HB5267

LRB095 17107 KBJ 43161 b

95TH GENERAL ASSEMBLY

State of Illinois

2007 and 2008

HB5267

by Rep. Timothy L. Schmitz

SYNOPSIS AS INTRODUCED:

New Act

Creates the Consumer Access to Health Care Information Act. Provides that the Division of Insurance shall make available on the Divisions's Internet website a consumer guide to health care. Sets forth the specific information that must be included in the Division's consumer guide, including specific links to different agency websites. Provides that each health care facility shall develop, implement, and enforce written policies for the billing of facility health care services and supplies. Provides that a facility shall establish and implement a procedure for handling consumer complaints, and must make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. Provides tha the provisions of the Act may not be waived, voided, or nullified by a contract or an agreement between a facility and a consumer. Effective immediately.

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FISCAL NOTE ACT MAY APPLY

STATE MANDATES ACT MAY REQUIRE REIMBURSEMENT

A BILL FOR

AN ACT concerning regulation.

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

Section 1. Short title. This Act may be cited as the Consumer Access to Health Care Information Act.

Section 5. Definitions. In this Act:

"Average charge" means the mathematical average of facility charges for an inpatient admission or outpatient surgical procedure. The term does not include charges for a particular inpatient admission or outpatient surgical procedure that exceed the average by more than 2 standard deviations.

"Billed charge" means the amount a facility charges for an inpatient admission, outpatient surgical procedure, or health care service or supply. "Costs" means the fixed and variable expenses incurred by a facility in the provision of a health care service.

"Consumer" means any person who is considering receiving, is receiving, or has received a health care service or supply as a patient from a facility. The term includes the personal representative of the patient.

"Director" means the Director of Insurance.

"Division" means the Division of Insurance of the

Department of Financial and Professional Regulation.

Facility" means an ambulatory surgical center, a birthing center, or a hospital.

Section 10. Division website. (a) The Division shall make available on the Division's Internet website a consumer guide to health care. The Division shall include information in the guide concerning facility pricing practices and the correlation between a facility's average charge for an inpatient admission or outpatient surgical procedure and the actual, billed charge for the admission or procedure, including notice that the average charge for a particular inpatient admission or outpatient surgical procedure will vary from the actual, billed charge for the admission or procedure based on:

(1) the person's medical condition;

(2) any unknown medical conditions of the person;

(3) the person's diagnosis and recommended treatment protocols ordered by the physician providing care to the person; and

(4) other factors associated with the inpatient admission or outpatient surgical procedure.

(b) The Division shall include information in the guide to advise consumers that:

(1) the average charge for an inpatient admission or outpatient surgical procedure may vary between facilities depending on a facility's cost structure, the range and

frequency of the services provided, intensity of care, and payor mix;

(2) the average charge by a facility for an inpatient admission or outpatient surgical procedure will vary from the facility's costs or the amount that the facility may be reimbursed by a health benefit plan for the admission or surgical procedure;

(3) the consumer may be personally liable for payment for an inpatient admission, outpatient surgical procedure, or health care service or supply depending on the consumer's health benefit plan coverage;

(4) the consumer should contact the consumer's health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance, and other plan provisions that may impact the consumer's liability for payment for an inpatient admission, outpatient surgical procedure, or health care service or supply; and

(5) the consumer, if uninsured, may be eligible for a discount on facility charges based on a sliding fee scale or a written charity care policy established by the facility.

(c) The Division shall include on the consumer guide to health care website:

(1) an Internet link for consumers to access quality of care data, including:

(A) the Hospital Compare website within the United States Department of Health and Human Services website;

(B) the Joint Commission on Accreditation of Healthcare Organizations website; and

(2) a disclaimer noting the websites that are not provided by this State or an agency of this State.

(d) The Division may accept gifts and grants to fund the consumer guide to health care. On the Division's Internet website, the Division may not identify, recognize, or acknowledge in any format the donors or grantors to the consumer guide to health care.

Section 15. Facility policies.

(a) Each facility shall develop, implement, and enforce written policies for the billing of facility health care services and supplies. The policies must address:

(1) any discounting of facility charges to an uninsured consumer;

(2) any discounting of facility charges provided to a financially or medically indigent consumer who qualifies for indigent services based on a sliding fee scale or a written charity care policy established by the facility and the documented income and other resources of the consumer;

(3) the providing of an itemized statement required by subsection (e) of this Section;

(4) whether interest will be applied to any billed service not covered by a third-party payor and the rate of any interest charged;

(5) the procedure for handling complaints; and

(6) the providing of a conspicuous written disclosure to a consumer at the time the consumer is first admitted to the facility or first receives services at the facility that:

(A) provides confirmation whether the facility is a participating provider under the consumer's third-party payor coverage on the date services are to be rendered based on the information received from the consumer at the time the confirmation is provided; and

(B) informs the consumer that a physician or other health care provider who may provide services to the consumer while in the facility may not be a participating provider with the same third-party payors as the facility.

(b) For services provided in an emergency department of a hospital or as a result of an emergent direct admission, the hospital shall provide the written disclosure required by paragraph (6) of Subsection (a) of this Section before discharging the patient from the emergency department or hospital, as appropriate.

(c) Each facility shall post in the general waiting area and in the waiting areas of any off-site or on-site

registration, admission, or business office a clear and conspicuous notice of the availability of the policies required by Subsection (a) of this Section.

(d) The facility shall provide an estimate of the facility's charges for any elective inpatient admission or nonemergency outpatient surgical procedure or other service on request and before the scheduling of the admission or procedure or service. The estimate must be provided not later than the 10th business day after the date on which the estimate is requested. The facility must advise the consumer that:

(1) the request for an estimate of charges may result in a delay in the scheduling and provision of the inpatient admission, outpatient surgical procedure, or other service;

(2) the actual charges for an inpatient admission, outpatient surgical procedure, or other service will vary based on the person's medical condition and other factors associated with performance of the procedure or service;

(3) the actual charges for an inpatient admission, outpatient surgical procedure, or other service may differ from the amount to be paid by the consumer or the consumer's third-party payor;

(4) the consumer may be personally liable for payment for the inpatient admission, outpatient surgical procedure, or other service depending on the consumer's health benefit plan coverage; and

(5) the consumer should contact the consumer's health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance, and other plan provisions that may impact the consumer's liability for payment for the inpatient admission, outpatient surgical procedure, or other service.

(e) A facility shall provide to the consumer at the consumer's request an itemized statement of the billed services if the consumer requests the statement not later than the first anniversary of the date the person is discharged from the facility. The facility shall provide the statement to the consumer not later than the 10th business day after the date on which the statement is requested.

(f) A facility shall provide an itemized statement of billed services to a third-party payor who is actually or potentially responsible for paying all or part of the billed services provided to a patient and who has received a claim for payment of those services. To be entitled to receive a statement, the third-party payor must request the statement from the facility and must have received a claim for payment. The request must be made not later than one year after the date on which the payor received the claim for payment. The facility shall provide the statement to the payor not later than the 30th day after the date on which the payor requests the statement. If a third-party payor receives a claim for payment

of part but not all of the billed services, the third-party payor may request an itemized statement of only the billed services for which payment is claimed or to which any deduction or copayment applies.

(g) A facility in violation of this Section is subject to enforcement action by the appropriate licensing agency.

(h) If a consumer or a third-party payor requests more than 2 copies of the statement, the facility may charge a reasonable fee for the third and subsequent copies provided. The fee may not exceed the sum of:

(1) a basic retrieval or processing fee, which must include the fee for providing the first 10 pages of the copies and which may not exceed $30;

(2) a charge for each page of: (A) $1 for the 11th through the 60th page of the provided copies; (B) 50 cents for the 61st through the 400th page of the provided copies; and (C) 25 cents for any remaining pages of the provided copies; and

(3) the actual cost of mailing, shipping, or otherwise delivering the provided copies.

(i) If a consumer overpays a facility, the facility must refund the amount of the overpayment not later than the 30th day after the date the facility determines that an overpayment has been made.

Section 20. Complaint process. A facility shall establish

and implement a procedure for handling consumer complaints, and must make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. If the complaint cannot be resolved informally, the facility shall advise the consumer that a complaint may be filed with the Division and shall provide the consumer with the mailing address and telephone number of the Division.

Section 25. Consumer waiver prohibited. The provisions of this Act may not be waived, voided, or nullified by a contract or an agreement between a facility and a consumer.

Section 99. Effective date. This Act takes effect upon becoming law.