Rep. Mary E. Flowers

Filed: 3/26/2008

AMENDMENT TO HOUSE BILL 4223

AMENDMENT NO. _____. Amend House Bill 4223, AS AMENDED, 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. Health care services appeals, complaints, and external independent reviews.

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

(b) When an appeal concerns a decision or action by a policy of accident or health insurance or managed care plan, its employees, or its subcontractors that relates to (i) health care services, including, but not limited to, procedures or treatments 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, (ii) a

treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee's health, or (iii) nonrenewal or termination of a policy or plan, the policy or plan must allow for the filing of an appeal either orally or in writing. Upon submission of the appeal, a policy or plan must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the plan requires to evaluate the appeal. The policy or plan shall render a decision on the appeal within 24 hours after receipt of the required information. The policy or plan shall notify the party filing the appeal and the enrollee, enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal of its decision orally followed-up by a written notice of the determination.

(c) For all appeals related to health care services including, but not limited to, procedures or treatments for an enrollee and not covered by subsection (b) above, the policy or plan shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection, a policy or plan must notify the party filing an appeal, within 3 business days, of all information that the policy or plan requires to evaluate the appeal. The policy or plan shall render a decision on the appeal within 15 business days after receipt of the required information. The policy or plan shall

notify the party filing the appeal, the enrollee, the enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal orally of its decision followed-up by a written notice of the determination.

(d) An appeal under subsection (b) or (c) may be filed by the enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health care provider. A policy or plan shall designate a clinical peer to review appeals, because these appeals pertain to medical or clinical matters and such an appeal must be reviewed by an appropriate health care professional. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal. The written notice of determination required under subsections (b) and (c) shall include (i) clear and detailed reasons for the determination, (ii) the medical or clinical criteria for the determination, which shall be based upon sound clinical evidence and reviewed on a periodic basis, and (iii) in the case of an adverse determination, the procedures for requesting an external independent review under subsection (f).

(e) If an appeal filed under subsection (b) or (c) is denied for a reason including, but not limited to, the service, procedure, or treatment is not viewed as medically necessary, denial of specific tests or procedures, denial of referral to specialist physicians or denial of hospitalization requests or

length of stay requests, any involved party may request an external independent review under subsection (f) of the adverse determination.

(f) The party seeking an external independent review shall so notify the policy or plan. The policy or plan shall seek to resolve all external independent reviews in the most expeditious manner and shall make a determination and provide notice of the determination no more than 24 hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health or when extended health care services for an enrollee undergoing a course of treatment prescribed by a health care provider are at issue.

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

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

(A) select an external independent reviewer as

provided in subsection (h) of this Section; and

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

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

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

(5) An external independent reviewer who acts in good faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external independent review, unless the acts or omissions constitute wilful and wanton

misconduct. For purposes of any proceeding, the good faith of the person participating shall be presumed.

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

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

(A) be a clinical peer;

(B) have no direct financial interest in connection with the case; and

(C) have not been informed of the specific identity of the enrollee.

(g) The external independent reviewer and the medical review professional conducting the external review under this Section may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal

drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.

(6) The covered individual requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

A covered individual shall not pay any of the costs associated with the services of an external independent reviewer under this Section. All costs must be paid by the insurer.

(h) When a request for appeal is filed, the insurer shall:

(1) select a different external independent reviewer for each external independent review requested under this Section from the list of external independent reviewers that are certified by the Division under subsection (i) of this Section; and

(2) rotate the choice of an external independent reviewer among all certified external independent reviewers before repeating a selection.

(i) The Division of Insurance of the Department of

Financial and Professional Regulation shall establish and maintain a process for annual certification of external independent reviewers. The Division shall certify a number of external independent reviewers determined by the Division to be sufficient to fulfill the purposes of this Section. An external independent reviewer must meet the following minimum requirements for certification by the Division:

(1) Medical review professionals assigned by the external independent reviewer to perform external grievance reviews under this Section must:

(A) be board certified in the specialty in which a covered individual's proposed service would be provided;

(B) be knowledgeable about a proposed service through actual clinical experience;

(C) hold an unlimited license to practice in a state of the United States; and

(D) not have any history of disciplinary actions or sanctions, including:

(i) loss of staff privileges; or

(ii) restriction on participation;

taken or pending by any hospital, government, or regulatory body.

(2) The external independent reviewer must have a quality assurance mechanism to ensure:

(A) the timeliness and quality of reviews;

(B) the qualifications and independence of medical review professionals;

(C) the confidentiality of medical records and other review materials; and

(D) the satisfaction of covered individuals with the procedures utilized by the external independent reviewer, including the use of covered individual satisfaction surveys.

(3) The external independent reviewer must file with the Division all of the following information on or before March 1 of each year:

(A) The number and percentage of determinations made in favor of covered individuals.

(B) The number and percentage of determinations made in favor of insurers.

(C) The average time to process a determination.

(D) Any other information required by the Division.

The information required under this item (3) must be specified for each insurer for which the external independent reviewer performed reviews during the reporting year.

(4) The external independent reviewer must meet any additional requirements established by the Division.

The Division may not certify an external independent reviewer that is either (i) a professional or trade association

of health care providers or a subsidiary or an affiliate of a professional or trade association of health care providers or (ii) an insurer, a health maintenance organization, or a health plan association or a subsidiary or an affiliate of an insurer, health maintenance organization, or health plan association.

The Division may suspend or revoke an external independent reviewer's certification if the Division finds that the external independent reviewer is not in substantial compliance with the certification requirements under this subsection (i).

The Division shall make available to insurers a list of all certified external independent reviewers.

(j) The Division shall make the information provided to the Division under item (3) of subsection (i) available to the public in a format that does not identify individual covered individuals.

(k) An insurer shall each year file with the Division a description of the external independent review procedure established by the insurer under this Section, including the following for each external independent reviewer used by the insurer during the reporting year:

(1) the total number of external independent reviews handled through the procedure during the preceding calendar year;

(2) a compilation of the causes underlying those reviews; and

(3) a summary of the final disposition of those

reviews.

The information required by this subsection (k) must be filed with the Division on or before March 1 of each year.

The Division shall make the information required to be filed under this subsection (k) available to the public and prepare an annual compilation of the data that allows for comparative analysis. The Division may require any additional reports that are necessary and appropriate for the Division to carry out its duties under this Section.

(l) Nothing in this Section 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.

(m) 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 subsection, "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 37. The Managed Care Reform and Patient Rights Act is amended by changing Section 45 as follows:

(215 ILCS 134/45)

Sec. 45. Health care services appeals, complaints, and external independent reviews.

(a) A health care plan shall establish and maintain an appeals procedure as outlined in this Act. Compliance with this Act's appeals procedures shall satisfy a health care plan's obligation to provide appeal procedures under any other State law or rules. All appeals of a health care plan's administrative determinations and complaints regarding its administrative decisions shall be handled as required under Section 50.

(b) When an appeal concerns a decision or action by a health care plan, its employees, or its subcontractors that relates to (i) health care services, including, but not limited to, procedures or treatments, 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~~ (ii) a treatment referral, service, procedure, or other health care service, the denial of which

could significantly increase the risk to an enrollee's health, or (iii) nonrenewal or termination of a plan, the health care plan must allow for the filing of an appeal either orally or in writing. Upon submission of the appeal, a health care plan must notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after the submission of the appeal, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 24 hours after receipt of the required information. The health care plan shall notify the party filing the appeal and the enrollee, enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal of its decision orally followed-up by a written notice of the determination.

(c) For all appeals related to health care services including, but not limited to, procedures or treatments for an enrollee and not covered by subsection (b) above, the health care plan shall establish a procedure for the filing of such appeals. Upon submission of an appeal under this subsection, a health care plan must notify the party filing an appeal, within 3 business days, of all information that the plan requires to evaluate the appeal. The health care plan shall render a decision on the appeal within 15 business days after receipt of the required information. The health care plan shall notify the party filing the appeal, the enrollee, the enrollee's primary care physician, and any health care provider who recommended

the health care service involved in the appeal orally of its decision followed-up by a written notice of the determination.

(d) An appeal under subsection (b) or (c) may be filed by the enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health care provider. A health care plan shall designate a clinical peer to review appeals, because these appeals pertain to medical or clinical matters and such an appeal must be reviewed by an appropriate health care professional. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal. The written notice of determination required under subsections (b) and (c) shall include (i) clear and detailed reasons for the determination, (ii) the medical or clinical criteria for the determination, which shall be based upon sound clinical evidence and reviewed on a periodic basis, and (iii) in the case of an adverse determination, the procedures for requesting an external independent review under subsection (f).

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

(f) External independent review.

(1) The party seeking an external independent review shall so notify the health care plan. The health care plan shall seek to resolve all external independent reviews in the most expeditious manner and shall make a determination and provide notice of the determination no more than 24 hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health or when extended health care services for an enrollee undergoing a course of treatment prescribed by a health care provider are at issue.

(2) Within 30 days after the enrollee receives written notice of an adverse determination, if the enrollee decides to initiate an external independent review, the enrollee shall send to the health care plan a written request for an external independent review, including any information or documentation to support the enrollee's request for the covered service or claim for a covered service.

(3) Within 30 days after the health care plan receives a request for an external independent review from an enrollee, the health care plan shall:

(A) select an external independent reviewer as provided in subsection (h) of this Section; and ~~provide a mechanism for joint selection of an external independent reviewer by the enrollee, the enrollee's physician or other health care provider, and the health~~

~~care plan; and~~

(B) forward to the independent reviewer all medical records and supporting documentation pertaining to the case, a summary description of the applicable issues including a statement of the health care plan's decision, the criteria used, and the medical and clinical reasons for that decision.

(4) Within 5 days after receipt of all necessary information, the independent reviewer shall evaluate and analyze the case and render a decision that is based on whether or not the health care service or claim for the health care service is medically appropriate. The decision by the independent reviewer is final. If the external independent reviewer determines the health care service to be medically appropriate, the health care plan shall pay for the health care service.

(5) The health care plan shall be solely responsible for paying the fees of the external independent reviewer who is selected to perform the review.

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

(7) Future contractual or employment action by the health care plan regarding the patient's physician or other health care provider shall not be based solely on the physician's or other health care provider's participation in this procedure.

(8) For the purposes of this Section, an external independent reviewer shall:

(A) be a clinical peer;

(B) have no direct financial interest in connection with the case; and

(C) have not been informed of the specific identity of the enrollee.

(g) The external independent reviewer and the medical review professional conducting the external review under this Section may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.

(6) The covered individual requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

A covered individual shall not pay any of the costs associated with the services of an external independent reviewer under this Section. All costs must be paid by the insurer.

(h) When a request for appeal is filed, the insurer shall:

(1) select a different external independent reviewer for each external independent review requested under this Section from the list of external independent reviewers that are certified by the Division under subsection (i) of this Section; and

(2) rotate the choice of an external independent reviewer among all certified external independent reviewers before repeating a selection.

(i) The Division of Insurance of the Department of Financial and Professional Regulation shall establish and maintain a process for annual certification of external

independent reviewers. The Division shall certify a number of external independent reviewers determined by the Division to be sufficient to fulfill the purposes of this Section. An external independent reviewer must meet the following minimum requirements for certification by the Division:

(1) Medical review professionals assigned by the external independent reviewer to perform external grievance reviews under this Section must:

(A) be board certified in the specialty in which a covered individual's proposed service would be provided;

(B) be knowledgeable about a proposed service through actual clinical experience;

(C) hold an unlimited license to practice in a state of the United States; and

(D) not have any history of disciplinary actions or sanctions, including:

(i) loss of staff privileges; or

(ii) restriction on participation;

taken or pending by any hospital, government, or regulatory body.

(2) The external independent reviewer must have a quality assurance mechanism to ensure:

(A) the timeliness and quality of reviews;

(B) the qualifications and independence of medical review professionals;

(C) the confidentiality of medical records and other review materials; and

(D) the satisfaction of covered individuals with the procedures utilized by the external independent reviewer, including the use of covered individual satisfaction surveys.

(3) The external independent reviewer must file with the Division all of the following information on or before March 1 of each year:

(A) The number and percentage of determinations made in favor of covered individuals.

(B) The number and percentage of determinations made in favor of insurers.

(C) The average time to process a determination.

(D) Any other information required by the Division.

The information required under this item (3) must be specified for each insurer for which the external independent reviewer performed reviews during the reporting year.

(4) The external independent reviewer must meet any additional requirements established by the Division.

The Division may not certify an external independent reviewer that is either (i) a professional or trade association of health care providers or a subsidiary or an affiliate of a professional or trade association of health care providers or

(ii) an insurer, a health maintenance organization, or a health plan association or a subsidiary or an affiliate of an insurer, health maintenance organization, or health plan association.

The Division may suspend or revoke an external independent reviewer's certification if the Division finds that the external independent reviewer is not in substantial compliance with the certification requirements under this subsection (i).

The Division shall make available to insurers a list of all certified external independent reviewers.

(j) The Division shall make the information provided to the Division under item (3) of subsection (i) available to the public in a format that does not identify individual covered individuals.

(k) An insurer shall each year file with the Division a description of the external independent review procedure established by the insurer under this Section, including the following for each external independent reviewer used by the insurer during the reporting year:

(1) the total number of external independent reviews handled through the procedure during the preceding calendar year;

(2) a compilation of the causes underlying those reviews; and

(3) a summary of the final disposition of those reviews.

The information required by this subsection (k) must be

filed with the Division on or before March 1 of each year.

The Division shall make the information required to be filed under this subsection (k) available to the public and prepare an annual compilation of the data that allows for comparative analysis. The Division may require any additional reports that are necessary and appropriate for the Division to carry out its duties under this Section.

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

(m) 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.

(Source: P.A. 91-617, eff. 1-1-00.)

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.)".