HB5539

LRB10225169BMS34432b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB5539

Introduced 1/31/2022, by Rep. Michael Kelly

SYNOPSIS AS INTRODUCED:

215 ILCS 5/364.4 new

Amends the Illinois Insurance Code. Provides that each insurer shall make available on its publicly accessible website or through a toll-free telephone number an interactive mechanism where any member of the public may access specified health care cost information. Provides that the Department of Insurance shall adopt rules to define specified terms. Provides that an insurer shall provide notification on its website that the actual amount that a covered person will be responsible to pay following the receipt of a particular health care service may vary due to unforeseen costs that arise during the provision of the service. Provides that each estimate of out-of-pocket costs provided shall provide the out-of-pocket costs a covered person may owe if he or she has exceeded his or her deductible and the out-of-pocket costs a covered person may owe if he or she has not exceeded his or her deductible. Provides that an insurer may contract with a third party to satisfy part or all of the requirements. Provides that nothing in the provisions shall prohibit an insurer from charging a covered person cost sharing beyond that included in the estimate provided if the additional cost sharing resulted from unforeseen provisions of additional health care services and the cost-sharing requirements of the unforeseen health care services were disclosed in the covered person's policy or certificate of insurance. Provides that some of the provisions do not apply to a health maintenance organization.

LRB102 25169 BMS 34432 b

A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Illinois Insurance Code is amended by adding Section 364.4 as follows:

(215 ILCS 5/364.4 new)

Sec. 364.4. Health care cost information disclosure.

(a) As used in this Section:

"Emergency services" means health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

"Health benefit policy" or "policy" means any individual or group plan, policy, or contract for health care services amended, delivered, issued, or renewed in this State.

"Health care provider" means any physician, dentist, podiatric physician, pharmacist, optometrist, psychologist,

clinical social worker, advanced practice registered nurse, optician, licensed professional counselor, physical therapist, marriage and family therapist, athletic trainer, occupational therapist, speech-language pathologist, audiologist, dietitian, or physician assistant.

"Health care services" means:

(1) physical and occupational therapy services;

(2) obstetrical and gynecological services;

(3) radiology and imaging services;

(4) laboratory services;

(5) infusion services;

(6) inpatient or outpatient surgical procedures;

(7) outpatient nonsurgical diagnostic tests or procedures; and

(8) any services designated by the Director as shoppable by health care consumers.

"Hierarchical Condition Category Methodology" means a coding system designed by the Centers for Medicare and Medicaid Services to estimate future health care costs for patients.

(b) Each insurer shall make available on its publicly accessible website or through a toll-free telephone number an interactive mechanism where any member of the public may:

(1) for each health benefit policy offered, compare the payment amounts accepted by in-network providers from the insurer for the provision of a particular health care

service within the previous year;

(2) for each health benefit policy offered, obtain an estimate of the average amount accepted by in-network providers from the insurer for the provision of a particular health care service within the previous year;

(3) for each health benefit policy offered, obtain an estimate of the out-of-pocket costs that the covered person would owe his or her provider following the provision of a particular health care service;

(4) compare quality metrics applicable to in-network providers for major diagnostic categories with adjustments by risk and severity based upon the Hierarchical Condition Category Methodology or a nationally recognized health care quality reporting standard designated by the Director. Metrics shall be based on reasonably universal and uniform databases with sufficient claim volume. If applicable to the provider, quality metrics include, but are not limited to:

(A) risk-adjusted readmission rates and absolute hospital readmission rates;

(B) risk-adjusted hospitalization rates and absolute hospitalization rates;

(C) admission volume;

(D) utilization volume;

(E) risk-adjusted rates of adverse events; and

(F) risk-adjusted total cost of care and absolute

relative total cost of care; and

(5) access any all-payer health claims database that may be maintained by the Department.

The Department shall adopt rules that define the following terms: "risk-adjusted hospital readmission rates", "absolute hospital readmission rates", "risk-adjusted hospitalization rates", "absolute hospitalization rates", "admission volume", "utilization volume", "risk-adjusted rates of adverse events", "risk-adjusted total cost of care", and "absolute relative total cost of care".

(c) An insurer shall provide notification on its website that the actual amount that a covered person will be responsible to pay following the receipt of a particular health care service may vary due to unforeseen costs that arise during the provision of the service.

(d) Each estimate of out-of-pocket costs provided pursuant to paragraph (3) of subsection (b) shall provide:

(1) the out-of-pocket costs a covered person may owe if he or she has exceeded his or her deductible; and

(2) the out-of-pocket costs a covered person may owe if he or she has not exceeded his or her deductible.

(e) An insurer may contract with a third party to satisfy part or all of the requirements of this Section.

(f) Nothing in this Section shall prohibit an insurer from charging a covered person cost sharing beyond that included in the estimate provided pursuant to paragraph (3) of subsection

(b) if the additional cost sharing resulted from unforeseen provisions of additional health care services and the cost-sharing requirements of the unforeseen health care services were disclosed in the covered person's policy or certificate of insurance.

(g) The requirements of this Section, with the exception of paragraph (4) of subsection (b), do not apply to a health maintenance organization, as defined in the Health Maintenance Organization Act.