Illinois Insurance Facts

Illinois Department of Insurance

The Prompt Pay Law

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Note: This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department

The Illinois Prompt Pay Law (215 ILCS 5/368a) requires insurance companies, HMOs and other payors such as independent practice associations and physician-hospital organizations to pay capitation amounts and claims within a specified time period. Failure to make payments within the required time entitles the health care professional or health care facility to interest. The Prompt Pay Law **does not apply** to self-insured employers or to trusts or insurance policies written outside Illinois. However, for HMOs, the law does apply in certain situations to contracts written outside of Illinois if the HMO member is a resident of Illinois and the HMO has established a provider network in Illinois.

Terms Used in the Law

Types of Payments:

- **Periodic payments** - such as prospective capitation payments**;**
- **Payments other than periodic payments** - such as payments that require a claim, bill, capitation encounter data, or capitation reconciliation reports.

Payor Categories:

- **IPAs** - independent practice associations;
- **PHOs** - physician-hospital organizations;
- **Payors other than IPAs or PHOs** - include insurance companies, health maintenance organizations, managed care plans, preferred provider organizations, and third party administrators.

What Are the Requirements of the Prompt Pay Law?

Periodic payments shall be made within **60 days** after an insured or enrollee has selected a health care professional or health care facility or the date the selection becomes effective, whichever is later. Subsequent periodic payments shall be made in accordance with a **monthly** periodic cycle.

Payments other than periodic payments shall be paid within **30 days** after receipt of due written proof of loss. The payor is required to notify the insured, insured's assignee, health care

professional or health care facility if due proof of loss has not been received within **30 days** after the claim is received.

What if Payments Are Not Made within the Required Time-Frames?

For **periodic payments,** failure by a payor to pay within the period of time required by the law 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. The interest is required to be paid within 30 days after the payment. Interest of less than $1 need not be paid.

For **payments other than periodic payments,** failure by the payor to pay shall entitle the health care professional or health care facility to interest at the rate of 9% per year from the 30th day after receipt of due proof of loss to the date of the late payment. Interest payments must be made within 30 days after the late payment. Interest of less than $1 need not be paid.

How Will the Department of Insurance Enforce the Prompt Pay Law?

For payors other than IPAs and PHOs, the Department of Insurance will enforce the Prompt Pay Law in the same way all insurance laws are enforced, including through the complaint process and market conduct exams. For IPAs and PHOs, the Prompt Pay Law grants specific authority to our Division for enforcement of this law.

The Prompt Pay Law contains remedies (payment of interest) for claims that are not paid within the required time-fames**.** However, if a claim remains unpaid after the required date and the provider (or the patient) has not been notified by the payor of failure to provide sufficient documentation for a due proof of loss**,** we encourage the provider to contact the payor in writing to remedy the problem. If the claim remains unpaid after written remediation has been attempted directly, the provider may file a complaint using the Health Care Provider Complaint Form with the Department of Insurance. Verification of claim submittal and documentation of all efforts to obtain payment, such as written correspondence between the provider and payor must be attached to the complaint. A copy of the uniform bill and a copy of the patient's insurance card must also be attached. **Provider complaints are limited to one complaint form per patient**

For More Information

Call our Consumer Services Section at (312) 814-2420 or
our Office of Consumer Health Insurance toll free at (877) 527-9431
or visit us on our website at http://insurance.illinois.gov

A copy of the Illinois Prompt Pay Law, 215 ILCS 5/368a, is available at http://insurance.illinois.gov/LAH_HMO_IS3_Checklists/Reference/215ILCS5-368a.pdf.

Related Topics:
Understanding the Provider Complaint Process
Health Care Provider Complaint Form
Where to File Medicare, Medicaid and Other Health Plan Complaints
Usual & Customary Fees in Health Insurance Claims