



95TH GENERAL ASSEMBLY

State of Illinois

2007 and 2008

HB4223

by Rep. Mary E. Flowers - LaShawn K. Ford - Karen May

SYNOPSIS AS INTRODUCED:

See Index

Amends the State Employees Group Insurance Act of 1971, the Counties Code, the Illinois Municipal Code, the School Code, the Illinois Insurance Code, the Health Maintenance Organization Act, the Limited Health Service Organization Act, and the Voluntary Health Services Plans Act. Provides that a policy of accident or health insurance or managed care plan shall establish and maintain an appeals procedure related to the denial of health care benefits. Sets forth guidelines for maintaining an appeals procedure, including an expedited process for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee's health, or a treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health. Provides that if an initial appeal is denied by the policy or plan, an enrollee is entitled to seek external independent review of the decision made by the policy or plan. Sets forth guidelines and requirements for the external independent review process. Provides that nothing in the provision shall be construed to require a policy or plan to pay for a health care service not covered under the enrollee's certificate of coverage or policy. Provides that the Office of Consumer Health Insurance of the Division of Insurance of the Department of Financial and Professional Regulation shall adopt rules for the enforcement of the provision. Makes other changes.

LRB095 15305 KBJ 41293 b

FISCAL NOTE ACT
MAY APPLY

STATE MANDATES
ACT MAY REQUIRE
REIMBURSEMENT

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

6 (5 ILCS 375/6.11)

7 Sec. 6.11. Required health benefits; Illinois Insurance
8 Code requirements. The program of health benefits shall provide
9 the post-mastectomy care benefits required to be covered by a
10 policy of accident and health insurance under Section 356t of
11 the Illinois Insurance Code. The program of health benefits
12 shall provide the coverage required under Sections 356f.1,
13 356g.5, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, ~~and~~ 356z.9,
14 and 356z.10 ~~356z.9~~ of the Illinois Insurance Code. The program
15 of health benefits must comply with Section 155.37 of the
16 Illinois Insurance Code.

17 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
18 95-520, eff. 8-28-07; revised 12-4-07.)

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

21 (55 ILCS 5/5-1069.3)

1 Sec. 5-1069.3. Required health benefits. If a county,
2 including a home rule county, is a self-insurer for purposes of
3 providing health insurance coverage for its employees, the
4 coverage shall include coverage for the post-mastectomy care
5 benefits required to be covered by a policy of accident and
6 health insurance under Section 356t and the coverage required
7 under Sections 356f.1, 356g.5, 356u, 356w, 356x, 356z.6, ~~and~~
8 356z.9, and 356z.10 ~~356z.9~~ of the Illinois Insurance Code. The
9 requirement that health benefits be covered as provided in this
10 Section is an exclusive power and function of the State and is
11 a denial and limitation under Article VII, Section 6,
12 subsection (h) of the Illinois Constitution. A home rule county
13 to which this Section applies must comply with every provision
14 of this Section.

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

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

19 (65 ILCS 5/10-4-2.3)

20 Sec. 10-4-2.3. Required health benefits. If a
21 municipality, including a home rule municipality, is a
22 self-insurer for purposes of providing health insurance
23 coverage for its employees, the coverage shall include coverage
24 for the post-mastectomy care benefits required to be covered by

1 a policy of accident and health insurance under Section 356t
2 and the coverage required under Sections 356f.1, 356g.5, 356u,
3 356w, 356x, 356z.6, ~~and~~ 356z.9, and 356z.10 ~~356z.9~~ of the
4 Illinois Insurance Code. The requirement that health benefits
5 be covered as provided in this is an exclusive power and
6 function of the State and is a denial and limitation under
7 Article VII, Section 6, subsection (h) of the Illinois
8 Constitution. A home rule municipality to which this Section
9 applies must comply with every provision of this Section.

10 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
11 95-520, eff. 8-28-07; revised 12-4-07.)

12 Section 20. The School Code is amended by changing Section
13 10-22.3f as follows:

14 (105 ILCS 5/10-22.3f)

15 Sec. 10-22.3f. Required health benefits. Insurance
16 protection and benefits for employees shall provide the
17 post-mastectomy care benefits required to be covered by a
18 policy of accident and health insurance under Section 356t and
19 the coverage required under Sections 356f.1, 356g.5, 356u,
20 356w, 356x, 356z.6, and 356z.9 of the Illinois Insurance Code.

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

23 Section 25. The Illinois Insurance Code is amended by

1 adding Section 356f.1 as follows:

2 (215 ILCS 5/356f.1 new)

3 Sec. 356f.1. Health care services appeals, complaints, and
4 external independent reviews.

5 (a) A policy of accident or health insurance or managed
6 care plan shall establish and maintain an appeals procedure as
7 outlined in this Section. Compliance with this Section's
8 appeals procedures shall satisfy a policy or plan's obligation
9 to provide appeal procedures under any other State law or
10 rules.

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

1 policy or plan shall render a decision on the appeal within 24
2 hours after receipt of the required information. The policy or
3 plan shall notify the party filing the appeal and the enrollee,
4 enrollee's primary care physician, and any health care provider
5 who recommended the health care service involved in the appeal
6 of its decision orally followed-up by a written notice of the
7 determination.

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

23 (d) An appeal under subsection (b) or (c) may be filed by
24 the enrollee, the enrollee's designee or guardian, the
25 enrollee's primary care physician, or the enrollee's health
26 care provider. A policy or plan shall designate a clinical peer

1 to review appeals, because these appeals pertain to medical or
2 clinical matters and such an appeal must be reviewed by an
3 appropriate health care professional. No one reviewing an
4 appeal may have had any involvement in the initial
5 determination that is the subject of the appeal. The written
6 notice of determination required under subsections (b) and (c)
7 shall include (i) clear and detailed reasons for the
8 determination, (ii) the medical or clinical criteria for the
9 determination, which shall be based upon sound clinical
10 evidence and reviewed on a periodic basis, and (iii) in the
11 case of an adverse determination, the procedures for requesting
12 an external independent review under subsection (f).

13 (e) If an appeal filed under subsection (b) or (c) is
14 denied for a reason including, but not limited to, the service,
15 procedure, or treatment is not viewed as medically necessary,
16 denial of specific tests or procedures, denial of referral to
17 specialist physicians or denial of hospitalization requests or
18 length of stay requests, any involved party may request an
19 external independent review under subsection (f) of the adverse
20 determination.

21 (f) The party seeking an external independent review shall
22 so notify the policy or plan. The policy or plan shall seek to
23 resolve all external independent reviews in the most
24 expeditious manner and shall make a determination and provide
25 notice of the determination no more than 24 hours after the
26 receipt of all necessary information when a delay would

1 significantly increase the risk to an enrollee's health or when
2 extended health care services for an enrollee undergoing a
3 course of treatment prescribed by a health care provider are at
4 issue.

5 (1) Within 30 days after the enrollee receives written
6 notice of an adverse determination, if the enrollee decides
7 to initiate an external independent review, the enrollee
8 shall send to the policy or plan a written request for an
9 external independent review, including any information or
10 documentation to support the enrollee's request for the
11 covered service or claim for a covered service.

12 (2) Within 30 days after the policy or plan receives a
13 request for an external independent review from an enrollee
14 or, within 24 hours after the receipt of a request if a
15 delay would significantly increase the risk to the
16 enrollee's health, the policy or plan shall:

17 (a) provide a mechanism for joint selection of an
18 external independent reviewer by the enrollee, the
19 enrollee's physician or other health care provider,
20 and the policy or plan; and

21 (b) forward to the independent reviewer all
22 medical records and supporting documentation
23 pertaining to the case, a summary description of the
24 applicable issues including a statement of the
25 decision made by, the criteria used, and the medical
26 and clinical reasons for that decision.

1 (3) Within 5 days after receipt of all necessary
2 information or within 24 hours when a delay would
3 significantly increase the risk to an enrollee's health,
4 the independent reviewer shall evaluate and analyze the
5 case and render a decision that is based on whether or not
6 the health care service or claim for the health care
7 service is medically appropriate. The decision by the
8 independent reviewer is final. If the external independent
9 reviewer determines the health care service to be medically
10 appropriate, the policy or plan shall pay for the health
11 care service.

12 (4) The policy or plan shall be solely responsible for
13 paying the fees of the external independent reviewer who is
14 selected to perform the review.

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

22 (6) Future contractual or employment action by the
23 policy or plan regarding the patient's physician or other
24 health care provider shall not be based solely on the
25 physician's or other health care provider's participation
26 in this procedure.

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

3 (a) be a clinical peer;

4 (b) have no direct financial interest in
5 connection with the case; and

6 (c) have not been informed of the specific identity
7 of the enrollee.

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

11 (h) The Office of Consumer Health Insurance of the Division
12 of Insurance of the Department of Financial and Professional
13 Regulation shall adopt rules for the enforcement of this
14 Section.

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

17 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

18 Sec. 5-3. Insurance Code provisions.

19 (a) Health Maintenance Organizations shall be subject to
20 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
21 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
22 154.6, 154.7, 154.8, 155.04, 355.2, 356f.1, 356m, 356v, 356w,
23 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9,
24 356z.10 ~~356z.9~~, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c,

1 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409,
2 412, 444, and 444.1, paragraph (c) of subsection (2) of Section
3 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2,
4 XXV, and XXVI of the Illinois Insurance Code.

5 (b) For purposes of the Illinois Insurance Code, except for
6 Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health
7 Maintenance Organizations in the following categories are
8 deemed to be "domestic companies":

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

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

13 (3) a corporation organized under the laws of another
14 state, 30% or more of the enrollees of which are residents
15 of this State, except a corporation subject to
16 substantially the same requirements in its state of
17 organization as is a "domestic company" under Article VIII
18 1/2 of the Illinois Insurance Code.

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

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

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

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

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

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

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

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

26 (d) The provisions of Article VIII 1/2 of the Illinois

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

6 (e) In considering any management contract or service
7 agreement subject to Section 141.1 of the Illinois Insurance
8 Code, the Director (i) shall, in addition to the criteria
9 specified in Section 141.2 of the Illinois Insurance Code, take
10 into account the effect of the management contract or service
11 agreement on the continuation of benefits to enrollees and the
12 financial condition of the health maintenance organization to
13 be managed or serviced, and (ii) need not take into account the
14 effect of the management contract or service agreement on
15 competition.

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

23 (i) the amount of, and other terms and conditions with
24 respect to, the refund or additional premium are set forth
25 in the group or enrollment unit contract agreed in advance
26 of the period for which a refund is to be paid or

1 additional premium is to be charged (which period shall not
2 be less than one year); and

3 (ii) the amount of the refund or additional premium
4 shall not exceed 20% of the Health Maintenance
5 Organization's profitable or unprofitable experience with
6 respect to the group or other enrollment unit for the
7 period (and, for purposes of a refund or additional
8 premium, the profitable or unprofitable experience shall
9 be calculated taking into account a pro rata share of the
10 Health Maintenance Organization's administrative and
11 marketing expenses, but shall not include any refund to be
12 made or additional premium to be paid pursuant to this
13 subsection (f)). The Health Maintenance Organization and
14 the group or enrollment unit may agree that the profitable
15 or unprofitable experience may be calculated taking into
16 account the refund period and the immediately preceding 2
17 plan years.

18 The Health Maintenance Organization shall include a
19 statement in the evidence of coverage issued to each enrollee
20 describing the possibility of a refund or additional premium,
21 and upon request of any group or enrollment unit, provide to
22 the group or enrollment unit a description of the method used
23 to calculate (1) the Health Maintenance Organization's
24 profitable experience with respect to the group or enrollment
25 unit and the resulting refund to the group or enrollment unit
26 or (2) the Health Maintenance Organization's unprofitable

1 experience with respect to the group or enrollment unit and the
2 resulting additional premium to be paid by the group or
3 enrollment unit.

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

8 (Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06;
9 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

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

12 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

13 Sec. 4003. Illinois Insurance Code provisions. Limited
14 health service organizations shall be subject to the provisions
15 of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c,
16 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8,
17 155.04, 155.37, 355.2, 356f.1, 356v, 356z.10 ~~356z.9~~, 368a, 401,
18 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and
19 Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and
20 XXVI of the Illinois Insurance Code. For purposes of the
21 Illinois Insurance Code, except for Sections 444 and 444.1 and
22 Articles XIII and XIII 1/2, limited health service
23 organizations in the following categories are deemed to be
24 domestic companies:

- 1 (1) a corporation under the laws of this State; or
2 (2) a corporation organized under the laws of another
3 state, 30% of more of the enrollees of which are residents
4 of this State, except a corporation subject to
5 substantially the same requirements in its state of
6 organization as is a domestic company under Article VIII
7 1/2 of the Illinois Insurance Code.

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

9 Section 40. The Voluntary Health Services Plans Act is
10 amended by changing Section 10 as follows:

11 (215 ILCS 165/10) (from Ch. 32, par. 604)

12 Sec. 10. Application of Insurance Code provisions. Health
13 services plan corporations and all persons interested therein
14 or dealing therewith shall be subject to the provisions of
15 Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c,
16 149, 155.37, 354, 355.2, 356f.1, 356g.5, 356r, 356t, 356u,
17 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6,
18 356z.8, 356z.9, 356z.10 ~~356z.9~~, 364.01, 367.2, 368a, 401,
19 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7)
20 and (15) of Section 367 of the Illinois Insurance Code.

21 (Source: P.A. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07;
22 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff.
23 8-28-07; revised 12-5-07.)

1 INDEX

2 Statutes amended in order of appearance

3 5 ILCS 375/6.11

4 55 ILCS 5/5-1069.3

5 65 ILCS 5/10-4-2.3

6 105 ILCS 5/10-22.3f

7 215 ILCS 5/356f.1 new

8 215 ILCS 125/5-3 from Ch. 111 1/2, par. 1411.2

9 215 ILCS 130/4003 from Ch. 73, par. 1504-3

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