AN ACT concerning insurance.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by changing Section 368a as follows:

(215 ILCS 5/368a)

Sec. 368a. Timely payment for health care services.

(a) This Section applies to insurers, health maintenance organizations, managed care plans, health care plans, preferred provider organizations, third party administrators, independent practice associations, and physician-hospital organizations (hereinafter referred to as "payors") that provide periodic payments, which are payments not requiring a claim, bill, capitation encounter data, or capitation reconciliation reports, such as prospective capitation payments, to health care professionals and health care facilities to provide medical or health care services for insureds or enrollees.

(1) A payor shall make periodic payments in accordance with item (3). Failure to make periodic payments within the period of time specified in item (3) shall entitle the health care professional or health care facility to interest at the rate of 9% per year from the date payment was required to be made to the date of the late payment, provided that interest amounting to less than $1 need not be paid. Any required interest payments shall be made within 30 days after the payment.

(2) When a payor requires selection of a health care professional or health care facility, the selection shall be completed by the insured or enrollee no later than 30 days after enrollment. The payor shall provide

written notice of this requirement to all insureds and enrollees. Nothing in this Section shall be construed to require a payor to select a health care professional or health care facility for an insured or enrollee.

(3) A payor shall provide the health care professional or health care facility with notice of the selection as a health care professional or health care facility by an insured or enrollee and the effective date of the selection within 60 calendar days after the selection. No later than the 60th day following the date an insured or enrollee has selected a health care professional or health care facility or the date that selection becomes effective, whichever is later, or in cases of retrospective enrollment only, 30 days after notice by an employer to the payor of the selection, a payor shall begin periodic payment of the required amounts to the insured's or enrollee's health care professional or health care facility, or the designee of either, calculated from the date of selection or the date the selection becomes effective, whichever is later. All subsequent payments shall be made in accordance with a monthly periodic cycle.

(b) Notwithstanding any other provision of this Section, independent practice associations and physician-hospital organizations shall begin making periodic payment of the required amounts within 60 days after an insured or enrollee has selected a health care professional or health care facility or the date that selection becomes effective, whichever is later. Before January 1, 2001, subsequent periodic payments shall be made in accordance with a 60-day periodic schedule, and after December 31, 2000, subsequent periodic payments shall be made in accordance with a monthly periodic schedule.

Notwithstanding any other provision of this Section, independent practice associations and physician-hospital organizations shall make all other payments for health services within 60 days after receipt of due proof of loss received before January 1, 2001 and within 30 days after receipt of due proof of loss received after December 31, 2000. Independent practice associations and physician-hospital organizations shall notify the insured, insured's assignee, health care professional, or health care facility of any failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim for health services.

Failure to pay within the required time period shall entitle the payee to interest at the rate of 9% per year from the date the payment is due to the date of the late payment, provided that interest amounting to less that $1 need not be paid. Any required interest payments shall be made within 30 days after the payment.

(c) All insurers, health maintenance organizations, managed care plans, health care plans, preferred provider organizations, and third party administrators shall ensure that all claims and indemnities concerning health care services other than for any periodic payment shall be paid within 30 days after receipt of due written proof of such loss. An insured, insured's assignee, health care professional, or health care facility shall be notified of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim for health care services. Failure to pay within such period shall entitle the payee to interest at the rate of 9% per year from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. Any required interest payments shall be made within 30 days after the payment.

(d) The Department shall enforce the provisions of this

Section pursuant to the enforcement powers granted to it by law.

(e) The Department is hereby granted specific authority to issue a cease and desist order, fine, or otherwise penalize independent practice associations and physician-hospital organizations that violate this Section. The Department shall adopt reasonable rules to enforce compliance with this Section by independent practice associations and physician-hospital organizations.

(f) Beginning 6 months after the date specified in Section 262 of the federal Health Insurance Portability and Accountability Act of 1996, pursuant to which third-party payors are required to comply with a standard or implementation specification for the electronic exchange of health information as adopted or established by the United States Secretary of Health and Human Services pursuant to that Act, the provisions of this Section apply only to claims submitted electronically to a third-party payor.

A provider and a third-party payor may enter into a contractual arrangement under which the third-party payor agrees to process claims that are not submitted electronically because of the financial hardship that electronic submission of claims would create for the provider or because of any other extenuating circumstance.

(Source: P.A. 91-605, eff. 12-14-99; 91-788, eff. 6-9-00.)