



98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

SB1878

Introduced 2/15/2013, by Sen. Andy Manar

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 07033 RPM 37092 b

1 AN ACT concerning insurance.

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

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

6 (215 ILCS 134/5)

7 Sec. 5. Health care patient rights.

8 (a) The General Assembly finds that:

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

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

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

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

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

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

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

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

18 (215 ILCS 134/15)

19 Sec. 15. Provision of information.

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

25 (1) the service area;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (215 ILCS 134/30)

19 Sec. 30. Prohibitions.

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

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

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

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

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

1 penalties under this Act.

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