

**Consumer Legal Guide**

# **Your Guide to Patients' Rights**

**What you Should Know  
about Managed Care**



**ILLINOIS STATE  
BAR ASSOCIATION**

## **PATIENTS' RIGHTS WHAT YOU SHOULD KNOW ABOUT MANAGED CARE**

If you receive your health care benefits through a managed care plan such as an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) – commonly referred to as MCOs (Managed Care Organizations) – you may benefit from a new Illinois law designed to limit certain MCO powers, expand the rights, remedies and information available to you and your health care providers and provide the care and insurance coverage you need.

Should an MCO decline to authorize or provide payment for care recommended by your physician because the plan concludes that the care is not medically necessary (**see Glossary for terms in italics**), you and your health care provider may want to challenge this adverse determination under the Illinois Managed Care Reform and Patient Rights Act (the “Act”) which became effective on January 1, 2000.

### **FAQS UNDER THE NEW LAW**

#### **Does the Managed Care Reform and Patient Rights Act apply to everyone who receives health care benefits from an MCO?**

No. However, the Act does apply to HMOs and many health plans purchased by an employer from an independent insurer or MCO. The Act does not apply to self-insured health benefit plans in which the employer bears the financial risk of providing health care benefits to its employees. Your participation in a self-insured plan – governed by a federal law called ERISA (the “Employee Retirement Income Security Act”) – does not mean that you are without legal rights, however. To learn whether your health care benefit plan is subject to the Managed Care Reform and Patient Rights Act, you can contact an attorney, the Illinois Department of Insurance or your plan’s benefit coordinator.

## **What is a “primary care physician” and can I choose my own?**

Many MCOs require that their members choose a primary care physician to coordinate their health care services. The primary care physician is essentially your regular doctor to whom you go for check-ups, physical exams and routine medical care. This can include doctors specializing in internal medicine, pediatrics or family/general practice, as well as obstetrics/gynecology. The primary care physician can also act as a gatekeeper to whom you go before seeking care from a medical specialist.

The Managed Care Reform and Patient Rights Act allows you to choose any available qualified doctor who is participating in your health plan to act as your primary care physician. Your MCO must provide you with a list of licensed and qualified physicians from which you may choose your primary care physician.

## **If I need a specialist for my care how will that doctor be chosen?**

The Managed Care Reform and Patient Rights Act is intended to provide you with greater input into the selection of the physician who ultimately will provide and coordinate your continuing care. If you have an ongoing medical condition, a standing referral process described in the Act will enable you to go directly to a specialist for care. For other types of referrals, the Act provides that access to specialty care must be determined in conjunction with your primary care physician in a way that ensures a close coordination of care between your health care providers.

## **Who makes decisions about whether my care and treatment are *medically necessary*?**

Most often, health plans will provide treatment only for medically necessary care. The Managed Care Reform and Patient Rights Act requires that determinations regarding medical necessity be made only by health care professionals. An MCO review of your physi-

cian's treatment choices must be based solely on the medical information that was available to your physician at the time the services were performed.

### **Can I appeal an adverse determination by my MCO?**

Yes, the Act provides that individuals may seek both internal and external review of *adverse determinations*.

A. Internal Review: If your health plan finds that treatment is not medically necessary, you have the right to demand that the plan reconsider its determination. After you have notified your plan that you wish for it to reconsider its decision, your plan will ask you to submit the necessary information from your physician. When you have provided that information, the plan is required to make a decision within 15 days (or 24 hours for urgent cases).

B. External Review: If, after internal review, the plan still finds that treatment is not medically necessary, you have the right to appeal that finding to an external reviewer. Essentially, the external reviewer is an independent arbitrator who will review all of the relevant information to determine whether treatment is medically appropriate. If you wish to seek an external review, you must notify your plan in writing within 30 days after the plan notifies you about its internal review decision.

### **Can my MCO in any way interfere with my doctor's ability to communicate with me about my health care?**

No. The Managed Care Reform and Patient Rights Act forbids MCOs from prohibiting or discouraging the free flow of communication between you and your physician.

### **In an emergency, will I have to seek prior authorization from my MCO before I can receive treatment?**

No. The Managed Care and Patients Rights Act prohibits a plan from requiring prior au-

thorization for emergency services necessary to evaluate or stabilize a condition that places your health in serious jeopardy. Further, the Act prohibits an MCO from denying coverage for medical services furnished after your emergency condition has been stabilized.

**Can my MCO require that less expensive drugs be substituted for those prescribed by my doctor?**

No. Health plans are forbidden from allowing a pharmacy to substitute drugs without the express written consent of your prescribing physician.

**Can I continue to see my current doctor if the doctor leaves the MCO while I am receiving an ongoing course of treatment?**

Yes, but only for a transitional period. This period generally lasts for 90 days. If, however, a woman has entered the third trimester of pregnancy at the time that the doctor leaves the plan, then the transitional period includes post-partum care whether or not it is within the 90-day time limit.

**If I enroll in an MCO while receiving an ongoing course of treatment from a non-MCO physician, can I continue to see that doctor?**

Yes. But again, the MCO must allow you to continue to see your current doctor only for a transitional period. This period, which generally lasts for 90 days, will be extended to include post-partum care for women who enroll in a plan after entering the third trimester of pregnancy.

As is the case with doctors who leave the plan, the Managed Care Reform and Patient Rights Act does not guarantee that you will be allowed to continue to see your doctor in all circumstances. If the doctor refuses to accept the level of reimbursement offered by the plan or refuses to abide by the plan's quality assurance rules, then the transitional period may not be available.

## **What information must an MCO provide me about my benefit plan and my physicians?**

If you are enrolled in a health plan governed by the Managed Care Reform and Patient Rights Act, you are entitled to receive extensive information regarding your plan including information concerning covered benefits with all exclusions, exceptions, and limitations; pre-certification requirements; the selection of primary care physicians and specialists; emergency coverage and benefits; and, the appeals process applicable to all complaints. You are entitled to this information when you enroll in a plan and annually thereafter.

Additional information is available upon request regarding the financial relationship between the MCO and its doctors and the qualifications of the plan's doctors.

## **Can the Illinois Department of Insurance assist me with questions or issues I have with my MCO?**

Yes. In addition to the rights you and your health care providers have to appeal MCO *adverse determinations*, you both have the right to appeal administrative issues to the Illinois Department of Insurance. The Act also requires the establishment of a Health Care Plan Consumer Advisory Committee and a new Office of Consumer Health Insurance. The Office of Consumer Health Insurance is charged with providing information and assistance to all health care consumers and educating consumers about health insurance marketing materials and patients' rights within individual plans. You can contact the Illinois Department of Insurance at the Consumer Health Insurance Hotline, **(877) 527-9431** and on the Internet at **[www.state.il.us/ins](http://www.state.il.us/ins)**.

## **Can my MCO be sued for medical malpractice?**

The Managed Care Reform and Patient Rights Act does not create a statutory right or mechanism to sue an MCO for medical mal-

practice. However, decisions of the Illinois Supreme and Appellate Courts permit suits against MCOs under certain specific circumstances. You may wish to consult with an attorney to determine if your specific complaint can be the subject of a lawsuit.

## **How Your Lawyer Can Help**

While the purpose of this brochure is to make you aware of your rights under the Illinois Managed Care Reform and Patient Rights Act, it does not attempt to cover all legal issues associated with the Act. In addition, this brochure may become outdated if additional State or Federal legislation changes the law. You should seek the advice of an attorney to determine the specific rights available to you.

## **GLOSSARY**

**Adverse determination** means a determination by a health care plan or by a utilization review program that a health care service is not medically necessary.

**Copayment** means a cost-sharing arrangement in which a plan member pays a specified charge for a specified service, such as \$10 for an office visit. The member is usually responsible for payment at the time the health care is rendered. Typical copayments are fixed or variable dollar amounts for physician office visits, prescriptions or hospital services. Some copayments are referred to as co-insurance with the distinguishing characteristics that copayments are preset dollar amounts and co-insurance is a defined percentage of the charges for services rendered. Also called a “copay”.

**Drug formulary** means a listing of prescription medications approved for use and/or coverage by the plan and dispensed through participating pharmacies to a covered person. The list is subject to periodic review and modification by the health plan.

**Eligible expenses** means reasonable and

customary charges or the agreed upon health services fee for health services and supplies covered under a health plan.

**Emergency medical condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (2) serious impairment to bodily functions; or
- (3) serious dysfunction of any bodily organ or part.

**Emergency services** means, with respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.

**Enrollee** means an individual who is enrolled for coverage under a health plan contract and who is eligible on his/her own behalf (not by virtue of being an eligible dependent) to receive the health services provided under the contract.

**Grievance procedure** means the process by which a health plan member or participating provider can air complaints and seek remedies.

**Health care professional** means a physician, a registered professional nurse, or other individual appropriately licensed or registered to provide health care services.

**Health care provider** means any health care professional, hospital, nursing home,

healthcare facility, pharmacy or other person or entity that is licensed or otherwise authorized to deliver health care services. Independent Practice Associations and Physician-Hospital Organizations are generally not health care providers.

**Health care services** means any services included in the furnishing to any individual of medical care, or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury including home health and pharmaceutical services and products.

**Independent Practice Association or IPA** means an organized group of health care professionals who provide health care services to enrollees in managed care health plans.

**Managed Care Organization (MCO)** is a generic term applied to companies offering managed care health plans.

**Managed Health Care Plan** means one or more products that integrate financing and management with the delivery of health care services to an enrolled population; employs or contracts with an organized provider network which delivers services and which (as a network or individual provider) either shares financial risk or has some incentive to deliver quality, cost-effective services; uses an information system capable of monitoring and evaluating patterns of members' use of medical services and the cost of those services.

**Medically necessary** means a service or treatment which is appropriate under the provisions of the health care plan and consistent with diagnosis, and which, in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered.

**Physician Hospital Organization** or **PHO** means an organized group of health care professionals and a hospital which provide health care services to enrollees in managed care health plans. A PHO is similar to an IPA with the difference being the participation of the hospital in the organization.

**Post-stabilization medical services** means health care services provided to an enrollee that are furnished in a licensed hospital by a provider that is qualified to furnish such services, and determined to be medically necessary and directly related to the emergency medical condition following stabilization.

**Pre-certification**, also known as pre-admission certification, pre-admission review and “precert,” means the process of obtaining certification or authorization from the health plan for non-emergency hospital admissions (inpatient or outpatient). Often involves appropriateness review against criteria and assignment of length of stay. Failure to obtain pre-certification often results in a financial penalty to either you or your health care provider.

**Primary Care Physician (PCP)** means a physician specializing in internal medicine, pediatric medicine or family/general practice. An obstetrician/gynecologist may be considered a primary care physician.

**“Reasonable and Customary” or “Usual” Charges** are terms used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community.

**Stabilization** means, with respect to the emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result.

**Utilization review** means an evaluation of the medical necessity, appropriateness and the efficiency of the use of health care services on a prospective, concurrent or retrospective basis.

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**This pamphlet is prepared and published by the Illinois State Bar Association as a public service.**

Every effort has been made to provide accurate information at the time of publication.

For the most current information, please consult your lawyer. If you need a lawyer and do not have one, call Illinois Lawyer Finder at (800) 922-8757 or online **[www.IllinoisLawyerFinder.com](http://www.IllinoisLawyerFinder.com)**

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