AN ACT concerning regulation.

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 Section 30 as follows:

(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.

(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) A health care plan shall apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of such insured for prescription drugs toward a covered individual's deductible, copay, or cost-sharing responsibility, or out-of-pocket maximum associated with the individual's health insurance. If, under federal law, application of this requirement would result in health savings account ineligibility under Section 223 of the Internal Revenue Code, this requirement applies to health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223, except with respect to items or services that are preventive care pursuant to

Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirement of this subsection applies regardless of whether the minimum deductible under Section 223 has been satisfied.

(e) Any violation of this Section shall be subject to the penalties under this Act.

(Source: P.A. 101-452, eff. 1-1-20.)

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