HB4443

LRB10016214SMS31872b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB4443

by Rep. Robyn Gabel

SYNOPSIS AS INTRODUCED:

215 ILCS 5/352 from Ch. 73, par. 964
215 ILCS 5/368a
305 ILCS 5/5-16.8

Amends the Illinois Insurance Code. Provides that all managed care plans shall ensure that all claims and indemnities concerning health care services shall be paid within 30 days after receipt of a claim that has provided specified information on a CMS-1500 Health Insurance Claim Form or a UB-04 (CMS-1450) form. Provides that certain health care providers shall be notified of any known failure of the claim and provide detailed information on how the claim may be satisfied to receive payment within 30 days after receipt. Provides that any undisputed portions of a claim must be reimbursed by the managed care plan within 30 days after receipt. Grants the Department of Insurance specific authority to issue a cease and desist order, fine, or otherwise penalize managed care plans that violate provisions concerning timely payment for health care services. Provides that a policy issued or delivered to the Department of Healthcare and Family Services that provides coverage to certain persons is subject to the provisions concerning timely payment for health care services. Makes conforming changes in the Illinois Public Aid Code.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Illinois Insurance Code is amended by changing Sections 352 and 368a as follows:

(215 ILCS 5/352) (from Ch. 73, par. 964)

Sec. 352. Scope of Article.

(a) Except as provided in subsections (b), (c), (d), and (e), this Article shall apply to all companies transacting in this State the kinds of business enumerated in clause (b) of Class 1 and clause (a) of Class 2 of section 4. Nothing in this Article shall apply to, or in any way affect policies or contracts described in clause (a) of Class 1 of Section 4; however, this Article shall apply to policies and contracts which contain benefits providing reimbursement for the expenses of long term health care which are certified or ordered by a physician including but not limited to professional nursing care, custodial nursing care, and non-nursing custodial care provided in a nursing home or at a residence of the insured.

(b) (Blank).

(c) A policy issued and delivered in this State that provides coverage under that policy for certificate holders who

are neither residents of nor employed in this State does not need to provide to those nonresident certificate holders who are not employed in this State the coverages or services mandated by this Article.

(d) Stop-loss insurance is exempt from all Sections of this Article, except this Section and Sections 353a, 354, 357.30, and 370. For purposes of this exemption, stop-loss insurance is further defined as follows:

(1) The policy must be issued to and insure an employer, trustee, or other sponsor of the plan, or the plan itself, but not employees, members, or participants.

(2) Payments by the insurer must be made to the employer, trustee, or other sponsors of the plan, or the plan itself, but not to the employees, members, participants, or health care providers.

(e) A policy issued or delivered in this State to the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) and providing coverage, under clause (b) of Class 1 or clause (a) of Class 2 as described in Section 4, to persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act is exempt from all restrictions, limitations, standards, rules, or regulations respecting benefits imposed by or under authority of this Code, except those specified by subsection (1) of Section 143, Section 368a, Section 370c, and Section 370c.1. Nothing in this

subsection, however, affects the total medical services available to persons eligible for medical assistance under the Illinois Public Aid Code.

(Source: P.A. 99-480, eff. 9-9-15.)

(215 ILCS 5/368a)

Sec. 368a. Timely payment for health care services.

(a) This Section applies to insurers, health maintenance organizations, managed care plans, health care plans, preferred provider organizations, third party administrators, independent practice associations, and physician-hospital organizations (hereinafter referred to as "payors") that provide periodic payments, which are payments not requiring a claim, bill, capitation encounter data, or capitation reconciliation reports, such as prospective capitation payments, to health care professionals and health care facilities to provide medical or health care services for insureds or enrollees.

(1) A payor shall make periodic payments in accordance with item (3). Failure to make periodic payments within the period of time specified in item (3) shall entitle the health care professional or health care facility to interest at the rate of 9% per year from the date payment was required to be made to the date of the late payment, provided that interest amounting to less than $1 need not be paid. Any required interest payments shall be made

within 30 days after the payment.

(2) When a payor requires selection of a health care professional or health care facility, the selection shall be completed by the insured or enrollee no later than 30 days after enrollment. The payor shall provide written notice of this requirement to all insureds and enrollees. Nothing in this Section shall be construed to require a payor to select a health care professional or health care facility for an insured or enrollee.

(3) A payor shall provide the health care professional or health care facility with notice of the selection as a health care professional or health care facility by an insured or enrollee and the effective date of the selection within 60 calendar days after the selection. No later than the 60th day following the date an insured or enrollee has selected a health care professional or health care facility or the date that selection becomes effective, whichever is later, or in cases of retrospective enrollment only, 30 days after notice by an employer to the payor of the selection, a payor shall begin periodic payment of the required amounts to the insured's or enrollee's health care professional or health care facility, or the designee of either, calculated from the date of selection or the date the selection becomes effective, whichever is later. All subsequent payments shall be made in accordance with a monthly periodic cycle.

(b) Notwithstanding any other provision of this Section, independent practice associations and physician-hospital organizations shall make periodic payment of the required amounts in accordance with a monthly periodic schedule after an insured or enrollee has selected a health care professional or health care facility or after that selection becomes effective, whichever is later.

Notwithstanding any other provision of this Section, independent practice associations and physician-hospital organizations shall make all other payments for health services within 30 days after receipt of due proof of loss. Independent practice associations and physician-hospital organizations shall notify the insured, insured's assignee, health care professional, or health care facility of any failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim for health services.

Failure to pay within the required time period shall entitle the payee to interest at the rate of 9% per year from the date the payment is due to the date of the late payment, provided that interest amounting to less than $1 need not be paid. Any required interest payments shall be made within 30 days after the payment.

(c) All insurers, health maintenance organizations, ~~managed care plans,~~ health care plans, preferred provider organizations, and third party administrators shall ensure that all claims and indemnities concerning health care services

other than for any periodic payment shall be paid within 30 days after receipt of due written proof of such loss. An insured, insured's assignee, health care professional, or health care facility shall be notified of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim for health care services. Failure to pay within such period shall entitle the payee to interest at the rate of 9% per year from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. Any required interest payments shall be made within 30 days after the payment.

(c-5) All managed care plans shall ensure that all claims and indemnities concerning health care services other than for any periodic payment shall be paid within 30 days after receipt of a claim as defined under paragraph (1) or (2) of this subsection. An insured, insured's assignee, health care professional, or health care facility shall be notified of any known failure to provide sufficient documentation for a claim or why the claim or portion thereof is not complete or is in some manner deficient and specify in detail the information, documentation, or processes necessary for the insured, insured's assignee, health care professional, or health care facility to satisfy the requirements of this subsection and receive payment within 30 days after receipt of the claim for health care services. Any undisputed portions of a claim must

be reimbursed by the managed care plan within 30 days after receipt. Failure to pay within such period shall entitle the payee to interest at the rate of 9% per year from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. Any required interest payments shall be made within 30 days after the payment.

For information submitted on a:

(1) CMS-1500 Health Insurance Claim Form, as periodically updated and revised, the following minimum requirements must be complete and received by the managed care plan before the form is considered a claim for purposes of this subsection (c-5):

Item Number	Item Description
1a	Insured's I.D. number
2	Patient's name
3	Patient's birth date and sex
4	Insured's name
10a	Patient's condition – employment
10b	Patient's condition – auto accident
10c	Patient's condition – other accident
11	Insured's policy group number (if provided on I.D. card)
11d	Is there another health benefit plan?
17a	I.D. number of referring physician

	(if required by insurer)
21	Diagnosis
24A	Dates of service
24B	Place of service
24D	Procedures, services, or supplies
24E	Diagnosis code
24F	Charges
25	Federal tax I.D. number
28	Total charge
31	Signature of physician or supplier with date
33	Physician's or supplier's billing name, address, zip code, and phone number

(2) UB-04 (CMS-1450), as periodically updated and revised, the following minimum requirements must be complete and received by the managed care plan before the form is considered a claim for purposes of this subsection (c-5):

Item Number	Item Description
1	Provider name and address
5	Federal tax I.D. number
6	Statement covers period
12	Patient name
14	Patient's birthdate

15	Patient's sex
17	Admission date
18	Admission hour
19	Type of admission
21	Discharge hour
42	Revenue codes
43	Revenue description
44	HCPCS/CPT4 codes
45	Service date
46	Service units
47	Total charges by revenue code
50	Payer I.D.
51	Provider number
58	Insured's name
60	Patient's I.D. number (policy number, social security number, or both)
62	Insurance group number (if on I.D. card)
67	Principal diagnosis code
76	Admitting diagnosis code
80	Principal procedure code and date
81	Other procedures code and date
82	Attending physician's I.D. number

(d) The Department shall enforce the provisions of this Section pursuant to the enforcement powers granted to it by law.

(e) The Department is hereby granted specific authority to issue a cease and desist order, fine, or otherwise penalize managed care plans, independent practice associations, and physician-hospital organizations that violate this Section. The Department shall adopt reasonable rules to enforce compliance with this Section by managed care plans, independent practice associations, and physician-hospital organizations.
(Source: P.A. 97-813, eff. 7-13-12.)

Section 10. The Illinois Public Aid Code is amended by changing Section 5-16.8 as follows:

(305 ILCS 5/5-16.8)

Sec. 5-16.8. Required health benefits. The medical assistance program shall (i) provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.6, and 356z.25 of the Illinois Insurance Code and (ii) be subject to the provisions of Sections 356z.19, 364.01, 368a, 370c, and 370c.1 of the Illinois Insurance Code.

On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

To ensure full access to the benefits set forth in this Section, on and after January 1, 2016, the Department shall ensure that provider and hospital reimbursement for post-mastectomy care benefits required under this Section are no lower than the Medicare reimbursement rate.

(Source: P.A. 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-642, eff. 7-28-16; 100-138, eff. 8-18-17.)