HB2366

LRB09807034RPM37093b

98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

HB2366

by Rep. Jim Durkin

SYNOPSIS AS INTRODUCED:

215 ILCS 134/5
215 ILCS 134/15
215 ILCS 134/30

Amends the Managed Care Reform and Patient Rights Act. Provides that an individual's right to purchase any health care services with that individual's own funds may not be invalidated through a contractual provision or requirement between the insurer and a participating health care provider. Requires audiological services providers to provide to enrollees, upon request, a detailed and itemized statement with information outlining the costs of audiological devices, the plan payment amounts, and the amount of out-of-pocket costs to be paid by the enrollee for the various device options available to treat the enrollee's condition. Provides that no health care plan nor its subcontractors may, by contract, written policy, procedure, or otherwise, mandate or prohibit an enrollee from purchasing audiological equipment with a value over and above the plan benefit.

LRB098 07034 RPM 37093 b

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 Managed Care Reform and Patient Rights Act is amended by changing Sections 5, 15, and 30 as follows:

(215 ILCS 134/5)

Sec. 5. Health care patient rights.

(a) The General Assembly finds that:

(1) A patient has the right to care consistent with professional standards of practice to assure quality nursing and medical practices, to choose the participating physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law.

(2) A patient has the right, regardless of source of payment, to examine and to receive a reasonable explanation of his or her total bill for health care services rendered by his or her physician or other health care provider, including the itemized charges for specific health care services received. A physician or other health care provider has responsibility only for a reasonable

explanation of those specific health care services provided by the health care provider.

(3) A patient has the right to timely prior notice of the termination whenever a health care plan cancels or refuses to renew an enrollee's participation in the plan.

(4) A patient has the right to privacy and confidentiality in health care. This right may be expressly waived in writing by the patient or the patient's guardian.

(5) An individual has the right to purchase any health care services with that individual's own funds, and that right may not be invalidated through a contractual provision or requirement between the insurer and a participating health care provider.

(b) Nothing in this Section shall preclude the health care plan from sharing information for plan quality assessment and improvement purposes as required by Section 80.

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

(215 ILCS 134/15)

Sec. 15. Provision of information.

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

(1) the service area;

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

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

(4) a description of the process for the selection of a primary care physician, any limitation on access to specialists, and the plan's standing referral policy;

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

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

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

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

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

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

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

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

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

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

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

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

(4) With regard to audiological services providers, a detailed and itemized statement with information outlining the costs of audiological devices, the plan payment amounts, and the amount of out-of-pocket costs to be paid by the enrollee for the various device options available to treat the enrollee's condition.

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

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

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

(215 ILCS 134/30)

Sec. 30. Prohibitions.

(a) No health care plan or its subcontractors may prohibit or discourage health care providers by contract or policy from discussing any health care services and health care providers, utilization review and quality assurance policies, terms and conditions of plans and plan policy with enrollees, prospective enrollees, providers, or the public.

(b) No health care plan by contract, written policy, or procedure may permit or allow an individual or entity to dispense a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act.

(b-5) No health care plan nor its subcontractors may, by contract, written policy, procedure, or otherwise, mandate or prohibit an enrollee from purchasing audiological equipment with a value over and above the plan benefit.

(c) No health care plan or its subcontractors may by contract, written policy, procedure, or otherwise mandate or require an enrollee to substitute his or her participating primary care physician under the plan during inpatient hospitalization, such as with a hospitalist physician licensed to practice medicine in all its branches, without the agreement of that enrollee's participating primary care physician. "Participating primary care physician" for health care plans and subcontractors that do not require coordination of care by a primary care physician means the participating physician treating the patient. All health care plans shall inform enrollees of any policies, recommendations, or guidelines concerning the substitution of the enrollee's primary care physician when hospitalization is necessary in the manner set forth in subsections (d) and (e) of Section 15.

(d) Any violation of this Section shall be subject to the

penalties under this Act.

(Source: P.A. 94-866, eff. 6-16-06.)