



Rep. Mary E. Flowers

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LRB095 15305 RPM 48567 a

1 AMENDMENT TO HOUSE BILL 4223

2 AMENDMENT NO. _____. Amend House Bill 4223, AS AMENDED, by
3 replacing everything after the enacting clause with the
4 following:

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

7 (5 ILCS 375/6.11)

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

1 Illinois Insurance Code.

2 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
3 95-520, eff. 8-28-07; revised 12-4-07.)

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

6 (55 ILCS 5/5-1069.3)

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

21 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
22 95-520, eff. 8-28-07; revised 12-4-07.)

23 Section 15. The Illinois Municipal Code is amended by

1 changing Section 10-4-2.3 as follows:

2 (65 ILCS 5/10-4-2.3)

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

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

21 (105 ILCS 5/10-22.3f)

22 Sec. 10-22.3f. Required health benefits. Insurance
23 protection and benefits for employees shall provide the

1 post-mastectomy care benefits required to be covered by a
2 policy of accident and health insurance under Section 356t and
3 the coverage required under Sections 356f.1, 356g.5, 356u,
4 356w, 356x, 356z.6, and 356z.9 of the Illinois Insurance Code.
5 (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07;
6 revised 12-4-07.)

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

9 (215 ILCS 5/356f.1 new)

10 Sec. 356f.1. Health care services appeals, complaints, and
11 external independent reviews.

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

18 (b) When an appeal concerns a decision or action by a
19 policy of accident or health insurance or managed care plan,
20 its employees, or its subcontractors that relates to (i) health
21 care services, including, but not limited to, procedures or
22 treatments for an enrollee with an ongoing course of treatment
23 ordered by a health care provider, the denial of which could
24 significantly increase the risk to an enrollee's health, (ii) a

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

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

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

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

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

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

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

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

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

26 (A) select an external independent reviewer as

1 provided in subsection (h) of this Section; and

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

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

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

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

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

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

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

10 (A) be a clinical peer;

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

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

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

19 (1) The insurer.

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

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

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

26 (5) The development or manufacture of the principal

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

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

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

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

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

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

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

26 (i) The Division of Insurance of the Department of

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

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

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

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

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

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

20 (i) loss of staff privileges; or

21 (ii) restriction on participation;

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

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

26 (A) the timeliness and quality of reviews;

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

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

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

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

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

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

16 (C) The average time to process a determination.

17 (D) Any other information required by the
18 Division.

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

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

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

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

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

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

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

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

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

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

26 (3) a summary of the final disposition of those

1 reviews.

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

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

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

13 (m) Notwithstanding any other rulemaking authority that
14 may exist, neither the Governor nor any agency or agency head
15 under the jurisdiction of the Governor has any authority to
16 make or promulgate rules to implement or enforce the provisions
17 of this amendatory Act of the 95th General Assembly. If,
18 however, the Governor believes that rules are necessary to
19 implement or enforce the provisions of this amendatory Act of
20 the 95th General Assembly, the Governor may suggest rules to
21 the General Assembly by filing them with the Clerk of the House
22 and the Secretary of the Senate and by requesting that the
23 General Assembly authorize such rulemaking by law, enact those
24 suggested rules into law, or take any other appropriate action
25 in the General Assembly's discretion. Nothing contained in this
26 amendatory Act of the 95th General Assembly shall be

1 interpreted to grant rulemaking authority under any other
2 Illinois statute where such authority is not otherwise
3 explicitly given. For the purposes of this subsection, "rules"
4 is given the meaning contained in Section 1-70 of the Illinois
5 Administrative Procedure Act, and "agency" and "agency head"
6 are given the meanings contained in Sections 1-20 and 1-25 of
7 the Illinois Administrative Procedure Act to the extent that
8 such definitions apply to agencies or agency heads under the
9 jurisdiction of the Governor.

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

12 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

13 Sec. 5-3. Insurance Code provisions.

14 (a) Health Maintenance Organizations shall be subject to
15 the provisions of Sections 133, 134, 137, 140, 141.1, 141.2,
16 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5,
17 154.6, 154.7, 154.8, 155.04, 355.2, 356f.1, 356m, 356v, 356w,
18 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9,
19 356z.10 ~~356z.9~~, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c,
20 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409,
21 412, 444, and 444.1, paragraph (c) of subsection (2) of Section
22 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2,
23 XXV, and XXVI of the Illinois Insurance Code.

24 (b) For purposes of the Illinois Insurance Code, except for

1 Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health
2 Maintenance Organizations in the following categories are
3 deemed to be "domestic companies":

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

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

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

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

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

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

1 effect on competition of the merger, consolidation, or
2 other acquisition of control;

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

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

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

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

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

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

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

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

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

24 (ii) the amount of the refund or additional premium
25 shall not exceed 20% of the Health Maintenance
26 Organization's profitable or unprofitable experience with

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

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

25 In no event shall the Illinois Health Maintenance
26 Organization Guaranty Association be liable to pay any

1 contractual obligation of an insolvent organization to pay any
2 refund authorized under this Section.

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

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

7 (215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

8 Sec. 4003. Illinois Insurance Code provisions. Limited
9 health service organizations shall be subject to the provisions
10 of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c,
11 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8,
12 155.04, 155.37, 355.2, 356f.1, 356v, 356z.10 ~~356z.9~~, 368a, 401,
13 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and
14 Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and
15 XXVI of the Illinois Insurance Code. For purposes of the
16 Illinois Insurance Code, except for Sections 444 and 444.1 and
17 Articles XIII and XIII 1/2, limited health service
18 organizations in the following categories are deemed to be
19 domestic companies:

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

21 (2) a corporation organized under the laws of another
22 state, 30% of more of the enrollees of which are residents
23 of this State, except a corporation subject to
24 substantially the same requirements in its state of

1 organization as is a domestic company under Article VIII
2 1/2 of the Illinois Insurance Code.

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

4 Section 37. The Managed Care Reform and Patient Rights Act
5 is amended by changing Section 45 as follows:

6 (215 ILCS 134/45)

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

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

17 (b) When an appeal concerns a decision or action by a
18 health care plan, its employees, or its subcontractors that
19 relates to (i) health care services, including, but not limited
20 to, procedures or treatments, for an enrollee with an ongoing
21 course of treatment ordered by a health care provider, the
22 denial of which could significantly increase the risk to an
23 enrollee's health, ~~or~~ (ii) a treatment referral, service,
24 procedure, or other health care service, the denial of which

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

15 (c) For all appeals related to health care services
16 including, but not limited to, procedures or treatments for an
17 enrollee and not covered by subsection (b) above, the health
18 care plan shall establish a procedure for the filing of such
19 appeals. Upon submission of an appeal under this subsection, a
20 health care plan must notify the party filing an appeal, within
21 3 business days, of all information that the plan requires to
22 evaluate the appeal. The health care plan shall render a
23 decision on the appeal within 15 business days after receipt of
24 the required information. The health care plan shall notify the
25 party filing the appeal, the enrollee, the enrollee's primary
26 care physician, and any health care provider who recommended

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

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

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

1 (f) External independent review.

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

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

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

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

1 ~~care plan; and~~

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

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

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

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

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

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

8 (A) be a clinical peer;

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

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

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

17 (1) The insurer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (i) loss of staff privileges; or

19 (ii) restriction on participation;

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

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

24 (A) the timeliness and quality of reviews;

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

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

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

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

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

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

14 (C) The average time to process a determination.

15 (D) Any other information required by the
16 Division.

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

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

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

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

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

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

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

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

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

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

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

26 The information required by this subsection (k) must be

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

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

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

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

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

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

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

12 (215 ILCS 165/10) (from Ch. 32, par. 604)

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

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