privileges so assigned. However,
22 such assignment is without prejudice to the company on account
23 of any payment it makes or individual policy it issues before
24 receipt of notice of the assignment. This amendatory Act of
25 1969 acknowledges, declares and codifies the existing right of

1 assignment of interests under accident and health insurance
2 policies.
3 (b) For the purposes of payment for covered services, if ~~If~~
4 an enrollee or insured of an insurer, health maintenance
5 organization, managed care plan, health care plan, preferred
6 provider organization, or third party administrator assigns a
7 claim to a health care professional or health care facility,
8 then payment shall be made directly to the health care
9 professional or health care facility regardless of whether the
10 professional is a participating or non-participating provider,
11 including any interest required under Section 368a, of this
12 Code for failure to pay claims within 30 days after receipt by
13 the insurer of due proof of loss. Nothing in this Section shall
14 be construed to prevent any parties from reconciling duplicate
15 payments.
16 (Source: P.A. 91-605, eff. 12-14-99; 91-788, eff. 6-9-00.)

17 (215 ILCS 5/370b) (from Ch. 73, par. 982b)
18 Sec. 370b. Reimbursement on equal basis. Notwithstanding
19 any provision of any individual or group policy of accident and
20 health insurance, or any provision of a policy, contract, plan
21 or agreement for hospital or medical service or indemnity,
22 wherever such policy, contract, plan or agreement provides for
23 reimbursement for any service provided by persons licensed
24 under the Medical Practice Act of 1987 or the Podiatric Medical
25 Practice Act of 1987, the person entitled to benefits or person

1 performing services under such policy, contract, plan or
2 agreement is entitled to reimbursement on an equal basis for
3 such service, when the service is performed by a person
4 licensed under the Medical Practice Act of 1987 or the
5 Podiatric Medical Practice Act of 1987 whether the person is a
6 participating or non-participating provider. The provisions of
7 this Section do not apply to any policy, contract, plan or
8 agreement in effect prior to September 19, 1969 or to preferred
9 provider arrangements or benefit agreements.
10 (Source: P.A. 90-14, eff. 7-1-97.)".