



Sen. Heather Steans

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1 AMENDMENT TO HOUSE BILL 3923

2 AMENDMENT NO. _____. Amend House Bill 3923 by replacing
3 everything after the enacting clause with the following:

4 "Section 1. Short title. This Act may be cited as the
5 Health Carrier External Review Act.

6 Section 5. Purpose and intent. The purpose of this Act is
7 to provide uniform standards for the establishment and
8 maintenance of external review procedures to assure that
9 covered persons have the opportunity for an independent review
10 of an adverse determination or final adverse determination, as
11 defined in this Act.

12 Section 10. Definitions. For the purposes of this Act:

13 "Adverse determination" means a determination by a health
14 carrier or its designee utilization review organization that an
15 admission, availability of care, continued stay, or other

1 health care service that is a covered benefit has been reviewed
2 and, based upon the information provided, does not meet the
3 health carrier's requirements for medical necessity,
4 appropriateness, health care setting, level of care, or
5 effectiveness, and the requested service or payment for the
6 service is therefore denied, reduced, or terminated.

7 "Authorized representative" means:

8 (1) a person to whom a covered person has given express
9 written consent to represent the covered person in an
10 external review, including the covered person's health
11 care provider;

12 (2) a person authorized by law to provide substituted
13 consent for a covered person; or

14 (3) the covered person's health care provider when the
15 covered person is unable to provide consent.

16 "Best evidence" means evidence based on:

17 (1) randomized clinical trials;

18 (2) if randomized clinical trials are not available,
19 then cohort studies or case-control studies;

20 (3) if items (1) and (2) are not available, then
21 case-series; or

22 (4) if items (1), (2), and (3) are not available, then
23 expert opinion.

24 "Case-series" means an evaluation of a series of patients
25 with a particular outcome, without the use of a control group.

26 "Clinical review criteria" means the written screening

1 procedures, decision abstracts, clinical protocols, and
2 practice guidelines used by a health carrier to determine the
3 necessity and appropriateness of health care services.

4 "Cohort study" means a prospective evaluation of 2 groups
5 of patients with only one group of patients receiving specific
6 intervention.

7 "Covered benefits" or "benefits" means those health care
8 services to which a covered person is entitled under the terms
9 of a health benefit plan.

10 "Covered person" means a policyholder, subscriber,
11 enrollee, or other individual participating in a health benefit
12 plan.

13 "Director" means the Director of the Department of
14 Insurance.

15 "Emergency medical condition" means a medical condition
16 manifesting itself by acute symptoms of sufficient severity,
17 including, but not limited to, severe pain, such that a prudent
18 layperson who possesses an average knowledge of health and
19 medicine could reasonably expect the absence of immediate
20 medical attention to result in:

21 (1) placing the health of the individual or, with
22 respect to a pregnant woman, the health of the woman or her
23 unborn child, in serious jeopardy;

24 (2) serious impairment to bodily functions; or

25 (3) serious dysfunction of any bodily organ or part.

26 "Emergency services" means health care items and services

1 furnished or required to evaluate and treat an emergency
2 medical condition.

3 "Evidence-based standard" means the conscientious,
4 explicit, and judicious use of the current best evidence based
5 on an overall systematic review of the research in making
6 decisions about the care of individual patients.

7 "Expert opinion" means a belief or an interpretation by
8 specialists with experience in a specific area about the
9 scientific evidence pertaining to a particular service,
10 intervention, or therapy.

11 "Facility" means an institution providing health care
12 services or a health care setting.

13 "Final adverse determination" means an adverse
14 determination involving a covered benefit that has been upheld
15 by a health carrier, or its designee utilization review
16 organization, at the completion of the health carrier's
17 internal grievance process procedures as set forth by the
18 Managed Care Reform and Patient Rights Act.

19 "Health benefit plan" means a policy, contract,
20 certificate, plan, or agreement offered or issued by a health
21 carrier to provide, deliver, arrange for, pay for, or reimburse
22 any of the costs of health care services.

23 "Health care provider" or "provider" means a physician,
24 hospital facility, or other health care practitioner licensed,
25 accredited, or certified to perform specified health care
26 services consistent with State law, responsible for

1 recommending health care services on behalf of a covered
2 person.

3 "Health care services" means services for the diagnosis,
4 prevention, treatment, cure, or relief of a health condition,
5 illness, injury, or disease.

6 "Health carrier" means an entity subject to the insurance
7 laws and regulations of this State, or subject to the
8 jurisdiction of the Director, that contracts or offers to
9 contract to provide, deliver, arrange for, pay for, or
10 reimburse any of the costs of health care services, including a
11 sickness and accident insurance company, a health maintenance
12 organization, or any other entity providing a plan of health
13 insurance, health benefits, or health care services. "Health
14 carrier" also means Limited Health Service Organizations
15 (LHSO) and Voluntary Health Service Plans.

16 "Health information" means information or data, whether
17 oral or recorded in any form or medium, and personal facts or
18 information about events or relationships that relate to:

19 (1) the past, present, or future physical, mental, or
20 behavioral health or condition of an individual or a member
21 of the individual's family;

22 (2) the provision of health care services to an
23 individual; or

24 (3) payment for the provision of health care services
25 to an individual.

26 "Independent review organization" means an entity that

1 conducts independent external reviews of adverse
2 determinations and final adverse determinations.

3 "Medical or scientific evidence" means evidence found in
4 the following sources:

5 (1) peer-reviewed scientific studies published in or
6 accepted for publication by medical journals that meet
7 nationally recognized requirements for scientific
8 manuscripts and that submit most of their published
9 articles for review by experts who are not part of the
10 editorial staff;

11 (2) peer-reviewed medical literature, including
12 literature relating to therapies reviewed and approved by a
13 qualified institutional review board, biomedical
14 compendia, and other medical literature that meet the
15 criteria of the National Institutes of Health's Library of
16 Medicine for indexing in Index Medicus (Medline) and
17 Elsevier Science Ltd. for indexing in Excerpta Medicus
18 (EMBASE);

19 (3) medical journals recognized by the Secretary of
20 Health and Human Services under Section 1861(t)(2) of the
21 federal Social Security Act;

22 (4) the following standard reference compendia:

23 (a) The American Hospital Formulary Service-Drug
24 Information;

25 (b) Drug Facts and Comparisons;

26 (c) The American Dental Association Accepted

1 Dental Therapeutics; and

2 (d) The United States Pharmacopoeia-Drug
3 Information;

4 (5) findings, studies, or research conducted by or
5 under the auspices of federal government agencies and
6 nationally recognized federal research institutes,
7 including:

8 (a) the federal Agency for Healthcare Research and
9 Quality;

10 (b) the National Institutes of Health;

11 (c) the National Cancer Institute;

12 (d) the National Academy of Sciences;

13 (e) the Centers for Medicare & Medicaid Services;

14 (f) the federal Food and Drug Administration; and

15 (g) any national board recognized by the National
16 Institutes of Health for the purpose of evaluating the
17 medical value of health care services; or

18 (6) any other medical or scientific evidence that is
19 comparable to the sources listed in items (1) through (5).

20 "Protected health information" means health information
21 (i) that identifies an individual who is the subject of the
22 information; or (ii) with respect to which there is a
23 reasonable basis to believe that the information could be used
24 to identify an individual.

25 "Retrospective review" means a review of medical necessity
26 conducted after services have been provided to a patient, but

1 does not include the review of a claim that is limited to an
2 evaluation of reimbursement levels, veracity of documentation,
3 accuracy of coding, or adjudication for payment.

4 "Utilization review" has the meaning provided by the
5 Managed Care Reform and Patient Rights Act.

6 "Utilization review organization" means a utilization
7 review program as defined in the Managed Care Reform and
8 Patient Rights Act.

9 Section 15. Applicability and scope.

10 (a) Except as provided in subsection (b) of this Section,
11 this Act shall apply to all health carriers.

12 (b) The provisions of this Act shall not apply to a policy
13 or certificate that provides coverage only for a specified
14 disease, specified accident or accident-only coverage, credit,
15 dental, disability income, hospital indemnity, long-term care
16 insurance as defined by Article XIXA of the Illinois Insurance
17 Code, vision care, or any other limited supplemental benefit; a
18 Medicare supplement policy of insurance as defined by the
19 Director by regulation; coverage under a plan through Medicare,
20 Medicaid, or the federal employees health benefits program; any
21 coverage issued under Chapter 55 of Title 10, U.S. Code and any
22 coverage issued as supplement to that coverage; any coverage
23 issued as supplemental to liability insurance, workers'
24 compensation, or similar insurance; automobile medical-payment
25 insurance or any insurance under which benefits are payable

1 with or without regard to fault, whether written on a group
2 blanket or individual basis.

3 Section 20. Notice of right to external review.

4 (a) At the same time the health carrier sends written
5 notice of a covered person's right to appeal a coverage
6 decision upon an adverse determination or a final adverse
7 determination as provided by the Managed Care Reform and
8 Patient Rights Act, a health carrier shall notify a covered
9 person and a covered person's health care provider in writing
10 of the covered person's right to request an external review as
11 provided by this Act. The written notice required shall include
12 the following, or substantially equivalent, language: "We have
13 denied your request for the provision of or payment for a
14 health care service or course of treatment. You have the right
15 to have our decision reviewed by an independent review
16 organization not associated with us if our decision involved
17 making a judgment as to the medical necessity, appropriateness,
18 health care setting, level of care, or effectiveness of the
19 health care service or treatment you requested by submitting a
20 written request for an external review to us. Upon receipt of
21 your request an independent review organization registered
22 with the Department of Insurance will be assigned to review our
23 decision.".

24 (b) This subsection (b) shall apply to an expedited review
25 prior to a final adverse determination. In addition to the

1 notice required in subsection (a), the health carrier shall
2 include a notice related to an adverse determination, a
3 statement informing the covered person all of the following:

4 (1) If the covered person has a medical condition where
5 the timeframe for completion of (A) an expedited internal
6 review of a grievance involving an adverse determination,
7 (B) a final adverse determination as set forth in the
8 Managed Care Reform and Patient Rights Act, or (C) a
9 standard external review as established in this Act, would
10 seriously jeopardize the life or health of the covered
11 person or would jeopardize the covered person's ability to
12 regain maximum function, then the covered person or the
13 covered person's authorized representative may file a
14 request for an expedited external review.

15 (2) The covered person or the covered person's
16 authorized representative may file a request for an
17 expedited external review at the same time the covered
18 person or the covered person's authorized representative
19 files a request for an expedited internal appeal involving
20 an adverse determination as set forth in the Managed Care
21 Reform and Patient Rights Act if the adverse determination
22 involves a denial of coverage based on a determination that
23 the recommended or requested health care service or
24 treatment is experimental or investigational and the
25 covered person's health care provider certifies in writing
26 that the recommended or requested health care service or

1 treatment that is the subject of the adverse determination
2 would be significantly less effective if not promptly
3 initiated. The independent review organization assigned to
4 conduct the expedited external review will determine
5 whether the covered person shall be required to complete
6 the expedited review of the grievance prior to conducting
7 the expedited external review.

8 (3) If an adverse determination concerns a denial of
9 coverage based on a determination that the recommended or
10 requested health care service or treatment is experimental
11 or investigational and the covered person's health care
12 provider certifies in writing that the recommended or
13 requested health care service or treatment that is the
14 subject of the request would be significantly less
15 effective if not promptly initiated, then the covered
16 person or the covered person's authorized representative
17 may request an expedited external review.

18 (c) This subsection (c) shall apply to an expedited review
19 upon final adverse determination. In addition to the notice
20 required in subsection (a), the health carrier shall include a
21 notice related to a final adverse determination, a statement
22 informing the covered person all of the following:

23 (1) if the covered person has a medical condition where
24 the timeframe for completion of a standard external review
25 would seriously jeopardize the life or health of the
26 covered person or would jeopardize the covered person's

1 ability to regain maximum function, then the covered person
2 or the covered person's authorized representative may file
3 a request for an expedited external review; or

4 (2) if a final adverse determination concerns an
5 admission, availability of care, continued stay, or health
6 care service for which the covered person received
7 emergency services, but has not been discharged from a
8 facility, then the covered person, or the covered person's
9 authorized representative, may request an expedited
10 external review; or

11 (3) if a final adverse determination concerns a denial
12 of coverage based on a determination that the recommended
13 or requested health care service or treatment is
14 experimental or investigational, and the covered person's
15 health care provider certifies in writing that the
16 recommended or requested health care service or treatment
17 that is the subject of the request would be significantly
18 less effective if not promptly initiated, then the covered
19 person or the covered person's authorized representative
20 may request an expedited external review.

21 (d) In addition to the information to be provided pursuant
22 to subsections (a), (b), and (c) of this Section, the health
23 carrier shall include a copy of the description of both the
24 required standard and expedited external review procedures.
25 The description shall highlight the external review procedures
26 that give the covered person or the covered person's authorized

1 representative the opportunity to submit additional
2 information, including any forms used to process an external
3 review.

4 Section 25. Request for external review. A covered person
5 or the covered person's authorized representative may make a
6 request for a standard external or expedited external review of
7 an adverse determination or final adverse determination.
8 Requests under this Section shall be made directly to the
9 health carrier that made the adverse or final adverse
10 determination. All requests for external review shall be in
11 writing except for requests for expedited external reviews
12 which may be made orally. Health carriers must provide covered
13 persons with forms to request external reviews.

14 Section 30. Exhaustion of internal grievance process.

15 Except as provided in subsection (b) of Section 20, a
16 request for an external review shall not be made until the
17 covered person has exhausted the health carrier's internal
18 grievance process as set forth in the Managed Care Reform and
19 Patient Rights Act. A covered person shall also be considered
20 to have exhausted the health carrier's internal grievance
21 process for purposes of this section if:

22 (1) the covered person or the covered person's
23 authorized representative filed a request for an internal
24 review of an adverse determination pursuant to the Managed

1 Care Reform and Patient Rights Act and has not received a
2 written decision on the request from the health carrier
3 within 15 days after receipt of the required information
4 but not more than 30 days after the request was filed by
5 the covered person or the covered person's authorized
6 representative, except to the extent the covered person or
7 the covered person's authorized representative requested
8 or agreed to a delay; however, a covered person or the
9 covered person's authorized representative may not make a
10 request for an external review of an adverse determination
11 involving a retrospective review determination until the
12 covered person has exhausted the health carrier's internal
13 grievance process;

14 (2) the covered person or the covered person's
15 authorized representative filed a request for an expedited
16 internal review of an adverse determination pursuant to the
17 Managed Care Reform and Patient Rights Act and has not
18 received a decision on request from the health carrier
19 within 48 hours, except to the extent the covered person or
20 the covered person's authorized representative requested
21 or agreed to a delay; or

22 (3) the health carrier agrees to waive the exhaustion
23 requirement.

24 Section 35. Standard external review.

25 (a) Within 4 months after the date of receipt of a notice

1 of an adverse determination or final adverse determination, a
2 covered person or the covered person's authorized
3 representative may file a request for an external review with
4 the health carrier.

5 (b) Within 5 business days following the date of receipt of
6 the external review request, the health carrier shall complete
7 a preliminary review of the request to determine whether:

8 (1) the individual is or was a covered person in the
9 health benefit plan at the time the health care service was
10 requested or at the time the health care service was
11 provided;

12 (2) the health care service that is the subject of the
13 adverse determination or the final adverse determination
14 is a covered service under the covered person's health
15 benefit plan, but the health carrier has determined that
16 the health care service is not covered because it does not
17 meet the health carrier's requirements for medical
18 necessity, appropriateness, health care setting, level of
19 care, or effectiveness;

20 (3) the covered person has exhausted the health
21 carrier's internal grievance process as set forth in this
22 Act;

23 (4) for appeals relating to a determination based on
24 treatment being experimental or investigational, the
25 requested health care service or treatment that is the
26 subject of the adverse determination or final adverse

1 determination is a covered benefit under the covered
2 person's health benefit plan except for the health
3 carrier's determination that the service or treatment is
4 experimental or investigational for a particular medical
5 condition and is not explicitly listed as an excluded
6 benefit under the covered person's health benefit plan with
7 the health carrier and that the covered person's health
8 care provider, who is a physician licensed to practice
9 medicine in all its branches, has certified that one of the
10 following situations is applicable:

11 (A) standard health care services or treatments
12 have not been effective in improving the condition of
13 the covered person;

14 (B) standard health care services or treatments
15 are not medically appropriate for the covered person;

16 (C) there is no available standard health care
17 service or treatment covered by the health carrier that
18 is more beneficial than the recommended or requested
19 health care service or treatment;

20 (D) the health care service or treatment is likely
21 to be more beneficial to the covered person, in the
22 health care provider's opinion, than any available
23 standard health care services or treatments; or

24 (E) that scientifically valid studies using
25 accepted protocols demonstrate that the health care
26 service or treatment requested is likely to be more

1 beneficial to the covered person than any available
2 standard health care services or treatments; and

3 (5) the covered person has provided all the information
4 and forms required to process an external review, as
5 specified in this Act.

6 (c) Within one business day after completion of the
7 preliminary review, the health carrier shall notify the covered
8 person and, if applicable, the covered person's authorized
9 representative in writing whether the request is complete and
10 eligible for external review. If the request:

11 (1) is not complete, the health carrier shall inform
12 the covered person and, if applicable, the covered person's
13 authorized representative in writing and include in the
14 notice what information or materials are required by this
15 Act to make the request complete; or

16 (2) is not eligible for external review, the health
17 carrier shall inform the covered person and, if applicable,
18 the covered person's authorized representative in writing
19 and include in the notice the reasons for its
20 ineligibility.

21 The notice of initial determination of ineligibility shall
22 include a statement informing the covered person and, if
23 applicable, the covered person's authorized representative
24 that a health carrier's initial determination that the external
25 review request is ineligible for review may be appealed to the
26 Director by filing a complaint with the Director.

1 Notwithstanding a health carrier's initial determination
2 that the request is ineligible for external review, the
3 Director may determine that a request is eligible for external
4 review and require that it be referred for external review. In
5 making such determination, the Director's decision shall be in
6 accordance with the terms of the covered person's health
7 benefit plan and shall be subject to all applicable provisions
8 of this Act.

9 (d) Whenever a request is eligible for external review the
10 health carrier shall, within 5 business days:

11 (1) assign an independent review organization from the
12 list of approved independent review organizations compiled
13 and maintained by the Director; and

14 (2) notify in writing the covered person and, if
15 applicable, the covered person's authorized representative
16 of the request's eligibility and acceptance for external
17 review and the name of the independent review organization.

18 The health carrier shall include in the notice provided to
19 the covered person and, if applicable, the covered person's
20 authorized representative a statement that the covered person
21 or the covered person's authorized representative may, within 5
22 business days following the date of receipt of the notice
23 provided pursuant to item (2) of this subsection (d), submit in
24 writing to the assigned independent review organization
25 additional information that the independent review
26 organization shall consider when conducting the external

1 review. The independent review organization is not required to,
2 but may, accept and consider additional information submitted
3 after 5 business days.

4 (e) The assignment of an approved independent review
5 organization to conduct an external review in accordance with
6 this Section shall be made from those approved independent
7 review organizations qualified to conduct external review as
8 required by Sections 50 and 55 of this Act.

9 (f) Upon assignment of an independent review organization,
10 the health carrier or its designee utilization review
11 organization shall, within 5 business days, provide to the
12 assigned independent review organization the documents and any
13 information considered in making the adverse determination or
14 final adverse determination; in such cases, the following
15 provisions shall apply:

16 (1) Except as provided in item (2) of this subsection
17 (f), failure by the health carrier or its utilization
18 review organization to provide the documents and
19 information within the specified time frame shall not delay
20 the conduct of the external review.

21 (2) If the health carrier or its utilization review
22 organization fails to provide the documents and
23 information within the specified time frame, the assigned
24 independent review organization may terminate the external
25 review and make a decision to reverse the adverse
26 determination or final adverse determination.

1 (3) Within one business day after making the decision
2 to terminate the external review and make a decision to
3 reverse the adverse determination or final adverse
4 determination under item (2) of this subsection (f), the
5 independent review organization shall notify the health
6 carrier, the covered person and, if applicable, the covered
7 person's authorized representative, of its decision to
8 reverse the adverse determination.

9 (g) Upon receipt of the information from the health carrier
10 or its utilization review organization, the assigned
11 independent review organization shall review all of the
12 information and documents and any other information submitted
13 in writing to the independent review organization by the
14 covered person and the covered person's authorized
15 representative.

16 (h) Upon receipt of any information submitted by the
17 covered person or the covered person's authorized
18 representative, the independent review organization shall
19 forward the information to the health carrier within 1 business
20 day.

21 (1) Upon receipt of the information, if any, the health
22 carrier may reconsider its adverse determination or final
23 adverse determination that is the subject of the external
24 review.

25 (2) Reconsideration by the health carrier of its
26 adverse determination or final adverse determination shall

1 not delay or terminate the external review.

2 (3) The external review may only be terminated if the
3 health carrier decides, upon completion of its
4 reconsideration, to reverse its adverse determination or
5 final adverse determination and provide coverage or
6 payment for the health care service that is the subject of
7 the adverse determination or final adverse determination.
8 In such cases, the following provisions shall apply:

9 (A) Within one business day after making the
10 decision to reverse its adverse determination or final
11 adverse determination, the health carrier shall notify
12 the covered person and if applicable, the covered
13 person's authorized representative, and the assigned
14 independent review organization in writing of its
15 decision.

16 (B) Upon notice from the health carrier that the
17 health carrier has made a decision to reverse its
18 adverse determination or final adverse determination,
19 the assigned independent review organization shall
20 terminate the external review.

21 (i) In addition to the documents and information provided
22 by the health carrier or its utilization review organization
23 and the covered person and the covered person's authorized
24 representative, if any, the independent review organization,
25 to the extent the information or documents are available and
26 the independent review organization considers them

1 appropriate, shall consider the following in reaching a
2 decision:

3 (1) the covered person's pertinent medical records;

4 (2) the covered person's health care provider's
5 recommendation;

6 (3) consulting reports from appropriate health care
7 providers and other documents submitted by the health
8 carrier, the covered person, the covered person's
9 authorized representative, or the covered person's
10 treating provider;

11 (4) the terms of coverage under the covered person's
12 health benefit plan with the health carrier to ensure that
13 the independent review organization's decision is not
14 contrary to the terms of coverage under the covered
15 person's health benefit plan with the health carrier;

16 (5) the most appropriate practice guidelines, which
17 shall include applicable evidence-based standards and may
18 include any other practice guidelines developed by the
19 federal government, national or professional medical
20 societies, boards, and associations;

21 (6) any applicable clinical review criteria developed
22 and used by the health carrier or its designee utilization
23 review organization; and

24 (7) the opinion of the independent review
25 organization's clinical reviewer or reviewers after
26 considering items (1) through (6) of this subsection (i) to

1 the extent the information or documents are available and
2 the clinical reviewer or reviewers considers the
3 information or documents appropriate; and

4 (8) for a denial of coverage based on a determination
5 that the health care service or treatment recommended or
6 requested is experimental or investigational, whether and
7 to what extent:

8 (A) the recommended or requested health care
9 service or treatment has been approved by the federal
10 Food and Drug Administration, if applicable, for the
11 condition;

12 (B) medical or scientific evidence or
13 evidence-based standards demonstrate that the expected
14 benefits of the recommended or requested health care
15 service or treatment is more likely than not to be
16 beneficial to the covered person than any available
17 standard health care service or treatment and the
18 adverse risks of the recommended or requested health
19 care service or treatment would not be substantially
20 increased over those of available standard health care
21 services or treatments; or

22 (C) the terms of coverage under the covered
23 person's health benefit plan with the health carrier to
24 ensure that the health care service or treatment that
25 is the subject of the opinion is experimental or
26 investigational would otherwise be covered under the

1 terms of coverage of the covered person's health
2 benefit plan with the health carrier.

3 (j) Within 5 days after the date of receipt of all
4 necessary information, the assigned independent review
5 organization shall provide written notice of its decision to
6 uphold or reverse the adverse determination or the final
7 adverse determination to the health carrier, the covered person
8 and, if applicable, the covered person's authorized
9 representative. In reaching a decision, the assigned
10 independent review organization is not bound by any claim
11 determinations reached prior to the submission of information
12 the independent review organization. In such cases, the
13 following provisions shall apply:

14 (1) The independent review organization shall include
15 in the notice:

16 (A) a general description of the reason for the
17 request for external review;

18 (B) the date the independent review organization
19 received the assignment from the health carrier to
20 conduct the external review;

21 (C) the time period during which the external
22 review was conducted;

23 (D) references to the evidence or documentation,
24 including the evidence-based standards, considered in
25 reaching its decision;

26 (E) the date of its decision; and

1 (F) the principal reason or reasons for its
2 decision, including what applicable, if any,
3 evidence-based standards that were a basis for its
4 decision.

5 (2) For reviews of experimental or investigational
6 treatments, the notice shall include the following
7 information:

8 (A) a description of the covered person's medical
9 condition;

10 (B) a description of the indicators relevant to
11 whether there is sufficient evidence to demonstrate
12 that the recommended or requested health care service
13 or treatment is more likely than not to be more
14 beneficial to the covered person than any available
15 standard health care services or treatments and the
16 adverse risks of the recommended or requested health
17 care service or treatment would not be substantially
18 increased over those of available standard health care
19 services or treatments;

20 (C) a description and analysis of any medical or
21 scientific evidence considered in reaching the
22 opinion;

23 (D) a description and analysis of any
24 evidence-based standards; and

25 (E) whether the recommended or requested health
26 care service or treatment has been approved by the

1 federal Food and Drug Administration, for the
2 condition;

3 (F) whether medical or scientific evidence or
4 evidence-based standards demonstrate that the expected
5 benefits of the recommended or requested health care
6 service or treatment is more likely than not to be more
7 beneficial to the covered person than any available
8 standard health care service or treatment and the
9 adverse risks of the recommended or requested health
10 care service or treatment would not be substantially
11 increased over those of available standard health care
12 services or treatments; and

13 (G) the written opinion of the clinical reviewer,
14 including the reviewer's recommendation as to whether
15 the recommended or requested health care service or
16 treatment should be covered and the rationale for the
17 reviewer's recommendation.

18 (3) In reaching a decision, the assigned independent
19 review organization is not bound by any decisions or
20 conclusions reached during the health carrier's
21 utilization review process or the health carrier's
22 internal grievance or appeals process.

23 (4) Upon receipt of a notice of a decision reversing
24 the adverse determination or final adverse determination,
25 the health carrier immediately shall approve the coverage
26 that was the subject of the adverse determination or final

1 adverse determination.

2 Section 40. Expedited external review.

3 (a) A covered person or a covered person's authorized
4 representative may file a request for an expedited external
5 review with the health carrier either orally or in writing:

6 (1) immediately after the date of receipt of a notice
7 prior to a final adverse determination as provided by
8 subsection (b) of Section 20 of this Act;

9 (2) immediately after the date of receipt of a notice a
10 final adverse determination as provided by subsection (c)
11 of Section 20 of this Act; or

12 (3) if a health carrier fails to provide a decision on
13 request for an expedited internal appeal within 48 hours as
14 provided by item (2) of Section 30 of this Act.

15 (b) Immediately upon receipt of the request for an
16 expedited external review as provided under subsections (b) and
17 (c) of Section 20, the health carrier shall determine whether
18 the request meets the reviewability requirements set forth in
19 items (1), (2), and (4) of subsection (b) of Section 35. In
20 such cases, the following provisions shall apply:

21 (1) The health carrier shall immediately notify the
22 covered person and, if applicable, the covered person's
23 authorized representative of its eligibility
24 determination.

25 (2) The notice of initial determination shall include a

1 statement informing the covered person and, if applicable,
2 the covered person's authorized representative that a
3 health carrier's initial determination that an external
4 review request is ineligible for review may be appealed to
5 the Director.

6 (3) The Director may determine that a request is
7 eligible for expedited external review notwithstanding a
8 health carrier's initial determination that the request is
9 ineligible and require that it be referred for external
10 review.

11 (4) In making a determination under item (3) of this
12 subsection (b), the Director's decision shall be made in
13 accordance with the terms of the covered person's health
14 benefit plan and shall be subject to all applicable
15 provisions of this Act.

16 (c) Upon determining that a request meets the requirements
17 of subsections (b) and (c) of Section 20, the health carrier
18 shall immediately assign an independent review organization
19 from the list of approved independent review organizations
20 compiled and maintained by the Director to conduct the
21 expedited review. In such cases, the following provisions shall
22 apply:

23 (1) The assignment of an approved independent review
24 organization to conduct an external review in accordance
25 with this Section shall be made from those approved
26 independent review organizations qualified to conduct

1 external review as required by Sections 50 and 55 of this
2 Act.

3 (2) Immediately upon assigning an independent review
4 organization to perform an expedited external review, but
5 in no case more than 24 hours after assigning the
6 independent review organization, the health carrier or its
7 designee utilization review organization shall provide or
8 transmit all necessary documents and information
9 considered in making the final adverse determination to the
10 assigned independent review organization electronically or
11 by telephone or facsimile or any other available
12 expeditious method.

13 (3) If the health carrier or its utilization review
14 organization fails to provide the documents and
15 information within the specified timeframe, the assigned
16 independent review organization may terminate the external
17 review and make a decision to reverse the adverse
18 determination or final adverse determination.

19 (4) Within one business day after making the decision
20 to terminate the external review and make a decision to
21 reverse the adverse determination or final adverse
22 determination under item (2) of this subsection (b), the
23 independent review organization shall notify the health
24 carrier, the covered person and, if applicable, the covered
25 person's authorized representative of its decision to
26 reverse the adverse determination.

1 (d) In addition to the documents and information provided
2 by the health carrier or its utilization review organization
3 and any documents and information provided by the covered
4 person and the covered person's authorized representative, the
5 independent review organization shall consider information as
6 required by subsection (i) of Section 35 of this Act in
7 reaching a decision.

8 (e) As expeditiously as the covered person's medical
9 condition or circumstances requires, but in no event more than
10 24 hours after the receipt of all pertinent information, the
11 assigned independent review organization shall:

12 (1) make a decision to uphold or reverse the final
13 adverse determination; and

14 (2) notify the health carrier, the covered person, the
15 covered person's health care provider, and if applicable,
16 the covered person's authorized representative, of the
17 decision.

18 (f) In reaching a decision, the assigned independent review
19 organization is not bound by any decisions or conclusions
20 reached during the health carrier's utilization review process
21 or the health carrier's internal grievance process as set forth
22 in the Managed Care Reform and Patient Rights Act.

23 (g) Upon receipt of notice of a decision reversing the
24 final adverse determination, the health carrier shall
25 immediately approve the coverage that was the subject of the
26 final adverse determination.

1 (h) Within 48 hours after the date of providing the notice
2 required in item (2) of subsection (d), the assigned
3 independent review organization shall provide written
4 confirmation of the decision to the health carrier, the covered
5 person, and if applicable, the covered person's authorized
6 representative including the information set forth in
7 subsection (j) of Section 35 of this Act as applicable.

8 (i) An expedited external review may not be provided for
9 retrospective adverse or final adverse determinations.

10 Section 45. Binding nature of external review decision. An
11 external review decision is binding on the health carrier. An
12 external review decision is binding on the covered person
13 except to the extent the covered person has other remedies
14 available under applicable federal or State law. A covered
15 person or the covered person's authorized representative may
16 not file a subsequent request for external review involving the
17 same adverse determination or final adverse determination for
18 which the covered person has already received an external
19 review decision pursuant to this Act.

20 Section 50. Approval of independent review organizations.

21 (a) The Director shall approve independent review
22 organizations eligible to be assigned to conduct external
23 reviews under this Act.

24 (b) In order to be eligible for approval by the Director

1 under this Section to conduct external reviews under this Act
2 an independent review organization:

3 (1) except as otherwise provided in this Section, shall
4 be accredited by a nationally recognized private
5 accrediting entity that the Director has determined has
6 independent review organization accreditation standards
7 that are equivalent to or exceed the minimum qualifications
8 for independent review; and

9 (2) shall submit an application for approval in
10 accordance with subsection (d) of this Section.

11 (c) The Director shall develop an application form for
12 initially approving and for reapproving independent review
13 organizations to conduct external reviews.

14 (d) Any independent review organization wishing to be
15 approved to conduct external reviews under this Act shall
16 submit the application form and include with the form all
17 documentation and information necessary for the Director to
18 determine if the independent review organization satisfies the
19 minimum qualifications established under this Act. The
20 Director may:

21 (1) approve independent review organizations that are
22 not accredited by a nationally recognized private
23 accrediting entity if there are no acceptable nationally
24 recognized private accrediting entities providing
25 independent review organization accreditation; and

26 (2) by rule establish an application fee that

1 independent review organizations shall submit to the
2 Director with an application for approval and renewing.

3 (e) An approval is effective for 2 years, unless the
4 Director determines before its expiration that the independent
5 review organization is not satisfying the minimum
6 qualifications established under this Act.

7 (f) Whenever the Director determines that an independent
8 review organization has lost its accreditation or no longer
9 satisfies the minimum requirements established under this Act,
10 the Director shall terminate the approval of the independent
11 review organization and remove the independent review
12 organization from the list of independent review organizations
13 approved to conduct external reviews under this Act that is
14 maintained by the Director.

15 (g) The Director shall maintain and periodically update a
16 list of approved independent review organizations.

17 (h) The Director may promulgate regulations to carry out
18 the provisions of this Section.

19 Section 55. Minimum qualifications for independent review
20 organizations.

21 (a) To be approved to conduct external reviews, an
22 independent review organization shall have and maintain
23 written policies and procedures that govern all aspects of both
24 the standard external review process and the expedited external
25 review process set forth in this Act that include, at a

1 minimum:

2 (1) a quality assurance mechanism that ensures that:

3 (A) external reviews are conducted within the
4 specified timeframes and required notices are provided
5 in a timely manner;

6 (B) selection of qualified and impartial clinical
7 reviewers to conduct external reviews on behalf of the
8 independent review organization and suitable matching
9 of reviewers to specific cases and that the independent
10 review organization employs or contracts with an
11 adequate number of clinical reviewers to meet this
12 objective;

13 (C) for adverse determinations involving
14 experimental or investigational treatments, in
15 assigning clinical reviewers, the independent review
16 organization selects physicians or other health care
17 professionals who, through clinical experience in the
18 past 3 years, are experts in the treatment of the
19 covered person's condition and knowledgeable about the
20 recommended or requested health care service or
21 treatment;

22 (D) the health carrier, the covered person, and the
23 covered person's authorized representative shall not
24 choose or control the choice of the physicians or other
25 health care professionals to be selected to conduct the
26 external review;

1 (E) confidentiality of medical and treatment
2 records and clinical review criteria; and

3 (F) any person employed by or under contract with
4 the independent review organization adheres to the
5 requirements of this Act;

6 (2) a toll-free telephone service operating on a
7 24-hour-day, 7-day-a-week basis that accepts, receives,
8 and records information related to external reviews and
9 provides appropriate instructions; and

10 (3) an agreement to maintain and provide to the
11 Director the information set out in Section 70 of this Act.

12 (b) All clinical reviewers assigned by an independent
13 review organization to conduct external reviews shall be
14 physicians or other appropriate health care providers who meet
15 the following minimum qualifications:

16 (1) be an expert in the treatment of the covered
17 person's medical condition that is the subject of the
18 external review;

19 (2) be knowledgeable about the recommended health care
20 service or treatment through recent or current actual
21 clinical experience treating patients with the same or
22 similar medical condition of the covered person;

23 (3) hold a non-restricted license in a state of the
24 United States and, for physicians, a current certification
25 by a recognized American medical specialty board in the
26 area or areas appropriate to the subject of the external

1 review; and

2 (4) have no history of disciplinary actions or
3 sanctions, including loss of staff privileges or
4 participation restrictions, that have been taken or are
5 pending by any hospital, governmental agency or unit, or
6 regulatory body that raise a substantial question as to the
7 clinical reviewer's physical, mental, or professional
8 competence or moral character.

9 (c) In addition to the requirements set forth in subsection
10 (a), an independent review organization may not own or control,
11 be a subsidiary of, or in any way be owned, or controlled by,
12 or exercise control with a health benefit plan, a national,
13 State, or local trade association of health benefit plans, or a
14 national, State, or local trade association of health care
15 providers.

16 (d) Conflicts of interest prohibited. In addition to the
17 requirements set forth in subsections (a), (b), and (c) of this
18 Section, to be approved pursuant to this Act to conduct an
19 external review of a specified case, neither the independent
20 review organization selected to conduct the external review nor
21 any clinical reviewer assigned by the independent organization
22 to conduct the external review may have a material
23 professional, familial or financial conflict of interest with
24 any of the following:

25 (1) the health carrier that is the subject of the
26 external review;

1 (2) the covered person whose treatment is the subject
2 of the external review or the covered person's authorized
3 representative;

4 (3) any officer, director or management employee of the
5 health carrier that is the subject of the external review;

6 (4) the health care provider, the health care
7 provider's medical group or independent practice
8 association recommending the health care service or
9 treatment that is the subject of the external review;

10 (5) the facility at which the recommended health care
11 service or treatment would be provided; or

12 (6) the developer or manufacturer of the principal
13 drug, device, procedure, or other therapy being
14 recommended for the covered person whose treatment is the
15 subject of the external review.

16 (e) An independent review organization that is accredited
17 by a nationally recognized private accrediting entity that has
18 independent review accreditation standards that the Director
19 has determined are equivalent to or exceed the minimum
20 qualifications of this Section shall be presumed to be in
21 compliance with this Section and shall be eligible for approval
22 under this Act.

23 (f) An independent review organization shall be unbiased.
24 An independent review organization shall establish and
25 maintain written procedures to ensure that it is unbiased in
26 addition to any other procedures required under this Section.

1 (g) Nothing in this Act precludes or shall be interpreted
2 to preclude a health carrier from contracting with approved
3 independent review organizations to conduct external reviews
4 assigned to it from such health carrier.

5 Section 60. Hold harmless for independent review
6 organizations. No independent review organization or clinical
7 reviewer working on behalf of an independent review
8 organization or an employee, agent or contractor of an
9 independent review organization shall be liable for damages to
10 any person for any opinions rendered or acts or omissions
11 performed within the scope of the organization's or person's
12 duties under the law during or upon completion of an external
13 review conducted pursuant to this Act, unless the opinion was
14 rendered or act or omission performed in bad faith or involved
15 gross negligence.

16 Section 65. External review reporting requirements.

17 (a) Each health carrier shall maintain written records in
18 the aggregate on all requests for external review for each
19 calendar year and submit a report to the Director in the format
20 specified by the Director by March 1 of each year.

21 (b) The report shall include in the aggregate:

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

23 (2) the total number of requests for expedited external
24 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 Section 70. Funding of external review. The health carrier
2 shall be solely responsible for paying the cost of external
3 reviews conducted by independent review organizations.

4 Section 75. Disclosure requirements.

5 (a) Each health carrier shall include a description of the
6 external review procedures in, or attached to, the policy,
7 certificate, membership booklet, and outline of coverage or
8 other evidence of coverage it provides to covered persons.

9 (b) The description required under subsection (a) of this
10 Section shall include a statement that informs the covered
11 person of the right of the covered person to file a request for
12 an external review of an adverse determination or final adverse
13 determination with the health carrier. The statement shall
14 explain that external review is available when the adverse
15 determination or final adverse determination involves an issue
16 of medical necessity, appropriateness, health care setting,
17 level of care, or effectiveness. The statement shall include
18 the toll-free telephone number and address of the Office of
19 Consumer Health Insurance within the Department of Insurance.

20 Section 90. The Illinois Insurance Code is amended by
21 changing Section 155.36 and by adding Sections 359b and 359c as
22 follows:

1 (215 ILCS 5/155.36)

2 Sec. 155.36. Managed Care Reform and Patient Rights Act.
3 Insurance companies that transact the kinds of insurance
4 authorized under Class 1(b) or Class 2(a) of Section 4 of this
5 Code shall comply with Sections 45 and ~~Section~~ 85 and the
6 definition of the term "emergency medical condition" in Section
7 10 of the Managed Care Reform and Patient Rights Act.

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

9 (215 ILCS 5/359b new)

10 Sec. 359b. Committee to create a uniform small employer
11 group-health status questionnaire and individual health
12 statement.

13 (a) For the purposes of this Section:

14 "Employee health-status questionnaire" means a
15 questionnaire that poses questions about an individual
16 employee's or covered dependent's health history and that is to
17 be completed by the individual employee or covered dependent of
18 a small employer that seeks health insurance coverage from a
19 small employer carrier.

20 "Health benefit plan", "small employer", and "small
21 employer carrier" shall have the meaning given the terms in the
22 Small Employer Health Insurance Rating Act.

23 "Individual health insurance coverage" and "individual
24 market" shall have the meaning given the terms in the Illinois
25 Health Insurance Portability and Accountability Act.

1 (b) A committee is established in the Department consisting
2 of 11 members, including the Director or the Director's
3 designee, who are appointed by the Director. The Director shall
4 appoint to the committee 5 representatives as recommended by
5 the Illinois Insurance Association, Illinois Life Insurance
6 Council, Professional Independent Insurance Agents of
7 Illinois, Illinois Association of Health Underwriters,
8 Illinois Chamber of Commerce, Illinois Manufacturers
9 Association, Illinois Retail Merchants Association, and
10 National Federation of Independent Businesses and 5 consumer
11 representatives. The Director or the Director's designee shall
12 serve as chairperson of the committee.

13 (c) The committee shall develop a uniform employee
14 health-status questionnaire to simplify the health insurance
15 application process for small employers. The committee shall
16 study employee-health status questionnaires currently used by
17 major small employer carriers in this State and consolidate the
18 questionnaires into a uniform questionnaire. The questionnaire
19 shall be designed to permit its use both as a written document
20 and through electronic or other alternative delivery formats.

21 A uniform employee health-status questionnaire shall allow
22 small employers that are required to provide information
23 regarding their employees to a small employer carrier when
24 applying for a small employer group health insurance policy to
25 use a standardized questionnaire that small employer carriers
26 shall be required to use. The development of the uniform

1 employee health-status questionnaire is intended to relieve
2 small employers of the burden of completing separate
3 application forms for each small employer carrier with which
4 the employer applies for insurance or from which the employer
5 seeks information regarding such matters as rates, coverage,
6 and availability. The use of the uniform employee health-status
7 questionnaire by small employer carriers and small employers
8 shall be mandatory.

9 (d) On or before July 1, 2010, the committee shall develop
10 the uniform employee health-status questionnaire for adoption
11 by the Department. Beginning January 1, 2011, a small employer
12 carrier shall use the questionnaire for all small employer
13 groups for which it requires employees and their covered
14 dependents to complete questionnaires.

15 (e) The Director, as needed, may reconvene the committee to
16 consider whether changes are necessary to the uniform employee
17 health status questionnaire. If the committee determines that
18 changes to the questionnaire are necessary, then the Director
19 may adopt revisions to the questionnaire as recommended by the
20 committee. Small employer carriers shall use the revised
21 questionnaire beginning 90 days after the Director adopts any
22 revision.

23 (f) Nothing in this Section shall be construed to limit or
24 restrict a small employer carrier's ability to appropriately
25 rate risk under a small employer health benefit plan.

26 (g) On or before July 1, 2010, the committee shall develop

1 a standard individual market health statement to simplify the
2 health insurance application process for individuals. The
3 committee shall study health statements currently used by major
4 carriers in this State who offer individual health insurance
5 coverage and consolidate the statements into a standard
6 individual market health statement. The standard individual
7 market health statement shall be designed to permit its use
8 both as a written document and through electronic or other
9 alternative delivery formats. For purposes of the individual
10 market health statement, the Director may, but shall not be
11 required to, establish a committee distinct from that formed to
12 develop an application for small employers. In that event, the
13 composition of the committee shall be as prescribed in
14 subsection (b) of this Section, although individual
15 participants may change.

16 (h) Beginning January 1, 2011, all carriers who offer
17 individual health insurance coverage and evaluate the health
18 status of individuals shall use the standard individual market
19 health statement.

20 (i) The Director, as needed, may reconvene the committee to
21 consider whether changes are necessary to the standard
22 individual market health statement. If the committee
23 determines that changes to the statement are necessary, the
24 Director may adopt revisions to the statement as recommended by
25 the committee. All carriers who offer individual health
26 insurance coverage shall use the revised statement beginning 90

1 days after the Director adopts any revision.

2 (j) Nothing in this Section shall prevent a carrier from
3 using health information after enrollment for the purpose of
4 providing services or arranging for the provision of services
5 under a health benefit plan or a policy of individual health
6 insurance coverage.

7 (k) Nothing in this Section shall be construed to limit or
8 restrict a health carrier's ability to appropriately rate risk,
9 refuse to issue or renew coverage, or otherwise rescind,
10 terminate, or restrict coverage under a health benefit plan or
11 a policy of individual health insurance coverage or conduct
12 further review of the information submitted on the statement by
13 contacting an individual, the individual's health care
14 provider, or any other entity for additional health status
15 related information.

16 (l) Committee members are not eligible for compensation but
17 may receive reimbursement of expenses.

18 (215 ILCS 5/359c new)

19 Sec. 359c. Accident and health expense reporting.

20 (a) Beginning January 1, 2011 and every 6 months
21 thereafter, any carrier providing a group or individual major
22 medical policy of accident or health insurance shall prepare
23 and provide to the Department of Insurance a statement of the
24 aggregate administrative expenses of the carrier, based on the
25 premiums earned in the immediately preceding 6-month period on

1 the accident or health insurance business of the carrier. The
2 semi-annual statements shall be filed on or before July 31 for
3 the preceding 6-month period ending June 30 and on or before
4 February 1 for the preceding 6-month period ending December 31.
5 The statements shall itemize and separately detail all of the
6 following information with respect to the carrier's accident or
7 health insurance business:

8 (1) the amount of premiums earned by the carrier both
9 before and after any costs related to the carrier's
10 purchase of reinsurance coverage;

11 (2) the total amount of claims for losses paid by the
12 carrier both before and after any reimbursement from
13 reinsurance coverage including any costs incurred related
14 to:

15 (A) disease, case, or chronic care management
16 programs;

17 (B) wellness and health education programs;

18 (C) fraud prevention;

19 (D) maintaining provider networks and provider
20 credentialing;

21 (E) health information technology for personal
22 electronic health records; and

23 (F) utilization review and utilization management;

24 (3) the amount of any losses incurred by the carrier
25 but not reported to the carrier in the current or prior
26 reporting period;

1 (4) the amount of costs incurred by the carrier for
2 State fees and federal and State taxes including:

3 (A) any high risk pool and guaranty fund
4 assessments levied on the carrier by the State; and

5 (B) any regulatory compliance costs including
6 State fees for form and rate filings, licensures,
7 market conduct exams, and financial reports;

8 (5) the amount of costs incurred by the carrier for
9 reinsurance coverage;

10 (6) the amount of costs incurred by the carrier that
11 are related to the carrier's payment of marketing expenses
12 including commissions; and

13 (7) any other administrative expenses incurred by the
14 carrier.

15 (b) The information provided pursuant to subsection (a) of
16 this Section shall be separately aggregated for the following
17 lines of major medical insurance:

18 (1) individually underwritten;

19 (2) groups of 2 to 25 members;

20 (3) groups of 26 to 50 members;

21 (4) groups of 51 or more members.

22 (c) The Department shall make the submitted information
23 publicly available on the Department's website or such other
24 media as appropriate in a form useful for consumers.

25 Section 95. The Managed Care Reform and Patient Rights Act

1 is amended by changing Sections 40 and 45 as follows:

2 (215 ILCS 134/40)

3 Sec. 40. Access to specialists.

4 (a) All health care plans that require each enrollee to
5 select a health care provider for any purpose including
6 coordination of care shall permit an enrollee to choose any
7 available primary care physician licensed to practice medicine
8 in all its branches participating in the health care plan for
9 that purpose. The health care plan shall provide the enrollee
10 with a choice of licensed health care providers who are
11 accessible and qualified. Nothing in this Act shall be
12 construed to prohibit a health care plan from requiring a
13 health care provider to meet the health care plan's criteria in
14 order to coordinate access to health care.

15 (b) A health care plan shall establish a procedure by which
16 an enrollee who has a condition that requires ongoing care from
17 a specialist physician or other health care provider may apply
18 for a standing referral to a specialist physician or other
19 health care provider if a referral to a specialist physician or
20 other health care provider is required for coverage. The
21 application shall be made to the enrollee's primary care
22 physician. This procedure for a standing referral must specify
23 the necessary criteria and conditions that must be met in order
24 for an enrollee to obtain a standing referral. A standing
25 referral shall be effective for the period necessary to provide

1 the referred services or one year, except in the event of
2 termination of a contract or policy in which case Section 25 on
3 transition of services shall apply, if applicable. A primary
4 care physician may renew and re-renew a standing referral.

5 (c) The enrollee may be required by the health care plan to
6 select a specialist physician or other health care provider who
7 has a referral arrangement with the enrollee's primary care
8 physician or to select a new primary care physician who has a
9 referral arrangement with the specialist physician or other
10 health care provider chosen by the enrollee. If a health care
11 plan requires an enrollee to select a new physician under this
12 subsection, the health care plan must provide the enrollee with
13 both options provided in this subsection. When a participating
14 specialist with a referral arrangement is not available, the
15 primary care physician, in consultation with the enrollee,
16 shall arrange for the enrollee to have access to a qualified
17 participating health care provider, and the enrollee shall be
18 allowed to stay with his or her primary care physician. If a
19 secondary referral is necessary, the specialist physician or
20 other health care provider shall advise the primary care
21 physician. The primary care physician shall be responsible for
22 making the secondary referral. In addition, the health care
23 plan shall require the specialist physician or other health
24 care provider to provide regular updates to the enrollee's
25 primary care physician.

26 (d) When the type of specialist physician or other health

1 care provider needed to provide ongoing care for a specific
2 condition is not represented in the health care plan's provider
3 network, the primary care physician shall arrange for the
4 enrollee to have access to a qualified non-participating health
5 care provider within a reasonable distance and travel time at
6 no additional cost beyond what the enrollee would otherwise pay
7 for services received within the network. The referring
8 physician shall notify the plan when a referral is made outside
9 the network.

10 (e) The enrollee's primary care physician shall remain
11 responsible for coordinating the care of an enrollee who has
12 received a standing referral to a specialist physician or other
13 health care provider. If a secondary referral is necessary, the
14 specialist physician or other health care provider shall advise
15 the primary care physician. The primary care physician shall be
16 responsible for making the secondary referral. In addition, the
17 health care plan shall require the specialist physician or
18 other health care provider to provide regular updates to the
19 enrollee's primary care physician.

20 (f) If an enrollee's application for any referral is
21 denied, an enrollee may appeal the decision through the health
22 care plan's external independent review process as provided by
23 the Illinois Health Carrier External Review Act ~~in accordance~~
24 ~~with subsection (f) of Section 45 of this Act.~~

25 (g) Nothing in this Act shall be construed to require an
26 enrollee to select a new primary care physician when no

1 referral arrangement exists between the enrollee's primary
2 care physician and the specialist selected by the enrollee and
3 when the enrollee has a long-standing relationship with his or
4 her primary care physician.

5 (h) In promulgating rules to implement this Act, the
6 Department shall define "standing referral" and "ongoing
7 course of treatment".

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

9 (215 ILCS 134/45)

10 Sec. 45. Health care services appeals, complaints, and
11 external independent reviews.

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

20 (b) When an appeal concerns a decision or action by a
21 health care plan, its employees, or its subcontractors that
22 relates to (i) health care services, including, but not limited
23 to, procedures or treatments, for an enrollee with an ongoing
24 course of treatment ordered by a health care provider, the
25 denial of which could significantly increase the risk to an

1 enrollee's health, or (ii) a treatment referral, service,
2 procedure, or other health care service, the denial of which
3 could significantly increase the risk to an enrollee's health,
4 the health care plan must allow for the filing of an appeal
5 either orally or in writing. Upon submission of the appeal, a
6 health care plan must notify the party filing the appeal, as
7 soon as possible, but in no event more than 24 hours after the
8 submission of the appeal, of all information that the plan
9 requires to evaluate the appeal. The health care plan shall
10 render a decision on the appeal within 24 hours after receipt
11 of the required information. The health care plan shall notify
12 the party filing the appeal and the enrollee, enrollee's
13 primary care physician, and any health care provider who
14 recommended the health care service involved in the appeal of
15 its decision orally followed-up by a written notice of the
16 determination.

17 (c) For all appeals related to health care services
18 including, but not limited to, procedures or treatments for an
19 enrollee and not covered by subsection (b) above, the health
20 care plan shall establish a procedure for the filing of such
21 appeals. Upon submission of an appeal under this subsection, a
22 health care plan must notify the party filing an appeal, within
23 3 business days, of all information that the plan requires to
24 evaluate the appeal. The health care plan shall render a
25 decision on the appeal within 15 business days after receipt of
26 the required information. The health care plan shall notify the

1 party filing the appeal, the enrollee, the enrollee's primary
2 care physician, and any health care provider who recommended
3 the health care service involved in the appeal orally of its
4 decision followed-up by a written notice of the determination.

5 (d) An appeal under subsection (b) or (c) may be filed by
6 the enrollee, the enrollee's designee or guardian, the
7 enrollee's primary care physician, or the enrollee's health
8 care provider. A health care plan shall designate a clinical
9 peer to review appeals, because these appeals pertain to
10 medical or clinical matters and such an appeal must be reviewed
11 by an appropriate health care professional. No one reviewing an
12 appeal may have had any involvement in the initial
13 determination that is the subject of the appeal. The written
14 notice of determination required under subsections (b) and (c)
15 shall include (i) clear and detailed reasons for the
16 determination, (ii) the medical or clinical criteria for the
17 determination, which shall be based upon sound clinical
18 evidence and reviewed on a periodic basis, and (iii) in the
19 case of an adverse determination, the procedures for requesting
20 an external independent review as provided by the Illinois
21 Health Carrier External Review Act ~~under subsection (f)~~.

22 (e) If an appeal filed under subsection (b) or (c) is
23 denied for a reason including, but not limited to, the service,
24 procedure, or treatment is not viewed as medically necessary,
25 denial of specific tests or procedures, denial of referral to
26 specialist physicians or denial of hospitalization requests or

1 length of stay requests, any involved party may request an
2 external independent review as provided by the Illinois Health
3 Carrier External Review Act ~~under subsection (f) of the adverse~~
4 ~~determination.~~

5 (f) Until July 1, 2013, if an external independent review
6 decision made pursuant to the Illinois Health Carrier External
7 Review Act upholds a determination adverse to the covered
8 person, the covered person has the right to appeal the final
9 decision to the Department; if the external review decision is
10 found by the Director to have been arbitrary and capricious,
11 then the Director, with consultation from a licensed medical
12 professional, may overturn the external review decision and
13 require the health carrier to pay for the health care service
14 or treatment; such decision, if any, shall be made solely on
15 the legal or medical merits of the claim. ~~External independent~~
16 ~~review.~~

17 ~~(1) The party seeking an external independent review~~
18 ~~shall so notify the health care plan. The health care plan~~
19 ~~shall seek to resolve all external independent reviews in~~
20 ~~the most expeditious manner and shall make a determination~~
21 ~~and provide notice of the determination no more than 24~~
22 ~~hours after the receipt of all necessary information when a~~
23 ~~delay would significantly increase the risk to an~~
24 ~~enrollee's health or when extended health care services for~~
25 ~~an enrollee undergoing a course of treatment prescribed by~~
26 ~~a health care provider are at issue.~~

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

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

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

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

21 ~~(4) Within 5 days after receipt of all necessary~~
22 ~~information, the independent reviewer shall evaluate and~~
23 ~~analyze the case and render a decision that is based on~~
24 ~~whether or not the health care service or claim for the~~
25 ~~health care service is medically appropriate. The decision~~
26 ~~by the independent reviewer is final. If the external~~

1 ~~independent reviewer determines the health care service to~~
2 ~~be medically appropriate, the health care plan shall pay~~
3 ~~for the health care service.~~

4 ~~(5) The health care plan shall be solely responsible~~
5 ~~for paying the fees of the external independent reviewer~~
6 ~~who is selected to perform the review.~~

7 ~~(6) An external independent reviewer who acts in good~~
8 ~~faith shall have immunity from any civil or criminal~~
9 ~~liability or professional discipline as a result of acts or~~
10 ~~omissions with respect to any external independent review,~~
11 ~~unless the acts or omissions constitute wilful and wanton~~
12 ~~misconduct. For purposes of any proceeding, the good faith~~
13 ~~of the person participating shall be presumed.~~

14 ~~(7) Future contractual or employment action by the~~
15 ~~health care plan regarding the patient's physician or other~~
16 ~~health care provider shall not be based solely on the~~
17 ~~physician's or other health care provider's participation~~
18 ~~in this procedure.~~

19 ~~(8) For the purposes of this Section, an external~~
20 ~~independent reviewer shall:~~

21 ~~(A) be a clinical peer;~~

22 ~~(B) have no direct financial interest in~~
23 ~~connection with the case; and~~

24 ~~(C) have not been informed of the specific identity~~
25 ~~of the enrollee.~~

26 ~~(9) Nothing in this Section shall be construed to require a~~

1 health care plan to pay for a health care service not covered
2 under the enrollee's certificate of coverage or policy.

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

4 Section 96. No acceleration or delay. Where this Act makes
5 changes in a statute that is represented in this Act by text
6 that is not yet or no longer in effect (for example, a Section
7 represented by multiple versions), the use of that text does
8 not accelerate or delay the taking effect of (i) the changes
9 made by this Act or (ii) provisions derived from any other
10 Public Act.

11 Section 97. Severability. The provisions of this Act are
12 severable under Section 1.31 of the Statute on Statutes.

13 Section 99. Effective date. This Act takes effect January
14 1, 2010, except that the changes to Section 155.36 of the
15 Illinois Insurance Code and Sections 40 and 45 of the Managed
16 Care Reform and Patient Rights Act and the Health Carrier
17 External Review Act take effect July 1, 2010.".