



Rep. Daniel J. Burke

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LRB097 13098 RPM 67206 a

1 AMENDMENT TO HOUSE BILL 3812

2 AMENDMENT NO. _____. Amend House Bill 3812 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Illinois Insurance Code is amended by
5 changing Section 368c as follows:

6 (215 ILCS 5/368c)

7 Sec. 368c. Remittance advice and procedures.

8 (a) A remittance advice shall be furnished to a health care
9 professional or health care provider that identifies the
10 disposition of each claim. The remittance advice shall identify
11 the services billed; the patient responsibility, if any; the
12 actual payment, if any, for the services billed; and the reason
13 for any reduction to the amount for which the claim was
14 submitted. For any reductions to the amount for which the claim
15 was submitted, the remittance shall identify any withholds and
16 the reason for any denial or reduction.

1 A remittance advice for capitation or prospective payment
2 arrangements shall be furnished to a health care professional
3 or health care provider pursuant to a contract with an insurer,
4 health maintenance organization, independent practice
5 association, or physician hospital organization in accordance
6 with the terms of the contract.

7 (b) When health care services are provided by a
8 non-participating health care professional or health care
9 provider, an insurer, health maintenance organization,
10 independent practice association, or physician hospital
11 organization may pay for covered services either to a patient
12 directly or to the non-participating health care professional
13 or health care provider.

14 (c) When a person presents a benefits information card, a
15 health care professional or health care provider shall make a
16 good faith effort to inform the person if the health care
17 professional or health care provider is not a participating
18 provider ~~has a participation contract~~ with the insurer, health
19 maintenance organization, or other entity identified on the
20 card.

21 (Source: P.A. 93-261, eff. 1-1-04.)

22 Section 10. The Managed Care Reform and Patient Rights Act
23 is amended by changing Section 15 as follows:

24 (215 ILCS 134/15)

1 Sec. 15. Provision of information.

2 (a) A health care plan shall provide ~~annually~~ to enrollees
3 and prospective enrollees, ~~upon request~~, a complete list of
4 participating health care providers in the health care plan's
5 service area and a description of the following terms of
6 coverage:

7 (1) the service area;

8 (2) the covered benefits and services with all
9 exclusions, exceptions, and limitations;

10 (3) the pre-certification and other utilization review
11 procedures and requirements;

12 (4) a description of the process for the selection of a
13 primary care physician, any limitation on access to
14 specialists, and the plan's standing referral policy for
15 participating providers and participating health care
16 professionals;

17 (5) the emergency coverage and benefits, including any
18 restrictions on emergency care services;

19 (6) the out-of-area coverage and benefits, if any;

20 (7) the enrollee's financial responsibility for
21 copayments, deductibles, premiums, and any other
22 out-of-pocket expenses;

23 (8) the provisions for continuity of treatment in the
24 event a health care provider's participation terminates
25 during the course of an enrollee's treatment by that
26 provider;

1 (9) the appeals process, forms, and time frames for
2 health care services appeals, complaints, and external
3 independent reviews, administrative complaints, and
4 utilization review complaints, including a phone number to
5 call to receive more information from the health care plan
6 concerning the appeals process; and

7 (10) a statement of all basic health care services and
8 all specific benefits and services mandated to be provided
9 to enrollees by any State law or administrative rule.

10 In the event of an inconsistency between any separate
11 written disclosure statement and the enrollee contract or
12 certificate, the terms of the enrollee contract or certificate
13 shall control.

14 (a-5) The required list of participating health care
15 providers shall be provided via the health care plan's Internet
16 website and shall be updated at least every 30 days on a
17 good-faith effort based on information made available to the
18 plan for credentialed providers. The health care plan shall
19 regularly inform policyholders, insureds, or enrollees to
20 consult the list of participating health care providers to
21 allow policyholders, insureds, or enrollees to make informed
22 decisions prior to making appointments. The health plan shall
23 also make available the procedures for making referrals within
24 the network to insureds, enrollees, and participating health
25 care providers and health care professionals, as well as the
26 possibility of reduced benefits for services provided by a

1 non-participating health care provider or a non-participating
2 health care professional. Further, the health care plan shall
3 maintain a toll-free telephone number for policyholders,
4 insureds, enrollees, or health care providers to verify whether
5 a health care provider is a participating provider.

6 (a-10) Notwithstanding any other provision of this Act or
7 the Illinois Insurance Code, when a person presents a benefits
8 information card, a health care provider shall make a good
9 faith effort to inform the person if the health care provider
10 is not a participating provider with the insurer, health
11 maintenance organization, or other entity identified on the
12 card.

13 (b) Upon written request, a health care plan shall provide
14 to enrollees a description of the financial relationships
15 between the health care plan and any health care provider and,
16 if requested, the percentage of copayments, deductibles, and
17 total premiums spent on healthcare related expenses and the
18 percentage of copayments, deductibles, and total premiums
19 spent on other expenses, including administrative expenses,
20 except that no health care plan shall be required to disclose
21 specific provider reimbursement.

22 (c) A participating health care provider shall provide all
23 of the following, where applicable, to enrollees upon request:

24 (1) Information related to the health care provider's
25 educational background, experience, training, specialty,
26 and board certification, if applicable.

1 (2) The names of licensed facilities on the provider
2 panel where the health care provider presently has
3 privileges for the treatment, illness, or procedure that is
4 the subject of the request.

5 (3) Information regarding the health care provider's
6 participation in continuing education programs and
7 compliance with any licensure, certification, or
8 registration requirements, if applicable.

9 (d) A health care plan shall provide the information
10 required to be disclosed under this Act upon enrollment and
11 annually thereafter in a legible and understandable format,
12 except as provided in item (a-5). The Department shall
13 promulgate rules to establish the format based, to the extent
14 practical, on the standards developed for supplemental
15 insurance coverage under Title XVIII of the federal Social
16 Security Act as a guide, so that a person can compare the
17 attributes of the various health care plans.

18 (e) The written disclosure requirements of this Section may
19 be met by disclosure to one enrollee in a household.

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