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94TH GENERAL ASSEMBLY

State of Illinois

2005 and 2006

HB5778

Introduced 4/3/2006, by Rep. Rosemary Mulligan

SYNOPSIS AS INTRODUCED:

215 ILCS 105/14.10 new
215 ILCS 106/65 new
215 ILCS 170/40
215 ILCS 170/45
215 ILCS 170/50
215 ILCS 170/52 new
215 ILCS 170/53 new
305 ILCS 5/5-5.05 new

Amends the Comprehensive Health Insurance Plan Act, the Children's Health Insurance Program Act, the Covering ALL KIDS Health Insurance Act, and the Illinois Public Aid Code to require the health insurance programs created by those Acts to use fee schedules that are competitive with those of non-governmental, third-party health insurance programs. Requires that reimbursement for any service must not be lower than Medicare reimbursement in effect on July 1, 2006. Provides that the fee schedule must be increased or decreased annually corresponding to the decrease or increase in total State tax revenue in the prior fiscal year. Requires payment for services to be made within 30 days after receipt of a bill or claim for payment. Further amends the Covering ALL KIDS Health Insurance Act. Provides that there shall be no co-payment or coinsurance for any services under the Covering ALL KIDS Health Insurance Program. Provides that the study conducted by the Department of Healthcare and Family Services must measure the effect of the Program on access to care by review of all available data, including identifying the number of physicians serving in the primary care case management program by county and, for counties with a population of 100,000 or greater, by geozip. Requires the Department to consult with stakeholders on the rules for healthcare professional participation in the Program. Sets forth provisions for healthcare professional participation and Program standards and provides that the Medicaid Advisory Committee must approve any rules implementing these provisions. Effective July 1, 2006.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning insurance.

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

Section 5. The Comprehensive Health Insurance Plan Act is amended by adding Section 14.10 as follows:

(215 ILCS 105/14.10 new)

Sec. 14.10. Competitive fee schedule. To ensure healthcare professional participation in the Plan, the fee schedule for the Plan must be competitive with those of non-governmental, third-party health insurance programs. Reimbursement for any service must not be lower than Medicare reimbursement in effect on July 1, 2006. The fee schedule must be decreased or increased every January 1 corresponding to the decrease or increase in total State tax revenue in the prior fiscal year. Payment for services must be made within 30 days after receipt of a bill or claim for payment in accordance with Section 368a of the Illinois Insurance Code.

Section 10. The Children's Health Insurance Program Act is amended by adding Section 65 as follows:

(215 ILCS 106/65 new)

Sec. 65. Competitive fee schedule. To ensure healthcare professional participation in the Program, the fee schedule for the Program must be competitive with those of non-governmental, third-party health insurance programs. Reimbursement for any service must not be lower than Medicare reimbursement in effect on July 1, 2006. The fee schedule must be decreased or increased every January 1 corresponding to the decrease or increase in total State tax revenue in the prior fiscal year. Payment for services must be made within 30 days after receipt of a bill or claim for payment in accordance with Section 368a

of the Illinois Insurance Code.

Section 15. The Covering ALL KIDS Health Insurance Act is amended by changing Sections 40, 45, and 50 and by adding Sections 52 and 53 as follows:

(215 ILCS 170/40)

(Section scheduled to be repealed on July 1, 2011)

(This Section may contain text from a Public Act with a delayed effective date)

Sec. 40. Cost-sharing.

(a) Children enrolled in the Program under subsection (a) of Section 35 are subject to the following cost-sharing requirements:

(1) The Department, by rule, shall set forth requirements concerning ~~co-payments and coinsurance for health care services and~~ monthly premiums. This cost-sharing shall be on a sliding scale based on family income. The Department may periodically modify such cost-sharing.

(2) There ~~Notwithstanding paragraph (1), there~~ shall be no co-payment or coinsurance required for any services under the Program ~~well-baby or well-child health care, including, but not limited to, age-appropriate immunizations as required under State or federal law~~.

(b) Children enrolled in a privately sponsored health insurance plan under subsection (b) of Section 35 are subject to the cost-sharing provisions stated in the privately sponsored health insurance plan.

(c) Notwithstanding any other provision of law, rates paid by the Department shall not be used in any way to determine the usual and customary or reasonable charge, which is the charge for health care that is consistent with the average rate or charge for similar services furnished by similar providers in a certain geographic area.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/45)

(Section scheduled to be repealed on July 1, 2011)

(This Section may contain text from a Public Act with a delayed effective date)

Sec. 45. Study.

(a) The Department shall conduct a study that includes, but is not limited to, the following:

(1) Establishing estimates, broken down by regions of the State, of the number of children with and without health insurance coverage; the number of children who are eligible for Medicaid or the Children's Health Insurance Program, and, of that number, the number who are enrolled in Medicaid or the Children's Health Insurance Program; and the number of children with access to dependent coverage through an employer, and, of that number, the number who are enrolled in dependent coverage through an employer.

(2) Surveying those families whose children have access to employer-sponsored dependent coverage but who decline such coverage as to the reasons for declining coverage.

(3) Ascertaining, for the population of children accessing employer-sponsored dependent coverage or who have access to such coverage, the comprehensiveness of dependent coverage available, the amount of cost-sharing currently paid by the employees, and the cost-sharing associated with such coverage.

(4) Measuring the health outcomes or other benefits for children utilizing the Covering ALL KIDS Health Insurance Program and analyzing the effects on utilization of healthcare services for children after enrollment in the Program compared to the preceding period of uninsured status.

(5) Measuring the effect of the Program on access to care by review of all available data, including identifying the number of physicians serving in the primary care case

management program by county and, for counties with a population of 100,000 or greater, by geozip.

(b) The studies described in subsection (a) shall be conducted in a manner that compares a time period preceding or at the initiation of the program with a later period.

(c) The Department shall submit the preliminary results of the study to the Governor and the General Assembly no later than July 1, 2008 and shall submit the final results to the Governor and the General Assembly no later than July 1, 2010.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/50)

(Section scheduled to be repealed on July 1, 2011)

(This Section may contain text from a Public Act with a delayed effective date)

Sec. 50. Consultation with stakeholders. The Department shall present details regarding implementation of the Program to the Medicaid Advisory Committee, and the Committee shall serve as the forum for healthcare providers, advocates, consumers, and other interested parties to advise the Department with respect to the Program. The Department shall consult with stakeholders on the rules for healthcare professional participation in the Program pursuant to Sections 52 and 53 of this Act. The Medicaid Advisory Committee shall approve any rules implementing Sections 52 and 53 of this Act.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/52 new)

(Section scheduled to be repealed on July 1, 2011)

Sec. 52. Healthcare professional participation. The Department shall establish requirements for participation by healthcare professionals by rule. These requirements shall be consistent with the following:

(1) Primary care providers or primary care case managers shall be physicians licensed to practice medicine in all its branches.

(2) Physicians serving as primary care providers may designate (i) physician assistants to provide services under the Program and (ii) advanced practice nurses to perform services under the Program in the nurses' written collaborative agreements with the designating collaborating physician.

(3) The Department shall ensure adequate access to specialty care for Program participants. All referrals shall be accomplished without undue delay.

(4) The Department shall establish a procedure by which an enrollee who has a condition that requires ongoing care from a specialist physician or other health care provider may apply for a standing referral to a specialist physician or other health care provider if a referral to a specialist physician or other health care provider is required for coverage. The application shall be made to the enrollee's primary care physician. The procedure for a standing referral must specify the necessary criteria and conditions that must be met in order for an enrollee to obtain a standing referral. A standing referral shall be effective for the period necessary to provide the referred services or one year, whichever is less. A primary care provider physician may renew and re-renew a standing referral.

The enrollee's primary care physician shall remain responsible for coordinating the care of an enrollee who has received a standing referral to a specialist physician or other healthcare provider. If a secondary referral is necessary, the specialist physician or other healthcare provider shall advise the primary care physician. The specialist physician shall be responsible for making the secondary referral. In addition, the Department shall require the specialist physician or other healthcare provider to provide regular updates to the enrollee's primary care physician.

If an enrollee's application for a referral is denied,

an enrollee may appeal the decision through an external independent review process in accordance with subsection (f) of Section 45 of the Managed Care Reform and Patient Rights Act.

(5) To ensure healthcare professional participation in the Program, the fee schedule for the Program must be competitive with those of non-governmental, third-party health insurance programs. Reimbursement for any service must not be lower than Medicare reimbursement in effect on July 1, 2006. The fee schedule must be decreased or increased every January 1 corresponding to the decrease or increase in total State tax revenue in the prior fiscal year. Payment for services must be made within 30 days after receipt of a bill or claim for payment in accordance with Section 368a of the Illinois Insurance Code.

(215 ILCS 170/53 new)

(Section scheduled to be repealed on July 1, 2011)

Sec. 53. Program standards.

(a) Any disease management programs implemented by the Department must be or must have been developed in consultation with physician organizations, such as State, national, and specialty medical societies, and any available standards or guidelines of these organizations. These programs must be based on evidence-based, scientifically sound principles that are accepted by the medical community. An enrollee must be excused from participation in a disease management program if the enrollee's physician licensed to practice medicine in all its branches, in his or her professional judgment, determines that participation is not beneficial to the enrollee.

(b) Any performance measures, such as primary care provider monitoring, implemented by the Department must be or must have been developed in consultation with physician organizations, such as State, national, and specialty medical societies, and any available standards or guidelines of these organizations. These measures must be based on evidence-based, scientifically

sound principles that are accepted by the medical community.

(c) The Department shall adopt variance procedures for the application of any disease management program or any performance measures to an individual enrollee.

Section 20. The Illinois Public Aid Code is amended by adding Section 5-5.05 as follows:

(305 ILCS 5/5-5.05 new)

Sec. 5-5.05. Competitive fee schedule. Notwithstanding any other provision of this Article, to ensure healthcare professional participation in the medical assistance program under this Article, the fee schedule for the program must be competitive with those of non-governmental, third-party health insurance programs. Reimbursement for any service must not be lower than Medicare reimbursement in effect on July 1, 2006. The fee schedule must be decreased or increased every January 1 corresponding to the decrease or increase in total State tax revenue in the prior fiscal year. Payment for services must be made within 30 days after receipt of a bill or claim for payment in accordance with Section 368a of the Illinois Insurance Code.

Section 99. Effective date. This Act takes effect July 1, 2006.