HB2251

98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

HB2251

by Rep. Timothy L. Schmitz

SYNOPSIS AS INTRODUCED:

215 ILCS 5/370u new
215 ILCS 134/5
215 ILCS 134/15

Amends the Health Care Reimbursement Article of the Illinois Insurance Code to provide that all insurers and administrators shall comply with the provision of the Managed Care Reform and Patient Rights Act that establishes a patient's right to receive timely prior verification of his or her health plan benefits before obtaining health care services and amends the Managed Care Reform and Patient Rights Act to set forth that provision. Further amends the Managed Care Reform and Patient Rights Act to provide that a health care plan shall provide enrollees or their designated health care providers with timely Internet access to verification of benefits for specific health care services prior to the enrollee obtaining such services and that the verification shall be binding on the health care plan.

LRB098 08658 RPM 38778 b

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Insurance Code is amended by adding
5 Section 370u as follows:

6 (215 ILCS 5/370u new)
7 Sec. 370u. Managed Care Reform and Patient Rights Act. All
8 insurers and administrators shall comply with item (2.5) of
9 subsection (a) of Section 5 of the Managed Care Reform and
10 Patient Rights Act.

11 Section 10. The Managed Care Reform and Patient Rights Act
12 is amended by changing Sections 5 and 15 as follows:

13 (215 ILCS 134/5)
14 Sec. 5. Health care patient rights.
15 (a) The General Assembly finds that:
16 (1) A patient has the right to care consistent with
17 professional standards of practice to assure quality
18 nursing and medical practices, to choose the participating
19 physician responsible for coordinating his or her care, to
20 receive information concerning his or her condition and
21 proposed treatment, to refuse any treatment to the extent

1 permitted by law, and to privacy and confidentiality of
2 records except as otherwise provided by law.
3 (2) A patient has the right, regardless of source of
4 payment, to examine and to receive a reasonable explanation
5 of his or her total bill for health care services rendered
6 by his or her physician or other health care provider,
7 including the itemized charges for specific health care
8 services received. A physician or other health care
9 provider has responsibility only for a reasonable
10 explanation of those specific health care services
11 provided by the health care provider.
12 (2.5) A patient has the right to receive timely prior
13 verification of his or her health plan benefits before
14 obtaining health care services.
15 (3) A patient has the right to timely prior notice of
16 the termination whenever a health care plan cancels or
17 refuses to renew an enrollee's participation in the plan.
18 (4) A patient has the right to privacy and
19 confidentiality in health care. This right may be expressly
20 waived in writing by the patient or the patient's guardian.
21 (5) An individual has the right to purchase any health
22 care services with that individual's own funds.
23 (b) Nothing in this Section shall preclude the health care
24 plan from sharing information for plan quality assessment and
25 improvement purposes as required by Section 80.
26 (Source: P.A. 91-617, eff. 1-1-00.)

1 (215 ILCS 134/15)
2 Sec. 15. Provision of information.
3 (a) A health care plan shall provide annually to enrollees
4 and prospective enrollees, upon request, a complete list of
5 participating health care providers in the health care plan's
6 service area and a description of the following terms of
7 coverage:
8 (1) the service area;
9 (2) the covered benefits and services with all
10 exclusions, exceptions, and limitations;
11 (3) the pre-certification and other utilization review
12 procedures and requirements;
13 (4) a description of the process for the selection of a
14 primary care physician, any limitation on access to
15 specialists, and the plan's standing referral policy;
16 (5) the emergency coverage and benefits, including any
17 restrictions on emergency care services;
18 (6) the out-of-area coverage and benefits, if any;
19 (7) the enrollee's financial responsibility for
20 copayments, deductibles, premiums, and any other
21 out-of-pocket expenses;
22 (8) the provisions for continuity of treatment in the
23 event a health care provider's participation terminates
24 during the course of an enrollee's treatment by that
25 provider;

1 (9) the appeals process, forms, and time frames for
2 health care services appeals, complaints, and external
3 independent reviews, administrative complaints, and
4 utilization review complaints, including a phone number to
5 call to receive more information from the health care plan
6 concerning the appeals process; and
7 (10) a statement of all basic health care services and
8 all specific benefits and services mandated to be provided
9 to enrollees by any State law or administrative rule.
10 In the event of an inconsistency between any separate
11 written disclosure statement and the enrollee contract or
12 certificate, the terms of the enrollee contract or certificate
13 shall control.
14 (a-5) A health care plan shall provide enrollees or their
15 designated health care providers with timely Internet access to
16 verification of benefits for specific health care services
17 prior to the enrollee obtaining such services. The verification
18 shall be binding on the health care plan.
19 (b) Upon written request, a health care plan shall provide
20 to enrollees a description of the financial relationships
21 between the health care plan and any health care provider and,
22 if requested, the percentage of copayments, deductibles, and
23 total premiums spent on healthcare related expenses and the
24 percentage of copayments, deductibles, and total premiums
25 spent on other expenses, including administrative expenses,
26 except that no health care plan shall be required to disclose

1 specific provider reimbursement.
2 (c) A participating health care provider shall provide all
3 of the following, where applicable, to enrollees upon request:
4 (1) Information related to the health care provider's
5 educational background, experience, training, specialty,
6 and board certification, if applicable.
7 (2) The names of licensed facilities on the provider
8 panel where the health care provider presently has
9 privileges for the treatment, illness, or procedure that is
10 the subject of the request.
11 (3) Information regarding the health care provider's
12 participation in continuing education programs and
13 compliance with any licensure, certification, or
14 registration requirements, if applicable.
15 (d) A health care plan shall provide the information
16 required to be disclosed under this Act upon enrollment and
17 annually thereafter in a legible and understandable format. The
18 Department shall promulgate rules to establish the format
19 based, to the extent practical, on the standards developed for
20 supplemental insurance coverage under Title XVIII of the
21 federal Social Security Act as a guide, so that a person can
22 compare the attributes of the various health care plans.
23 (e) The written disclosure requirements of this Section may
24 be met by disclosure to one enrollee in a household.
25 (Source: P.A. 91-617, eff. 1-1-00.)