1 AMENDMENT TO SENATE BILL 1776

2 AMENDMENT NO. ____. Amend Senate Bill 1776 by replacing
3 the title with the following:
4 "AN ACT concerning insurance."; and

5 by replacing everything after the enacting clause with the
6 following:

7 "Section 5. The Illinois Insurance Code is amended by
8 adding Sections 368b, 368c, and 368e as follows:

9 (215 ILCS 5/368b new)
10 Sec. 368b. Prohibition of waiver of requirements and
11 prohibitions. No contract between an insurer, health
12 maintenance organization, independent practice association,
13 or physician hospital organization and a health care
14 professional or health care provider shall contain any
15 provision, term, or condition that limits, restricts, or
16 otherwise waives any of the requirements and prohibitions set
17 forth in Section 368a, 368b, 368c, or 368e of this Article.
18 Any provision purporting to make such a waiver is void and
19 unenforceable.

20 (215 ILCS 5/368c new)

1 Sec. 368c. Payments.
2 (a) After the effective date of this amendatory Act of
3 the 93rd General Assembly, health care professionals or
4 health care providers offered a contract for signature by an
5 insurer, health maintenance organization, independent
6 practice association, or physician hospital organization to
7 be paid on a service by service basis shall, upon request, be
8 provided copies of the fee schedule or payment arrangement
9 and amounts for each health care service to be provided under
10 the contract prior to signing the contract. If the health
11 care professional or health care provider is not paid on a
12 service by service basis, the amounts payable and terms of
13 payment under that alternative payment system shall be
14 provided upon request.
15 (b) Payments under a contract with a health care
16 professional or health care provider shall not be changed
17 based upon rates agreed to by the professional or provider in
18 another contract with an insurer, health maintenance
19 organization, independent practice association, or physician
20 hospital organization. Nothing in this Section shall be
21 construed to prevent an insurer, health maintenance
22 organization, independent practice association, or physician
23 hospital organization from renegotiating its payments under a
24 contract with a health care professional or health care
25 provider.
26 (c) A payment statement shall be furnished to a health
27 care professional or health care provider paid on a service
28 by service basis for services provided under the contract
29 that identifies the disposition of each claim, including
30 services billed, the patient responsibility, if any, the
31 actual payment, if any, for the services billed by CPT or
32 other appropriate code, and the reason for any payment
33 reduction to the claim submitted, including any withholds,
34 and the reason for denial of any claim. Nothing in this

1 Section requires that a health care professional or health
2 care provider be paid on a service by service basis. Payments
3 may be made based on capitation and other payment
4 arrangements. Health care professionals and health care
5 providers shall be allowed to collect co-payments,
6 co-insurance, deductibles, and payment for non-covered
7 services directly from patients except as otherwise provided
8 by law. An insurer, health maintenance organization,
9 independent practice association, or physician hospital
10 organization may pay for covered services either to a patient
11 directly or a non-participating health care professional or
12 health care provider.
13 (d) When a person presents a health care service
14 benefits information card, a health care professional or
15 health care provider shall inform the person if he or she is
16 not participating with the insurer, health maintenance
17 organization, independent practice organization, or physician
18 hospital organization issuing the card.

19 (215 ILCS 5/368e new)
20 Sec. 368e. Recoupments. Any attempt to recoup payment
21 made to a health care professional or health care provider by
22 an insurer, health maintenance organization, independent
23 practice association, or physician-hospital organization
24 shall be initiated by providing a written explanation of any
25 proposed recoupment, including, but not limited to, the name
26 of the patient, the date of service, the service code, and
27 the payment amount, the details concerning the reasons for
28 the recoupment, and an explanation of the appeal process. A
29 health care professional or health care provider shall be
30 given 60 days to appeal the proposed recoupment or to repay
31 the recoupment amount. If the health care professional or
32 health care provider chooses to appeal the proposed
33 recoupment and, upon appeal, the proposed recoupment is

1 determined to be appropriate, the health care professional or
2 health care provider must pay the recoupment within 30 days
3 of receiving the notice of the final appeal's decision. If
4 the health care professional or health care provider does not
5 make any required recoupment payment within these time
6 frames, the insurer, health maintenance organization,
7 independent practice association, or physician hospital
8 organization may offset future payments to effectuate the
9 recoupment. Except in an instance in which the health care
10 professional or health care provider has been found guilty of
11 committing civil or criminal insurance fraud, no recoupment
12 of any payments may be initiated 24 months after the date the
13 moneys were paid, except when requested or initiated by a
14 governmental unit. It is not a recoupment when a health care
15 professional or health care provider is paid an amount
16 prospectively under a contract with an insurer, health
17 maintenance organization, independent practice association,
18 or physician hospital organization that includes a
19 retrospective reconciliation based on the services provided.

20 Section 10. The Health Maintenance Organization Act is
21 amended by changing Section 5-3 as follows:

22 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)
23 Sec. 5-3. Insurance Code provisions.
24 (a) Health Maintenance Organizations shall be subject to
25 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
26 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
27 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x,
28 356y, 356z.2, 367i, 368a, 368b, 368c, 368e, 401, 401.1, 402,
29 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph
30 (c) of subsection (2) of Section 367, and Articles IIA, VIII
31 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the
32 Illinois Insurance Code.

1 (b) For purposes of the Illinois Insurance Code, except
2 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
3 Health Maintenance Organizations in the following categories
4 are deemed to be "domestic companies":
5 (1) a corporation authorized under the Dental
6 Service Plan Act or the Voluntary Health Services Plans
7 Act;
8 (2) a corporation organized under the laws of this
9 State; or
10 (3) a corporation organized under the laws of
11 another state, 30% or more of the enrollees of which are
12 residents of this State, except a corporation subject to
13 substantially the same requirements in its state of
14 organization as is a "domestic company" under Article
15 VIII 1/2 of the Illinois Insurance Code.
16 (c) In considering the merger, consolidation, or other
17 acquisition of control of a Health Maintenance Organization
18 pursuant to Article VIII 1/2 of the Illinois Insurance Code,
19 (1) the Director shall give primary consideration
20 to the continuation of benefits to enrollees and the
21 financial conditions of the acquired Health Maintenance
22 Organization after the merger, consolidation, or other
23 acquisition of control takes effect;
24 (2)(i) the criteria specified in subsection (1)(b)
25 of Section 131.8 of the Illinois Insurance Code shall not
26 apply and (ii) the Director, in making his determination
27 with respect to the merger, consolidation, or other
28 acquisition of control, need not take into account the
29 effect on competition of the merger, consolidation, or
30 other acquisition of control;
31 (3) the Director shall have the power to require
32 the following information:
33 (A) certification by an independent actuary of
34 the adequacy of the reserves of the Health

1 Maintenance Organization sought to be acquired;
2 (B) pro forma financial statements reflecting
3 the combined balance sheets of the acquiring company
4 and the Health Maintenance Organization sought to be
5 acquired as of the end of the preceding year and as
6 of a date 90 days prior to the acquisition, as well
7 as pro forma financial statements reflecting
8 projected combined operation for a period of 2
9 years;
10 (C) a pro forma business plan detailing an
11 acquiring party's plans with respect to the
12 operation of the Health Maintenance Organization
13 sought to be acquired for a period of not less than
14 3 years; and
15 (D) such other information as the Director
16 shall require.
17 (d) The provisions of Article VIII 1/2 of the Illinois
18 Insurance Code and this Section 5-3 shall apply to the sale
19 by any health maintenance organization of greater than 10% of
20 its enrollee population (including without limitation the
21 health maintenance organization's right, title, and interest
22 in and to its health care certificates).
23 (e) In considering any management contract or service
24 agreement subject to Section 141.1 of the Illinois Insurance
25 Code, the Director (i) shall, in addition to the criteria
26 specified in Section 141.2 of the Illinois Insurance Code,
27 take into account the effect of the management contract or
28 service agreement on the continuation of benefits to
29 enrollees and the financial condition of the health
30 maintenance organization to be managed or serviced, and (ii)
31 need not take into account the effect of the management
32 contract or service agreement on competition.
33 (f) Except for small employer groups as defined in the
34 Small Employer Rating, Renewability and Portability Health

1 Insurance Act and except for medicare supplement policies as
2 defined in Section 363 of the Illinois Insurance Code, a
3 Health Maintenance Organization may by contract agree with a
4 group or other enrollment unit to effect refunds or charge
5 additional premiums under the following terms and conditions:
6 (i) the amount of, and other terms and conditions
7 with respect to, the refund or additional premium are set
8 forth in the group or enrollment unit contract agreed in
9 advance of the period for which a refund is to be paid or
10 additional premium is to be charged (which period shall
11 not be less than one year); and
12 (ii) the amount of the refund or additional premium
13 shall not exceed 20% of the Health Maintenance
14 Organization's profitable or unprofitable experience with
15 respect to the group or other enrollment unit for the
16 period (and, for purposes of a refund or additional
17 premium, the profitable or unprofitable experience shall
18 be calculated taking into account a pro rata share of the
19 Health Maintenance Organization's administrative and
20 marketing expenses, but shall not include any refund to
21 be made or additional premium to be paid pursuant to this
22 subsection (f)). The Health Maintenance Organization and
23 the group or enrollment unit may agree that the
24 profitable or unprofitable experience may be calculated
25 taking into account the refund period and the immediately
26 preceding 2 plan years.
27 The Health Maintenance Organization shall include a
28 statement in the evidence of coverage issued to each enrollee
29 describing the possibility of a refund or additional premium,
30 and upon request of any group or enrollment unit, provide to
31 the group or enrollment unit a description of the method used
32 to calculate (1) the Health Maintenance Organization's
33 profitable experience with respect to the group or enrollment
34 unit and the resulting refund to the group or enrollment unit

or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 91-357, eff. 7-29-99; 91-406, eff. 1-1-00; 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff. 6-9-00; 92-764, eff. 1-1-03.)

Section 15. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c, 149, 155.37, 354, 355.2, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 367.2, 368a, 368b, 368c, 368e, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 91-406, eff. 1-1-00; 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff. 6-9-00; 92-130, eff. 7-20-01; 92-440, eff. 8-17-01; 92-651, eff. 7-11-02; 92-764, eff. 1-1-03.)

Section 99. Effective date. This Act takes effect December 1, 2003.".