Rep. Mary E. Flowers

Filed: 5/21/2008

AMENDMENT TO HOUSE BILL 2286

AMENDMENT NO. _____. Amend House Bill 2286 by replacing everything after the enacting clause with the following:

"Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356f.1, 356g.5, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, ~~and~~ 356z.9, and 356z.10 ~~356z.9~~ of the Illinois Insurance Code. The program of health benefits must comply with Section 155.37 of the Illinois Insurance Code.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 10. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for 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 356f.1, 356g.5, 356u, 356w, 356x, 356z.6, ~~and~~ 356z.9, and 356z.10 ~~356z.9~~ of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 15. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for 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 356f.1, 356g.5, 356u, 356w, 356x, 356z.6, ~~and~~ 356z.9, and 356z.10 ~~356z.9~~ of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 20. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall 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 356f.1, 356g.5, 356u, 356w, 356x, 356z.6, and 356z.9 of the Illinois Insurance Code. (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; revised 12-4-07.)

Section 25. The Illinois Insurance Code is amended by adding Section 356f.1 as follows:

(215 ILCS 5/356f.1 new)

Sec. 356f.1. Third-party review.

(a) Definitions. For purposes of this Section, the following definitions shall apply:

"Authorized representative" means:

(1) a person to whom a covered person has given express written consent to represent the covered person in a third-party review;

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

(3) a family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

"Director" means the Director of the Division of Insurance of the Department of Financial and Professional Regulation.

"Covered person" means an individual whose coverage under an individual health insurance plan has been rescinded.

"Division" means the Division of Insurance of the Department of Financial and Professional Regulation.

"Disclose" means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

"Health insurance plan" means a policy, contract, certificate, or agreement issued by a health carrier to provide, deliver, arrange for, pay, or reimburse any of the costs of health care services. For the purposes of this definition, "health insurance plan" does not include one or more, or any combination of, the following: coverage only for accident or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; coverage similar to the foregoing as specified in federal regulations issued pursuant to Public Law 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits; dental or vision benefits; benefits for long-term care, nursing home care, home health care, or community-based care; specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or such other similar, limited benefits as are specified in rules; Medicare supplemental health insurance

as defined under Section 1882(g)(1) of the Social Security Act; coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; or other similar limited benefit supplemental coverages.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified in any state to perform specified health care services.

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

"Health carrier" means an entity subject to the insurance laws and rules of this State or subject to the jurisdiction of the Division that issues individual health insurance plans covering one or more residents of this State, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health corporation, or any other entity providing or issuing an individual health insurance plan.

"Health maintenance organization" means an organization licensed under the Health Maintenance Organization Act.

"Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act.

"Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

"Protected health information" means health information that identifies an individual who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify the individual.

"Rescission" means the process of voiding an individual health insurance plan, from its inception, on the grounds of material misrepresentation or omission on the application for insurance that would have resulted in a different decision by the health carrier with respect to issuing coverage.

"Review criteria" means the written screening procedures, decision abstracts, clinical protocols, the health carrier's underwriting manual, and practice guidelines used by a health carrier in making its rescission determination.

"Third-party review organization" means an entity that conducts independent third-party reviews of rescission decisions made by health carriers that are based on medical issues for health insurance plan coverage.

(b) Purpose, applicability, and scope. The purpose of this Section is to provide uniform standards for the establishment and maintenance of third-party review procedures to ensure that covered persons have the opportunity for an independent review of medical issues related to health carrier rescission decisions. This Section shall apply to rescission decisions made by health carriers that are based on medical issues for health insurance plan coverage. This Section does not extend to

allegations related to agent conduct or decisions not based on medical issues, such as residency and marital status.

(c) Notice of right to third-party review. A health carrier shall notify the covered person in writing of the covered person's right to request a third-party review to be conducted pursuant to subsection (f) of this Section and include the appropriate statements and information set forth in this subsection (c) at the same time the health carrier sends written notice of the rescission of the individual health insurance plan. As part of the written notice required under this subsection (c), a health carrier shall include the following, or substantially equivalent, language:

"We have rescinded your coverage with us based on a material misrepresentation contained in your application. After you have followed the procedures for our internal grievance process for this rescission decision (if applicable), you may have the right to have our decision reviewed by health care and legal professionals who have no association with us if our decision was based on a medical issue by submitting a request for third-party review to the Director at the following address: (insert address where covered persons are to submit requests for third-party review)."

The health carrier shall include the following information in or attached to the notice required under this subsection (c):

(1) a description of the standard and expedited third-party review procedures required under this Section, highlighting the provisions that give the covered person or the covered person's authorized representative the right to file a request for an expedited third-party review if the covered person has a medical condition where the timeframe for completion of an expedited review of the grievance or a standard third-party review under this Section would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(2) an authorization form or other document approved by the Director that complies with the requirements of 45 C.F.R. 164.508 by which the covered person, for purposes of conducting a third-party review under this Section, authorizes the health carrier and the covered person's treating provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the third-party review, as provided under State medical record privacy laws and Article XL of this Code.

(d) Third-party review requests. All requests for third-party review shall be made in writing to the Director.

An expedited third-party review process shall be made available for the review of health carrier rescission decisions. For expedited third-party review of a rescission

decision, a covered person or the covered person's authorized representative may file a written request for an expedited third-party review with the Director after the exhaustion of the health carrier's internal grievance process in accordance with the requirements of subsection (e) of this Section or after the receipt of the written notice of the right to third-party review pursuant to subsection (c) of this Section, whichever is later.

(e) Exhaustion of internal grievance process. A third-party review cannot commence until the covered person has exhausted the health carrier's internal grievance process in accordance with the requirements of this subsection (e).

For rescission decisions, a covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this Section if:

(1) the health carrier has an internal grievance process for rescission decisions and the covered person or the covered person's authorized representative has complied with all of the steps required in the health carrier's internal grievance process that is established pursuant to this Section and, except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within 30 days after the date the covered person or the covered person's authorized representative

filed the grievance with the health carrier or the date the health carrier receives any requested information, whichever is later;

(2) the grievance concerns a rescission decision and the covered person (i) is subject to procedures, treatments, or an ongoing course of treatment ordered by a health care provider, the suspension or termination of which could significantly increase the risk to the person's health or (ii) has received a treatment referral for a service, procedure, or other health care service, the denial of which could significantly increase the risk to the person's health, the policy or plan must allow for the filing of an expedited internal grievance either orally or in writing; upon submission of the expedited internal grievance, a policy or plan must notify the party filing the expedited internal grievance as soon as possible, but in no event more than 24 hours after the submission of the expedited internal grievance, of all information that the plan requires to evaluate the expedited internal grievance; the policy or plan shall render a decision on the expedited internal grievance within 24 hours after receipt of the required information; the policy or plan shall notify the party filing the expedited internal grievance and the person, the person's primary care physician, and any health care provider who recommended the health care service involved in the expedited internal

grievance of its decision orally followed by a written notice of the determination; or

(3) the health carrier waives the exhaustion requirement in writing.

(f) Third-party review process - standard and expedited. Immediately following receipt of a request for an expedited third-party review, or within one business day after the date of receipt of a request for a standard third-party review, the Director shall do the following:

(1) send a copy of the request to the health carrier; and

(2) send written notice to the covered person or the covered person's authorized representative informing him or her of the right to submit additional information to the Director that the covered person or the covered person's authorized representative would like considered by the health carrier. These materials must be submitted to the Director within 3 business days after receipt of the Director's written notice provided under this subsection (f).

Within one business day after receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to this subsection (f), the Director shall forward the information to the health carrier.

Upon receipt of the information, if any, required to be forwarded pursuant to this subsection (f), the health carrier

may reconsider its determination that is the subject of the third-party review. Reconsideration by the health carrier of its determination pursuant to this subsection (f) shall not delay or terminate the third-party review. The third-party review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its determination and provide coverage for the health care service or reinstate the health insurance plan. Within one business day after making the decision to reverse its determination pursuant to this subsection (f), the health carrier shall notify the covered person, the covered person's authorized representative, the assigned third-party review organization, and the Director in writing of its decision. The assigned third-party review organization shall terminate the third-party review upon receipt of the notice from the health carrier sent pursuant to this subsection (f).

Immediately following receipt of a request for an expedited third-party review or within 5 business days after the date of receipt of a standard third-party review request, the Director shall complete a preliminary review of the request to determine the following concerning rescission third-party reviews:

(i) the individual's coverage under an individual health insurance plan has been rescinded;

(ii) the rescission decision made by the health carrier is based on a medical issue;

(iii) if the health carrier has an internal grievance

process for rescission decisions, the covered person has exhausted the health carrier's internal grievance process as set forth in this Section, unless the covered person is exempt under subsection (e) of this Section; and

(iv) the covered person has provided all the information and forms required to proceed with the third-party review.

The Director shall notify the covered person, the covered person's authorized representative, and the health carrier in writing whether the request is complete and eligible for third-party review immediately after completion of the preliminary review under this subsection (f) for an expedited third-party review request or within one business day after completion of the preliminary review under this subsection (f) for a standard third-party review request. If the request is not complete, the Director shall include a statement in the notice required under this subsection (f) informing the covered person, the covered person's authorized representative, and the health carrier in writing and include in the notice what information or materials are needed to make the request complete. If the request is not eligible for third-party review, the Director shall include a statement in the notice required under this subsection (f) informing the covered person, the covered person's authorized representative, and the health carrier in writing and include in the notice the reasons for its ineligibility. If the request is complete and

eligible for third-party review, the Director shall immediately randomly assign a third-party review organization from the list of approved third-party review organizations compiled and maintained pursuant to subsection (j) of this Section to conduct the third-party review and shall notify the third-party review organization and the health carrier of the assignment.

The health carrier shall provide to the assigned third-party review organization the documents and any information considered in making its determination within one business day after the date of receipt of the notice provided pursuant to this subsection (f) for expedited third-party review or within 5 business days after the date of receipt of the notice provided pursuant to this subsection (f) for standard third-party reviews. Failure by the health carrier to provide the documents and information within the time specified in this subsection (f) shall not delay the conduct of the third-party review. If the health carrier fails to provide the documents and information within the time specified in this subsection (f), the assigned third-party review organization may terminate the third-party review and make a decision to reverse the health carrier's determination. Within one business day after making the decision under this subsection (f), the third-party review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health carrier, and the

Director.

(g) Third-party review process - health care review panel. The assigned third-party review organization shall select a panel of health care professional reviewers and legal reviewers to conduct the third-party review in accordance with subsection (f) of this Section immediately after being assigned by the Director to conduct an expedited third-party review or within one business day after being assigned by the Director to conduct a standard third-party review.

For third-party reviews of rescission decisions, the panel shall consist of one health care professional reviewer and 2 legal reviewers and must include individuals with expertise and knowledge of the individual health insurance market, including the underwriting process. In selecting the third-party review panel, the assigned third-party review organization shall select physicians, health care professionals, and attorneys who meet the minimum qualifications described in subsections (k) and (l) of this Section. Neither the covered person, the covered person's authorized representative, the health carrier, nor the Director shall choose or control the choice of the physicians, health care professionals, or attorneys selected to conduct the third-party review.

The third-party review panel shall provide an opinion to the assigned third-party review organization on whether the medical condition should be covered or whether the health insurance plan should be reinstated as expeditiously as the

covered person's medical condition or circumstances require, but in no event more than 2 business days after being selected to conduct the expedited third-party review or within 20 days after being selected to conduct the standard third-party review.

Each third-party review panel opinion shall be in writing and include the following information:

(1) a description of the covered person's medical condition;

(2) a description of the relevant information from the individual's application;

(3) a description and analysis of any medical or scientific evidence considered in reaching the opinion;

(4) a description and analysis of any applicable legal standard or requirement;

(5) an identification of the applicable terms of the health insurance plan; and

(6) an explanation of the panel's rationale for the opinion.

In rendering its decision, neither the third-party review panel nor the third-party review organization is bound by any decisions or conclusions reached during the health carrier's initial determination or the health carrier's internal grievance process, if applicable, as set forth in this Section; however, the third-party review panel and the third-party review organization must use the health carrier's underwriting

guidelines that were in effect at the time the person was first issued the health insurance plan.

The assigned third-party review organization shall make a decision and provide written notice of the decision, in accordance with this subsection (q), to the covered person, the covered person's authorized representative, the health carrier, and the Director immediately upon receipt of the third-party review panel opinion, but in no event more than 3 business days after being selected to conduct the expedited third-party review or within 20 days after receipt of the third-party review panel opinion, but in no event more than 45 days after being selected to conduct the standard third-party review.

The third-party review organization shall include the following information in the notice sent pursuant to this subsection (q):

(i) a general description of the reason for the request for third-party review;

(ii) the date the third-party review organization received the assignment to conduct the third-party review;

(iii) the written opinion of the third-party review panel, including the recommendation of the panel as to whether the medical condition should be covered or the health insurance plan reinstated;

(iv) the date the third-party review was conducted, if appropriate;

(v) the date of its decision;

(vi) the principal reason or reasons for its decision;

(vii) the rationale for its decision; and

(viii) references to the evidence or documentation considered in reaching its decision, including the relevant portions of the covered person's application, the terms of the health insurance plan, any medical and scientific evidence, and the applicable legal requirements.

Upon receipt of a notice of the third-party review organization's decision pursuant to this subsection (g) that reverses the health carrier's determination, the health carrier immediately shall reinstate the health insurance plan that was the subject of the third-party review.

(h) Binding nature of third-party review decision. A third-party review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable federal or State law.

A covered person or the covered person's authorized representative may not file a subsequent request for third-party review involving the same medical condition that was the subject of the rescission decision or health carrier determination for which the covered person has already received a third-party review decision pursuant to this Section.

(i) Exhaustion of third-party review process. A covered person or the covered person's authorized representative may

not pursue litigation of a health carrier's decisions based on medical issues involved in a denial of a claim based on the determination to rescind a policy until the covered person has exhausted the third-party review process as set forth in this Section.

(j) Approval of third-party review organizations. The Director shall approve third-party review organizations eligible to be assigned to conduct third-party reviews under this Section. In order to be eligible for approval by the Director under this Section to conduct third-party reviews under this Section, a third-party review organization shall submit an application for approval pursuant to this subsection (j). The Director shall develop an application form for initially approving and for re-approving third-party review organizations to conduct third-party reviews.

Any third-party review organization wishing to be approved to conduct third-party reviews under this Section shall submit the application form and include with the form all documentation and information necessary for the Director to determine if the third-party review organization satisfies the minimum qualifications established under subsections (k) and (l) of this Section. The Director may charge an application fee that third-party review organizations shall submit to the Director with an application for approval or re-approval. A third-party review organization shall be deemed approved 90 days after the date of receipt of a complete application

submitted under this subsection (j), unless the Director disapproves the application within that period or the Director extends the timeframe for an additional 90 days. If the Director extends the timeframe for an additional 90 days, the third-party review organization shall be deemed approved at the end of that additional period, unless the Director disapproves the application within the extended 90-day period.

An approval is effective for 2 years, unless the Director determines before its expiration that the third-party review organization is not satisfying the minimum qualifications established under subsections (k) and (l) of this Section. Whenever the Director determines that a third-party review organization no longer satisfies the minimum requirements established under subsections (k) and (l) of this Section, the Director shall terminate the approval of the third-party review organization and remove the third-party review organization from the list of third-party review organizations approved to conduct third-party reviews under this Section that is maintained by the Director. The Director shall maintain and periodically update a list of approved third-party review organizations.

(k) Minimum qualifications for third-party review organizations' written policies and procedures. To be approved under subsection (j) of this Section to conduct third-party reviews, a third-party review organization shall have and maintain written policies and procedures that govern all

aspects of both the standard third-party review process and the expedited third-party review process set forth in this Section, which include, at a minimum, the following:

(1) a quality assurance mechanism in place that ensures:

(A) that third-party reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(B) the selection of qualified and impartial health care professional reviewers and legal reviewers with expertise and knowledge about the individual health insurance market, including the underwriting process, to conduct each third-party review on behalf of the third-party review organization, suitable matching of reviewers to specific cases, and that the third-party review organization employs or contracts with an adequate number of health care professional reviewers and legal reviewers to meet this objective;

(C) the confidentiality of medical and treatment records and review criteria; and

(D) that any person employed by or under contract with the third-party review organization adheres to the requirements of this Section;

(2) a toll-free telephone service to receive information on a 24-hour-a-day, 7-day-a-week basis related to third-party reviews that is capable of accepting,

recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(3) agreement to maintain and provide to the Director the information set out in subsection (n) of this Section.

(l) Minimum qualifications for third-party review organizations. All legal reviewers assigned by a third-party review organization to conduct third-party reviews shall be licensed attorneys who meet the following minimum qualifications:

(1) possess demonstrated expertise in contract and insurance law with knowledge of the individual health insurance market, including the underwriting process;

(2) hold a non-restricted license to practice law in any state or the District of Columbia; and

(3) have no history of disciplinary actions or sanctions that have been taken or are pending by any state bar association, regulatory body, or court of law that raise a substantial question as to the legal reviewer's physical, mental, or professional competence or moral character.

All health care professional reviewers assigned by a third-party review organization to conduct third-party reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(A) be knowledgeable about the relevant health care

service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(B) hold a non-restricted license in any state or the District of Columbia and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the third-party review; and

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

In addition to the requirements set forth in subsection (k) of this Section, the third-party review organization selected to conduct the third-party review and any health care professional reviewer or legal reviewer assigned by the third-party review organization to conduct the third-party review may not own or control, be a subsidiary of, or in any way be owned or controlled by or exercise control with a health carrier; a national, state, or local trade association of health carriers; or a national, state, or local trade association of health care providers. The third-party review organization shall be unbiased. A third-party review

organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this Section.

In addition to the requirements set forth in this subsection and subsection (k) of this Section, to be approved pursuant to subsection (j) of this Section to conduct a third-party review of a specified case, neither the third-party review organization selected to conduct the third-party review nor any health care professional reviewer or legal reviewer assigned by the third-party review organization to conduct the third-party review may have a material professional, familial, or financial conflict of interest with any of the following:

(i) the health carrier that is the subject of the third-party review;

(ii) the covered person whose treatment is the subject of the third-party review or the covered person's authorized representative;

(iii) any officer, director, or management employee of the health carrier that is the subject of the third-party review;

(iv) the health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the third-party review;

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

(vi) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the third-party review.

In determining whether a material professional, familial, or financial conflict of interest exists for purposes of this subsection (l), the Director shall take into consideration situations where the third-party review organization, the health care professional reviewer, or legal reviewer may have an apparent professional, familial, or financial relationship or connection with a person described in this subsection (l), but the characteristics of that relationship or connection are such that they do not create a material professional, familial, or financial conflict of interest.

(m) Hold harmless for third-party review organizations. No third-party review organization; health care professional reviewer or legal reviewer working on behalf of a third-party review organization; or an employee, agent, or contractor of a third-party review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of a third-party review conducted pursuant to this Section, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

(n) Third-party review reporting requirements. A

third-party review organization assigned to conduct a third-party review shall maintain written records in the aggregate, by state, and by health carrier on all requests for which it received a request to conduct a third-party review during a calendar year. The third-party review organization shall retain the written records required pursuant to this subsection (n) for at least 3 years.

Each third-party review organization shall submit to the Director, upon request, a report in the format specified by the Director. The report shall include, at a minimum, the following information in the aggregate, by state, and for each health carrier:

(1) the total number of assigned third-party review requests;

(2) the number of third-party review requests resolved by the third-party review organization and, of those resolved, the number resolved upholding the health carrier's determination and the number resolved reversing the health carrier's determination;

(3) the average length of time for resolution;

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

(5) the number of third-party reviews that were terminated as the result of a reconsideration by the health carrier of its determination after the receipt of

additional information from the covered person or the covered person's authorized representative pursuant to subsection (f) of this Section; and

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

Each health carrier shall maintain written records in the aggregate, by state, and for each type of health insurance plan offered by the health carrier for all third-party review requests received by the health carrier pursuant to subsection (f) of this Section. The health carrier shall retain the written records required pursuant to this subsection (n) for at least 3 years. Each health carrier shall submit to the Director, upon request, a report on all third-party review requests received by the health carrier pursuant to subsection (f) of this Section in the format specified by the Director.

The Director shall annually collect data on the third-party reviews conducted in this State and issue a report that includes the information reported by third-party review organizations and health carriers under this subsection (n), along with the total number of written third-party review requests received by the Director.

(o) Funding of third-party review process. The health carrier against which a third-party review request is filed shall pay the reasonable and necessary costs associated with the review process. The Director shall maintain active management and oversight of the third-party review process,

including, but not limited to, the administrative costs associated with the process, and the fees associated with the use of health care professional reviewers and legal reviewers. The Director shall review and affirmatively endorse detailed billings from the third-party review organization before the detailed billings are sent to the health carrier.

(p) Health carrier disclosure requirements. Each health carrier shall include a description of the third-party review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons that includes, at a minimum, the following information:

(1) a statement that informs the covered person of the right to file a request for a third-party review of rescission decisions made by the health carrier are based on medical issues for health insurance plan coverage. The statement shall explain that third-party review is only available when the rescission decisions made by the health carrier are based on medical issues for health insurance plan coverage and include the telephone number and address of the Director where the policy is issued and delivered; and

(2) a statement that informs the covered person that, when filing a request for a third-party review, the covered person will be required to authorize the release of any medical records of the covered person that may be required

to be reviewed for the purpose of reaching a decision on the third-party review.

The disclosure required by this subsection (p) shall be in a format prescribed by the Director.

(q) Third-party review panel confidentiality. A third-party review organization shall not disclose the identity of the health care professional reviewers or legal reviewers involved in the third-party review process, unless otherwise directed to divulge this information by a federal or State court of law.

(r) Notwithstanding any other rulemaking authority that may exist, neither the Governor nor any agency or agency head under the jurisdiction of the Governor has any authority to make or promulgate rules to implement or enforce the provisions of this amendatory Act of the 95th General Assembly. If, however, the Governor believes that rules are necessary to implement or enforce the provisions of this amendatory Act of the 95th General Assembly, the Governor may suggest rules to the General Assembly by filing them with the Clerk of the House and the Secretary of the Senate and by requesting that the General Assembly authorize such rulemaking by law, enact those suggested rules into law, or take any other appropriate action in the General Assembly's discretion. Nothing contained in this amendatory Act of the 95th General Assembly shall be interpreted to grant rulemaking authority under any other Illinois statute where such authority is not otherwise

explicitly given. For the purposes of this amendatory Act of the 95th General Assembly, "rules" is given the meaning contained in Section 1-70 of the Illinois Administrative Procedure Act, and "agency" and "agency head" are given the meanings contained in Sections 1-20 and 1-25 of the Illinois Administrative Procedure Act to the extent that such definitions apply to agencies or agency heads under the jurisdiction of the Governor.

Section 30. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356f.1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10 ~~356z.9~~, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health

Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or

other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service

agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the

period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment 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. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 35. The Limited Health Service Organization Act is amended by changing Section 4003 as follows:

(215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

Sec. 4003. Illinois Insurance Code provisions. Limited health service organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 355.2, 356f.1, 356v, 356z.10 ~~356z.9~~, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code. For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited health service organizations in the following categories are deemed to be domestic companies:

(1) a corporation under the laws of this State; or

(2) a corporation organized under the laws of another state, 30% of more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a domestic company under Article VIII

1/2 of the Illinois Insurance Code.

(Source: P.A. 95-520, eff. 8-28-07; revised 12-5-07.)

Section 40. 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, 356f.1, 356g.5, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10 ~~356z.9~~, 364.01, 367.2, 368a, 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. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07; 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-5-07.)".