

SB0230



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB0230

Introduced 1/22/2025, by Sen. Lakesia Collins

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.3a

Amends the Illinois Insurance Code. In a provision concerning services provided by nonparticipating providers, provides that "health care facility" in the context of non-emergency services, includes a facility or office in which a patient receives reproductive health care, as defined in the Reproductive Health Act.

LRB104 06413 BAB 16449 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
5 changing Section 356z.3a as follows:

6 (215 ILCS 5/356z.3a)

7 Sec. 356z.3a. Billing; emergency services;
8 nonparticipating providers.

9 (a) As used in this Section:

10 "Ancillary services" means:

11 (1) items and services related to emergency medicine,
12 anesthesiology, pathology, radiology, and neonatology that
13 are provided by any health care provider;

14 (2) items and services provided by assistant surgeons,
15 hospitalists, and intensivists;

16 (3) diagnostic services, including radiology and
17 laboratory services, except for advanced diagnostic
18 laboratory tests identified on the most current list
19 published by the United States Secretary of Health and
20 Human Services under 42 U.S.C. 300gg-132(b) (3);

21 (4) items and services provided by other specialty
22 practitioners as the United States Secretary of Health and
23 Human Services specifies through rulemaking under 42

1 U.S.C. 300gg-132(b) (3);

2 (5) items and services provided by a nonparticipating
3 provider if there is no participating provider who can
4 furnish the item or service at the facility; and

5 (6) items and services provided by a nonparticipating
6 provider if there is no participating provider who will
7 furnish the item or service because a participating
8 provider has asserted the participating provider's rights
9 under the Health Care Right of Conscience Act.

10 "Cost sharing" means the amount an insured, beneficiary,
11 or enrollee is responsible for paying for a covered item or
12 service under the terms of the policy or certificate. "Cost
13 sharing" includes copayments, coinsurance, and amounts paid
14 toward deductibles, but does not include amounts paid towards
15 premiums, balance billing by out-of-network providers, or the
16 cost of items or services that are not covered under the policy
17 or certificate.

18 "Emergency department of a hospital" means any hospital
19 department that provides emergency services, including a
20 hospital outpatient department.

21 "Emergency medical condition" has the meaning ascribed to
22 that term in Section 10 of the Managed Care Reform and Patient
23 Rights Act.

24 "Emergency medical screening examination" has the meaning
25 ascribed to that term in Section 10 of the Managed Care Reform
26 and Patient Rights Act.

1 "Emergency services" means, with respect to an emergency
2 medical condition:

3 (1) in general, an emergency medical screening
4 examination, including ancillary services routinely
5 available to the emergency department to evaluate such
6 emergency medical condition, and such further medical
7 examination and treatment as would be required to
8 stabilize the patient regardless of the department of the
9 hospital or other facility in which such further
10 examination or treatment is furnished; or

11 (2) additional items and services for which benefits
12 are provided or covered under the coverage and that are
13 furnished by a nonparticipating provider or
14 nonparticipating emergency facility regardless of the
15 department of the hospital or other facility in which such
16 items are furnished after the insured, beneficiary, or
17 enrollee is stabilized and as part of outpatient
18 observation or an inpatient or outpatient stay with
19 respect to the visit in which the services described in
20 paragraph (1) are furnished. Services after stabilization
21 cease to be emergency services only when all the
22 conditions of 42 U.S.C. 300gg-111(a)(3)(C)(ii)(II) and
23 regulations thereunder are met.

24 "Freestanding Emergency Center" means a facility licensed
25 under Section 32.5 of the Emergency Medical Services (EMS)
26 Systems Act.

1 "Health care facility" means, in the context of
2 non-emergency services, any of the following:

3 (1) a hospital as defined in 42 U.S.C. 1395x(e);

4 (2) a hospital outpatient department;

5 (3) a critical access hospital certified under 42
6 U.S.C. 1395i-4(e);

7 (4) an ambulatory surgical treatment center as defined
8 in the Ambulatory Surgical Treatment Center Act; ~~or~~

9 (5) any recipient of a license under the Hospital
10 Licensing Act that is not otherwise described in this
11 definition; or-

12 (6) a facility or office in which a patient receives
13 reproductive health care, as defined in Section 1-10 of
14 the Reproductive Health Act.

15 "Health care provider" means a provider as defined in
16 subsection (d) of Section 370g. "Health care provider" does
17 not include a provider of air ambulance or ground ambulance
18 services.

19 "Health care services" has the meaning ascribed to that
20 term in subsection (a) of Section 370g.

21 "Health insurance issuer" has the meaning ascribed to that
22 term in Section 5 of the Illinois Health Insurance Portability
23 and Accountability Act.

24 "Nonparticipating emergency facility" means, with respect
25 to the furnishing of an item or service under a policy of group
26 or individual health insurance coverage, any of the following

1 facilities that does not have a contractual relationship
2 directly or indirectly with a health insurance issuer in
3 relation to the coverage:

4 (1) an emergency department of a hospital;

5 (2) a Freestanding Emergency Center;

6 (3) an ambulatory surgical treatment center as defined
7 in the Ambulatory Surgical Treatment Center Act; or

8 (4) with respect to emergency services described in
9 paragraph (2) of the definition of "emergency services", a
10 hospital.

11 "Nonparticipating provider" means, with respect to the
12 furnishing of an item or service under a policy of group or
13 individual health insurance coverage, any health care provider
14 who does not have a contractual relationship directly or
15 indirectly with a health insurance issuer in relation to the
16 coverage.

17 "Participating emergency facility" means any of the
18 following facilities that has a contractual relationship
19 directly or indirectly with a health insurance issuer offering
20 group or individual health insurance coverage setting forth
21 the terms and conditions on which a relevant health care
22 service is provided to an insured, beneficiary, or enrollee
23 under the coverage:

24 (1) an emergency department of a hospital;

25 (2) a Freestanding Emergency Center;

26 (3) an ambulatory surgical treatment center as defined

1 in the Ambulatory Surgical Treatment Center Act; or
2 (4) with respect to emergency services described in
3 paragraph (2) of the definition of "emergency services", a
4 hospital.

5 For purposes of this definition, a single case agreement
6 between an emergency facility and an issuer that is used to
7 address unique situations in which an insured, beneficiary, or
8 enrollee requires services that typically occur out-of-network
9 constitutes a contractual relationship and is limited to the
10 parties to the agreement.

11 "Participating health care facility" means any health care
12 facility that has a contractual relationship directly or
13 indirectly with a health insurance issuer offering group or
14 individual health insurance coverage setting forth the terms
15 and conditions on which a relevant health care service is
16 provided to an insured, beneficiary, or enrollee under the
17 coverage. A single case agreement between an emergency
18 facility and an issuer that is used to address unique
19 situations in which an insured, beneficiary, or enrollee
20 requires services that typically occur out-of-network
21 constitutes a contractual relationship for purposes of this
22 definition and is limited to the parties to the agreement.

23 "Participating provider" means any health care provider
24 that has a contractual relationship directly or indirectly
25 with a health insurance issuer offering group or individual
26 health insurance coverage setting forth the terms and

1 conditions on which a relevant health care service is provided
2 to an insured, beneficiary, or enrollee under the coverage.

3 "Qualifying payment amount" has the meaning given to that
4 term in 42 U.S.C. 300gg-111(a)(3)(E) and the regulations
5 promulgated thereunder.

6 "Recognized amount" means the lesser of the amount
7 initially billed by the provider or the qualifying payment
8 amount.

9 "Stabilize" means "stabilization" as defined in Section 10
10 of the Managed Care Reform and Patient Rights Act.

11 "Treating provider" means a health care provider who has
12 evaluated the individual.

13 "Visit" means, with respect to health care services
14 furnished to an individual at a health care facility, health
15 care services furnished by a provider at the facility, as well
16 as equipment, devices, telehealth services, imaging services,
17 laboratory services, and preoperative and postoperative
18 services regardless of whether the provider furnishing such
19 services is at the facility.

20 (b) Emergency services. When a beneficiary, insured, or
21 enrollee receives emergency services from a nonparticipating
22 provider or a nonparticipating emergency facility, the health
23 insurance issuer shall ensure that the beneficiary, insured,
24 or enrollee shall incur no greater out-of-pocket costs than
25 the beneficiary, insured, or enrollee would have incurred with
26 a participating provider or a participating emergency

1 facility. Any cost-sharing requirements shall be applied as
2 though the emergency services had been received from a
3 participating provider or a participating facility. Cost
4 sharing shall be calculated based on the recognized amount for
5 the emergency services. If the cost sharing for the same item
6 or service furnished by a participating provider would have
7 been a flat-dollar copayment, that amount shall be the
8 cost-sharing amount unless the provider has billed a lesser
9 total amount. In no event shall the beneficiary, insured,
10 enrollee, or any group policyholder or plan sponsor be liable
11 to or billed by the health insurance issuer, the
12 nonparticipating provider, or the nonparticipating emergency
13 facility for any amount beyond the cost sharing calculated in
14 accordance with this subsection with respect to the emergency
15 services delivered. Administrative requirements or limitations
16 shall be no greater than those applicable to emergency
17 services received from a participating provider or a
18 participating emergency facility.

19 (b-5) Non-emergency services at participating health care
20 facilities.

21 (1) When a beneficiary, insured, or enrollee utilizes
22 a participating health care facility and, due to any
23 reason, covered ancillary services are provided by a
24 nonparticipating provider during or resulting from the
25 visit, the health insurance issuer shall ensure that the
26 beneficiary, insured, or enrollee shall incur no greater

1 out-of-pocket costs than the beneficiary, insured, or
2 enrollee would have incurred with a participating provider
3 for the ancillary services. Any cost-sharing requirements
4 shall be applied as though the ancillary services had been
5 received from a participating provider. Cost sharing shall
6 be calculated based on the recognized amount for the
7 ancillary services. If the cost sharing for the same item
8 or service furnished by a participating provider would
9 have been a flat-dollar copayment, that amount shall be
10 the cost-sharing amount unless the provider has billed a
11 lesser total amount. In no event shall the beneficiary,
12 insured, enrollee, or any group policyholder or plan
13 sponsor be liable to or billed by the health insurance
14 issuer, the nonparticipating provider, or the
15 participating health care facility for any amount beyond
16 the cost sharing calculated in accordance with this
17 subsection with respect to the ancillary services
18 delivered. In addition to ancillary services, the
19 requirements of this paragraph shall also apply with
20 respect to covered items or services furnished as a result
21 of unforeseen, urgent medical needs that arise at the time
22 an item or service is furnished, regardless of whether the
23 nonparticipating provider satisfied the notice and consent
24 criteria under paragraph (2) of this subsection.

25 (2) When a beneficiary, insured, or enrollee utilizes
26 a participating health care facility and receives

1 non-emergency covered health care services other than
2 those described in paragraph (1) of this subsection from a
3 nonparticipating provider during or resulting from the
4 visit, the health insurance issuer shall ensure that the
5 beneficiary, insured, or enrollee incurs no greater
6 out-of-pocket costs than the beneficiary, insured, or
7 enrollee would have incurred with a participating provider
8 unless the nonparticipating provider or the participating
9 health care facility on behalf of the nonparticipating
10 provider satisfies the notice and consent criteria
11 provided in 42 U.S.C. 300gg-132 and regulations
12 promulgated thereunder. If the notice and consent criteria
13 are not satisfied, then:

14 (A) any cost-sharing requirements shall be applied
15 as though the health care services had been received
16 from a participating provider;

17 (B) cost sharing shall be calculated based on the
18 recognized amount for the health care services; and

19 (C) in no event shall the beneficiary, insured,
20 enrollee, or any group policyholder or plan sponsor be
21 liable to or billed by the health insurance issuer,
22 the nonparticipating provider, or the participating
23 health care facility for any amount beyond the cost
24 sharing calculated in accordance with this subsection
25 with respect to the health care services delivered.

26 (c) Notwithstanding any other provision of this Code,

1 except when the notice and consent criteria are satisfied for
2 the situation in paragraph (2) of subsection (b-5), any
3 benefits a beneficiary, insured, or enrollee receives for
4 services under the situations in subsection (b) or (b-5) are
5 assigned to the nonparticipating providers or the facility
6 acting on their behalf. Upon receipt of the provider's bill or
7 facility's bill, the health insurance issuer shall provide the
8 nonparticipating provider or the facility with a written
9 explanation of benefits that specifies the proposed
10 reimbursement and the applicable deductible, copayment, or
11 coinsurance amounts owed by the insured, beneficiary, or
12 enrollee. The health insurance issuer shall pay any
13 reimbursement subject to this Section directly to the
14 nonparticipating provider or the facility.

15 (d) For bills assigned under subsection (c), the
16 nonparticipating provider or the facility may bill the health
17 insurance issuer for the services rendered, and the health
18 insurance issuer may pay the billed amount or attempt to
19 negotiate reimbursement with the nonparticipating provider or
20 the facility. Within 30 calendar days after the provider or
21 facility transmits the bill to the health insurance issuer,
22 the issuer shall send an initial payment or notice of denial of
23 payment with the written explanation of benefits to the
24 provider or facility. If attempts to negotiate reimbursement
25 for services provided by a nonparticipating provider do not
26 result in a resolution of the payment dispute within 30 days

1 after receipt of written explanation of benefits by the health
2 insurance issuer, then the health insurance issuer or
3 nonparticipating provider or the facility may initiate binding
4 arbitration to determine payment for services provided on a
5 per-bill or batched-bill basis, in accordance with Section
6 300gg-111 of the Public Health Service Act and the regulations
7 promulgated thereunder. The party requesting arbitration shall
8 notify the other party arbitration has been initiated and
9 state its final offer before arbitration. In response to this
10 notice, the nonrequesting party shall inform the requesting
11 party of its final offer before the arbitration occurs.
12 Arbitration shall be initiated by filing a request with the
13 Department of Insurance.

14 (e) The Department of Insurance shall publish a list of
15 approved arbitrators or entities that shall provide binding
16 arbitration. These arbitrators shall be American Arbitration
17 Association or American Health Lawyers Association trained
18 arbitrators. Both parties must agree on an arbitrator from the
19 Department of Insurance's or its approved entity's list of
20 arbitrators. If no agreement can be reached, then a list of 5
21 arbitrators shall be provided by the Department of Insurance
22 or the approved entity. From the list of 5 arbitrators, the
23 health insurance issuer can veto 2 arbitrators and the
24 provider or facility can veto 2 arbitrators. The remaining
25 arbitrator shall be the chosen arbitrator. This arbitration
26 shall consist of a review of the written submissions by both

1 parties. The arbitrator shall not establish a rebuttable
2 presumption that the qualifying payment amount should be the
3 total amount owed to the provider or facility by the
4 combination of the issuer and the insured, beneficiary, or
5 enrollee. Binding arbitration shall provide for a written
6 decision within 45 days after the request is filed with the
7 Department of Insurance. Both parties shall be bound by the
8 arbitrator's decision. The arbitrator's expenses and fees,
9 together with other expenses, not including attorney's fees,
10 incurred in the conduct of the arbitration, shall be paid as
11 provided in the decision.

12 (f) (Blank).

13 (g) Section 368a of this Act shall not apply during the
14 pendency of a decision under subsection (d). Upon the issuance
15 of the arbitrator's decision, Section 368a applies with
16 respect to the amount, if any, by which the arbitrator's
17 determination exceeds the issuer's initial payment under
18 subsection (c), or the entire amount of the arbitrator's
19 determination if initial payment was denied. Any interest
20 required to be paid to a provider under Section 368a shall not
21 accrue until after 30 days of an arbitrator's decision as
22 provided in subsection (d), but in no circumstances longer
23 than 150 days from the date the nonparticipating
24 facility-based provider billed for services rendered.

25 (h) Nothing in this Section shall be interpreted to change
26 the prudent layperson provisions with respect to emergency

1 services under the Managed Care Reform and Patient Rights Act.

2 (i) Nothing in this Section shall preclude a health care
3 provider from billing a beneficiary, insured, or enrollee for
4 reasonable administrative fees, such as service fees for
5 checks returned for nonsufficient funds and missed
6 appointments.

7 (j) Nothing in this Section shall preclude a beneficiary,
8 insured, or enrollee from assigning benefits to a
9 nonparticipating provider when the notice and consent criteria
10 are satisfied under paragraph (2) of subsection (b-5) or in
11 any other situation not described in subsection (b) or (b-5).

12 (k) Except when the notice and consent criteria are
13 satisfied under paragraph (2) of subsection (b-5), if an
14 individual receives health care services under the situations
15 described in subsection (b) or (b-5), no referral requirement
16 or any other provision contained in the policy or certificate
17 of coverage shall deny coverage, reduce benefits, or otherwise
18 defeat the requirements of this Section for services that
19 would have been covered with a participating provider.
20 However, this subsection shall not be construed to preclude a
21 provider contract with a health insurance issuer, or with an
22 administrator or similar entity acting on the issuer's behalf,
23 from imposing requirements on the participating provider,
24 participating emergency facility, or participating health care
25 facility relating to the referral of covered individuals to
26 nonparticipating providers.

1 (1) Except if the notice and consent criteria are
2 satisfied under paragraph (2) of subsection (b-5),
3 cost-sharing amounts calculated in conformity with this
4 Section shall count toward any deductible or out-of-pocket
5 maximum applicable to in-network coverage.

6 (m) The Department has the authority to enforce the
7 requirements of this Section in the situations described in
8 subsections (b) and (b-5), and in any other situation for
9 which 42 U.S.C. Chapter 6A, Subchapter XXV, Parts D or E and
10 regulations promulgated thereunder would prohibit an
11 individual from being billed or liable for emergency services
12 furnished by a nonparticipating provider or nonparticipating
13 emergency facility or for non-emergency health care services
14 furnished by a nonparticipating provider at a participating
15 health care facility.

16 (n) This Section does not apply with respect to air
17 ambulance or ground ambulance services. This Section does not
18 apply to any policy of excepted benefits or to short-term,
19 limited-duration health insurance coverage.

20 (Source: P.A. 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23;
21 103-440, eff. 1-1-24.)