Rep. Daniel J. Burke

Filed: 2/21/2012

AMENDMENT TO HOUSE BILL 3812

AMENDMENT NO. _____. Amend House Bill 3812 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Section 368c as follows:

(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.

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

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

(c) When a person presents a benefits information card, a health care professional or health care provider shall make a good faith effort to inform the person if the health care professional or health care provider is not a participating provider ~~has a participation contract~~ with the insurer, health maintenance organization, or other entity identified on the card.

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

Section 10. The Managed Care Reform and Patient Rights Act is amended by changing Section 15 as follows:

(215 ILCS 134/15)

Sec. 15. Provision of information.

(a) A health care plan shall provide ~~annually~~ to enrollees and prospective enrollees, ~~upon request,~~ a complete list of participating health care providers in the health care plan's service area and a description of the following terms of coverage:

(1) the service area;

(2) the covered benefits and services with all exclusions, exceptions, and limitations;

(3) the pre-certification and other utilization review procedures and requirements;

(4) a description of the process for the selection of a primary care physician, any limitation on access to specialists, and the plan's standing referral policy for both participating and non-participating providers, including access to specialists in accordance with Section 40 of this Act;

(5) the emergency coverage and benefits, including any restrictions on emergency care services;

(6) the out-of-area coverage and benefits, if any;

(7) the enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses;

(8) the provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by that

provider;

(9) the appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process; and

(10) a statement of all basic health care services and all specific benefits and services mandated to be provided to enrollees by any State law or administrative rule.

In the event of an inconsistency between any separate written disclosure statement and the enrollee contract or certificate, the terms of the enrollee contract or certificate shall control.

(a-5) The required list of participating health care providers shall be provided via the health care plan's Internet website and shall be updated at least every 30 days. The health care plan shall regularly inform policyholders, insureds, or enrollees to consult the list of participating health care providers to allow policyholders, insureds, or enrollees to make informed decisions prior to making appointments. The health plan shall also make available the procedures for making referrals both within and outside the network to insureds, enrollees, and participating health care providers. Further, the health care plan shall maintain a toll-free telephone number for policyholders, insureds, enrollees, or health care

providers to verify whether a health care provider is a participating provider.

(a-10) Notwithstanding any other provision of this Act or the Illinois Insurance Code, when a person presents a benefits information card, a health care provider shall make a good faith effort to inform the person if the health care provider is not a participating provider with the insurer, health maintenance organization, or other entity identified on the card.

(b) Upon written request, a health care plan shall provide to enrollees a description of the financial relationships between the health care plan and any health care provider and, if requested, the percentage of copayments, deductibles, and total premiums spent on healthcare related expenses and the percentage of copayments, deductibles, and total premiums spent on other expenses, including administrative expenses, except that no health care plan shall be required to disclose specific provider reimbursement.

(c) A participating health care provider shall provide all of the following, where applicable, to enrollees upon request:

(1) Information related to the health care provider's educational background, experience, training, specialty, and board certification, if applicable.

(2) The names of licensed facilities on the provider panel where the health care provider presently has privileges for the treatment, illness, or procedure that is

the subject of the request.

(3) Information regarding the health care provider's participation in continuing education programs and compliance with any licensure, certification, or registration requirements, if applicable.

(d) A health care plan shall provide the information required to be disclosed under this Act upon enrollment and annually thereafter in a legible and understandable format, except as provided in item (a-5). The Department shall promulgate rules to establish the format based, to the extent practical, on the standards developed for supplemental insurance coverage under Title XVIII of the federal Social Security Act as a guide, so that a person can compare the attributes of the various health care plans.

(e) The written disclosure requirements of this Section may be met by disclosure to one enrollee in a household.

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