AN ACT concerning regulation.

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

Section 5. The Health Carrier External Review Act is amended by changing Section 65 as follows:

(215 ILCS 180/65)

Sec. 65. External review reporting requirements.

(a) Each health carrier shall maintain written records in the aggregate, by state, and for each type of health benefit plan offered by the health carrier on all requests for external review that the health carrier received notice from the Director for each calendar year and submit a report to the Director in the format specified by the Director by June 1 ~~March 1~~ of each year.

(a-5) An independent review organization assigned pursuant to this Act to conduct an external review shall maintain written records in the aggregate by state and by health carrier on all requests for external review for which it conducted an external review during a calendar year and submit a report in the format specified by the Director by March 1 of each year.

(a-10) The report required by subsection (a-5) shall include in the aggregate by state, and for each health carrier:

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

(2) the number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(3) the average length of time for resolution;

(4) a summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Director;

(5) the number of external reviews that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(6) any other information the Director may request or require.

(a-15) The independent review organization shall retain the written records required pursuant to this Section for at least 3 years.

(b) The report required under subsection (a) of this Section shall include in the aggregate, by state, and by type of health benefit plan:

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

(2) the total number of requests for expedited external review;

(3) the total number of requests for external review denied;

(4) the number of requests for external review resolved, including:

(A) the number of requests for external review resolved upholding the adverse determination or final adverse determination;

(B) the number of requests for external review resolved reversing the adverse determination or final adverse determination;

(C) the number of requests for expedited external review resolved upholding the adverse determination or final adverse determination; and

(D) the number of requests for expedited external review resolved reversing the adverse determination or final adverse determination;

(5) the average length of time for resolution for an external review;

(6) the average length of time for resolution for an expedited external review;

(7) a summary of the types of coverages or cases for which an external review was sought, as specified below:

(A) denial of care or treatment (dissatisfaction regarding prospective non-authorization of a request for care or treatment recommended by a provider excluding diagnostic procedures and referral requests;

partial approvals and care terminations are also considered to be denials);

(B) denial of diagnostic procedure (dissatisfaction regarding prospective non-authorization of a request for a diagnostic procedure recommended by a provider; partial approvals are also considered to be denials);

(C) denial of referral request (dissatisfaction regarding non-authorization of a request for a referral to another provider recommended by a PCP);

(D) claims and utilization review (dissatisfaction regarding the concurrent or retrospective evaluation of the coverage, medical necessity, efficiency or appropriateness of health care services or treatment plans; prospective "Denials of care or treatment", "Denials of diagnostic procedures" and "Denials of referral requests" should not be classified in this category, but the appropriate one above);

(8) the number of external reviews that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(9) any other information the Director may request or require.

(Source: P.A. 96-857, eff. 7-1-10; 97-574, eff. 8-26-11.)

Section 99. Effective date. This Act takes effect January 1, 2017.