



96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

HB5471

Introduced 2/5/2010, by Rep. Mary E. Flowers

SYNOPSIS AS INTRODUCED:

215 ILCS 134/45
215 ILCS 180/20
215 ILCS 180/25
215 ILCS 180/45
215 ILCS 180/80 new

Amends the Managed Care Reform and Patient Rights Act and the Health Carrier External Review Act to provide that a determination by the Director of Insurance to uphold an external review decision that is adverse to an enrollee is subject to the process of administrative review pursuant to the Code of Civil Procedure. Further amends the Health Carrier External Review Act. Provides that when a health carrier sends any request for payment to a covered person, the health carrier shall include a written statement of the health care patient rights. Provides that the Office of Consumer Health Insurance within the Department of Insurance shall provide consultation and case management and shall establish a toll-free phone number for covered persons. Provides that every health carrier shall expend in the form of health care benefits no less than 85% of the aggregate dues, fees, and premiums received by the health carrier. Provides that a health carrier may average its total costs across all health benefit plans in compliance with the provision concerning minimum medical loss expenditures. Contains a nonacceleration clause. Makes other changes.

LRB096 16762 RPM 32057 b

1 AN ACT concerning insurance.

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

4 Section 5. The Managed Care Reform and Patient Rights Act
5 is amended by changing Section 45 as follows:

6 (215 ILCS 134/45)

7 (Text of Section before amendment by P.A. 96-857)

8 Sec. 45. Health care services appeals, complaints, and
9 external independent reviews.

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

18 (b) When an appeal concerns a decision or action by a
19 health care plan, its employees, or its subcontractors that
20 relates to (i) health care services, including, but not limited
21 to, procedures or treatments, for an enrollee with an ongoing
22 course of treatment ordered by a health care provider, the
23 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 under subsection (f).

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

1 external independent review under subsection (f) of the adverse
2 determination.

3 (f) External independent review.

4 (1) The party seeking an external independent review
5 shall so notify the health care plan. The health care plan
6 shall seek to resolve all external independent reviews in
7 the most expeditious manner and shall make a determination
8 and provide notice of the determination no more than 24
9 hours after the receipt of all necessary information when a
10 delay would significantly increase the risk to an
11 enrollee's health or when extended health care services for
12 an enrollee undergoing a course of treatment prescribed by
13 a health care provider are at issue.

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

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

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

1 and the health care plan; and

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

8 (4) Within 5 days after receipt of all necessary
9 information, the independent reviewer shall evaluate and
10 analyze the case and render a decision that is based on
11 whether or not the health care service or claim for the
12 health care service is medically appropriate. The decision
13 by the independent reviewer is final. If the external
14 independent reviewer determines the health care service to
15 be medically appropriate, the health care plan shall pay
16 for the health care service.

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

20 (6) An external independent reviewer who acts in good
21 faith shall have immunity from any civil or criminal
22 liability or professional discipline as a result of acts or
23 omissions with respect to any external independent review,
24 unless the acts or omissions constitute wilful and wanton
25 misconduct. For purposes of any proceeding, the good faith
26 of the person participating shall be presumed.

1 (7) Future contractual or employment action by the
2 health care plan regarding the patient's physician or other
3 health care provider shall not be based solely on the
4 physician's or other health care provider's participation
5 in this procedure.

6 (8) For the purposes of this Section, an external
7 independent reviewer shall:

8 (A) be a clinical peer;

9 (B) have no direct financial interest in
10 connection with the case; and

11 (C) have not been informed of the specific identity
12 of the enrollee.

13 (9) A determination by the Director to uphold an
14 external review decision that is adverse to an enrollee is
15 subject to the process of administrative review pursuant to
16 Article III of the Code of Civil Procedure.

17 (g) Nothing in this Section shall be construed to require a
18 health care plan to pay for a health care service not covered
19 under the enrollee's certificate of coverage or policy.

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

21 (Text of Section after amendment by P.A. 96-857)

22 Sec. 45. Health care services appeals, complaints, and
23 external independent reviews.

24 (a) A health care plan shall establish and maintain an
25 appeals procedure as outlined in this Act. Compliance with this

1 Act's appeals procedures shall satisfy a health care plan's
2 obligation to provide appeal procedures under any other State
3 law or rules. All appeals of a health care plan's
4 administrative determinations and complaints regarding its
5 administrative decisions shall be handled as required under
6 Section 50.

7 (b) When an appeal concerns a decision or action by a
8 health care plan, its employees, or its subcontractors that
9 relates to (i) health care services, including, but not limited
10 to, procedures or treatments, for an enrollee with an ongoing
11 course of treatment ordered by a health care provider, the
12 denial of which could significantly increase the risk to an
13 enrollee's health, or (ii) a treatment referral, service,
14 procedure, or other health care service, the denial of which
15 could significantly increase the risk to an enrollee's health,
16 the health care plan must allow for the filing of an appeal
17 either orally or in writing. Upon submission of the appeal, a
18 health care plan must notify the party filing the appeal, as
19 soon as possible, but in no event more than 24 hours after the
20 submission of the appeal, of all information that the plan
21 requires to evaluate the appeal. The health care plan shall
22 render a decision on the appeal within 24 hours after receipt
23 of the required information. The health care plan shall notify
24 the party filing the appeal and the enrollee, enrollee's
25 primary care physician, and any health care provider who
26 recommended the health care service involved in the appeal of

1 its decision orally followed-up by a written notice of the
2 determination.

3 (c) For all appeals related to health care services
4 including, but not limited to, procedures or treatments for an
5 enrollee and not covered by subsection (b) above, the health
6 care plan shall establish a procedure for the filing of such
7 appeals. Upon submission of an appeal under this subsection, a
8 health care plan must notify the party filing an appeal, within
9 3 business days, of all information that the plan requires to
10 evaluate the appeal. The health care plan shall render a
11 decision on the appeal within 15 business days after receipt of
12 the required information. The health care plan shall notify the
13 party filing the appeal, the enrollee, the enrollee's primary
14 care physician, and any health care provider who recommended
15 the health care service involved in the appeal orally of its
16 decision followed-up by a written notice of the determination.

17 (d) An appeal under subsection (b) or (c) may be filed by
18 the enrollee, the enrollee's designee or guardian, the
19 enrollee's primary care physician, or the enrollee's health
20 care provider. A health care plan shall designate a clinical
21 peer to review appeals, because these appeals pertain to
22 medical or clinical matters and such an appeal must be reviewed
23 by an appropriate health care professional. No one reviewing an
24 appeal may have had any involvement in the initial
25 determination that is the subject of the appeal. The written
26 notice of determination required under subsections (b) and (c)

1 shall include (i) clear and detailed reasons for the
2 determination, (ii) the medical or clinical criteria for the
3 determination, which shall be based upon sound clinical
4 evidence and reviewed on a periodic basis, and (iii) in the
5 case of an adverse determination, the procedures for requesting
6 an external independent review as provided by the Illinois
7 Health Carrier External Review Act.

8 (e) If an appeal filed under subsection (b) or (c) is
9 denied for a reason including, but not limited to, the service,
10 procedure, or treatment is not viewed as medically necessary,
11 denial of specific tests or procedures, denial of referral to
12 specialist physicians or denial of hospitalization requests or
13 length of stay requests, any involved party may request an
14 external independent review as provided by the Illinois Health
15 Carrier External Review Act.

16 (f) Until July 1, 2013, if an external independent review
17 decision made pursuant to the Illinois Health Carrier External
18 Review Act upholds a determination adverse to the covered
19 person, the covered person has the right to appeal the final
20 decision to the Department; if the external review decision is
21 found by the Director to have been arbitrary and capricious,
22 then the Director, with consultation from a licensed medical
23 professional, may overturn the external review decision and
24 require the health carrier to pay for the health care service
25 or treatment; such decision, if any, shall be made solely on
26 the legal or medical merits of the claim. If an external review

1 decision is overturned by the Director pursuant to this Section
2 and the health carrier so requests, then the Director shall
3 assign a new independent review organization to reconsider the
4 overturned decision. The new independent review organization
5 shall follow subsection (d) of Section 40 of the Health Carrier
6 External Review Act in rendering a decision. A determination by
7 the Director to uphold an external review decision that is
8 adverse to an enrollee is subject to the process of
9 administrative review pursuant to Article III of the Code of
10 Civil Procedure.

11 (g) Future contractual or employment action by the
12 health care plan regarding the patient's physician or other
13 health care provider shall not be based solely on the
14 physician's or other health care provider's participation in
15 health care services appeals, complaints, or external
16 independent reviews under the Illinois Health Carrier External
17 Review Act.

18 (h) Nothing in this Section shall be construed to require a
19 health care plan to pay for a health care service not covered
20 under the enrollee's certificate of coverage or policy.

21 (Source: P.A. 96-857, eff. 7-1-10.)

22 Section 10. The Health Carrier External Review Act is
23 amended by changing Sections 20, 25, and 45 and by adding
24 Section 80 as follows:

1 (215 ILCS 180/20)

2 (This Section may contain text from a Public Act with a
3 delayed effective date)

4 Sec. 20. Notice of right to external review.

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

25 (b) This subsection (b) shall apply to an expedited review
26 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 (e) In every billing instance when a health carrier sends
5 any request for payment to a covered person, the health carrier
6 shall include a written statement of the health care patient
7 rights as set forth in Section 5 of the Managed Care Reform and
8 Patient Rights Act.

9 (Source: P.A. 96-857, eff. 7-1-10.)

10 (215 ILCS 180/25)

11 (This Section may contain text from a Public Act with a
12 delayed effective date)

13 Sec. 25. Request for external review.

14 (a) A covered person or the covered person's authorized
15 representative may make a request for a standard external or
16 expedited external review of an adverse determination or final
17 adverse determination. Requests under this Section shall be
18 made directly to the health carrier that made the adverse or
19 final adverse determination. All requests for external review
20 shall be in writing except for requests for expedited external
21 reviews which may be made orally. Health carriers must provide
22 covered persons with forms to request external reviews.

23 (b) The Office of Consumer Health Insurance within the
24 Department of Insurance shall provide consultation and case
25 management for covered persons. The Office of Consumer Health

1 Insurance shall establish a toll-free phone number for covered
2 persons who are engaged in an appeal or seeking external review
3 of an adverse determination or final adverse determination. The
4 Department shall adopt rules to implement this subsection (b).

5 (Source: P.A. 96-857, eff. 7-1-10.)

6 (215 ILCS 180/45)

7 (This Section may contain text from a Public Act with a
8 delayed effective date)

9 Sec. 45. Binding nature of external review decision. An
10 external review decision is binding on the health carrier. An
11 external review decision is binding on the covered person
12 except to the extent the covered person has other remedies
13 available under applicable federal or State law. A covered
14 person or the covered person's authorized representative may
15 not file a subsequent request for external review involving the
16 same adverse determination or final adverse determination for
17 which the covered person has already received an external
18 review decision pursuant to this Act. A determination by the
19 Director to uphold an external review decision that is adverse
20 to an enrollee is subject to the process of administrative
21 review pursuant to Article III of the Code of Civil Procedure.

22 (Source: P.A. 96-857, eff. 7-1-10.)

23 (215 ILCS 180/80 new)

24 Sec. 80. Minimum medical loss requirement.

1 (a) Every health carrier shall expend in the form of health
2 care benefits no less than 85% of the aggregate dues, fees,
3 premiums, or other periodic payments received by the health
4 carrier. For purposes of this Section, the health carrier may
5 deduct from the aggregate dues, fees, premiums, or other
6 periodic payments received by the health carrier the amount of
7 income taxes or other taxes that the health carrier expensed.

8 (b) To assess compliance with this Section, a health
9 carrier may average its total costs across all health benefit
10 plans issued, amended, or renewed in this State and all health
11 benefit plans issued, amended, or renewed by its affiliated
12 companies that are licensed to operate in this State.

13 (c) The Department shall adopt rules to implement this
14 Section and to establish uniform reporting by health carriers
15 of the information necessary to determine compliance with this
16 Section.

17 (d) The Department may exclude from the determination of
18 compliance with the requirement of subsection (a) of this
19 Section any new health benefit plans for up to the first 2
20 years that these health benefit plans are offered for sale in
21 this State, provided that the Department determines that the
22 new health benefit plans are substantially different from the
23 existing health benefit plans being issued, amended, or renewed
24 by the health carrier seeking the exclusion.

25 Section 95. No acceleration or delay. Where this Act makes

1 changes in a statute that is represented in this Act by text
2 that is not yet or no longer in effect (for example, a Section
3 represented by multiple versions), the use of that text does
4 not accelerate or delay the taking effect of (i) the changes
5 made by this Act or (ii) provisions derived from any other
6 Public Act.