HB4789

LRB10117586BMS67005b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB4789

Introduced 2/18/2020, by Rep. Daniel Swanson

SYNOPSIS AS INTRODUCED:

5 ILCS 375/6.17 new
55 ILCS 5/5-1069.9 new
65 ILCS 5/10-4-2.9 new
215 ILCS 124/5
215 ILCS 124/35 new

Amends the State Employees Group Insurance Act of 1971, the Counties Code, and the Illinois Municipal Code. Provides that the program of health benefits for persons in the service of the State, a self-insuring county, or a self-insuring municipality may not deny a claim from a medical facility operated by the Veterans Health Administration of the U.S. Department of Veterans Affairs on the basis that the medical facility is an out-of-network provider and may not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on a claim from a medical facility operated by the Veterans Health Administration of the U.S. Department of Veterans Affairs unless cost sharing is applied to such a claim from an in-network provider. Amends the Network Adequacy and Transparency Act. Provides that an insurer providing a network plan may not deny a claim from a medical facility operated by the Veterans Health Administration on the basis that the medical facility is a non-preferred provider and may not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on a claim from a medical facility operated by the Veterans Health Administration unless cost sharing is applied to such a claim from a preferred provider. Defines "Veterans Health Administration".

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FISCAL NOTE ACT MAY APPLY

STATE MANDATES ACT MAY REQUIRE REIMBURSEMENT

A BILL FOR

AN ACT concerning health insurance.

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

Section 5. The State Employees Group Insurance Act of 1971 is amended by adding Section 6.17 as follows:

(5 ILCS 375/6.17 new)

Sec. 6.17. Veterans Health Administration claims. The program of health benefits may not deny a claim from a medical facility operated by the Veterans Health Administration of the U.S. Department of Veterans Affairs on the basis that the medical facility is an out-of-network provider and may not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on a claim from a medical facility operated by the Veterans Health Administration of the U.S. Department of Veterans Affairs unless cost sharing is applied to such a claim from an in-network provider.

Section 10. The Counties Code is amended by adding Section 5-1069.9 as follows:

(55 ILCS 5/5-1069.9 new)

Sec. 5-1069.9. Veterans Health Administration claims. If a county, including a home rule county, is a self-insurer for the

purposes of providing health insurance coverage for its employees, it may not:

(1) deny a claim from a medical facility operated by the Veterans Health Administration of the U.S. Department of Veterans Affairs on the basis that the medical facility is an out-of-network provider; or

(2) impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on a claim from a medical facility operated by the Veterans Health Administration of the U.S. Department of Veterans Affairs unless cost sharing is applied to such a claim from an in-network provider.

Section 15. The Illinois Municipal Code is amended by adding Section 10-4-2.9 as follows:

(65 ILCS 5/10-4-2.9 new)

Sec. 10-4-2.9. Veterans Health Administration claims. If a municipality, including a home rule municipality, is a self-insurer for the purposes of providing health insurance coverage for its employees, it may not:

(1) deny a claim from a medical facility operated by the Veterans Health Administration of the U.S. Department of Veterans Affairs on the basis that the medical facility is an out-of-network provider; or

(2) impose a deductible, coinsurance, copayment, or

any other cost-sharing requirement on a claim from a medical facility operated by the Veterans Health Administration of the U.S. Department of Veterans Affairs unless cost sharing is applied to such a claim from an in-network provider.

Section 20. The Network Adequacy and Transparency Act is amended by changing Section 5 and by adding Section 35 as follows:

(215 ILCS 124/5)

Sec. 5. Definitions. In this Act:

"Authorized representative" means a person to whom a beneficiary has given express written consent to represent the beneficiary; a person authorized by law to provide substituted consent for a beneficiary; or the beneficiary's treating provider only when the beneficiary or his or her family member is unable to provide consent.

"Beneficiary" means an individual, an enrollee, an insured, a participant, or any other person entitled to reimbursement for covered expenses of or the discounting of provider fees for health care services under a program in which the beneficiary has an incentive to utilize the services of a provider that has entered into an agreement or arrangement with an insurer.

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

"Insurer" means any entity that offers individual or group accident and health insurance, including, but not limited to, health maintenance organizations, preferred provider organizations, exclusive provider organizations, and other plan structures requiring network participation, excluding the medical assistance program under the Illinois Public Aid Code, the State employees group health insurance program, workers compensation insurance, and pharmacy benefit managers.

"Material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of 10% or more in a specific type of providers, the removal of a major health system that causes a network to be significantly different from the network when the beneficiary purchased the network plan, or any change that would cause the network to no longer satisfy the requirements of this Act or the Department's rules for network adequacy and transparency.

"Network" means the group or groups of preferred providers providing services to a network plan.

"Network plan" means an individual or group policy of accident and health insurance that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers managed, owned, under contract with, or employed by the insurer.

"Ongoing course of treatment" means (1) treatment for a

life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits; (3) a course of treatment for a health condition that a treating provider attests that discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes; or (4) the third trimester of pregnancy through the post-partum period.

"Preferred provider" means any provider who has entered, either directly or indirectly, into an agreement with an employer or risk-bearing entity relating to health care services that may be rendered to beneficiaries under a network plan.

"Providers" means physicians licensed to practice medicine in all its branches, other health care professionals, hospitals, or other health care institutions that provide health care services.

"Telehealth" has the meaning given to that term in Section 356z.22 of the Illinois Insurance Code.

"Telemedicine" has the meaning given to that term in Section 49.5 of the Medical Practice Act of 1987.

"Tiered network" means a network that identifies and groups some or all types of provider and facilities into specific

groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

"Veterans Health Administration" means the agency within the U.S. Department of Veterans Affairs as set forth under 38 U.S.C. 7301.

"Woman's principal health care provider" means a physician licensed to practice medicine in all of its branches specializing in obstetrics, gynecology, or family practice.

(Source: P.A. 100-502, eff. 9-15-17.)

(215 ILCS 124/35 new)

Sec. 35. Veterans Health Administration claims.

(a) An insurer providing a network plan may not deny a claim from a medical facility operated by the Veterans Health Administration on the basis that the medical facility is a non-preferred provider.

(b) A network plan may not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on a claim from a medical facility operated by the Veterans Health Administration unless cost sharing is applied to such a claim from a preferred provider under the network plan.