SB1471

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB1471

Introduced 1/31/2025, by Sen. Linda Holmes

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.3a
215 ILCS 5/370g from Ch. 73, par. 982g
215 ILCS 125/4-15 from Ch. 111 1/2, par. 1409.8

Amends the Illinois Insurance Code. Provides that nothing in the provisions shall require an ambulance provider to bill a beneficiary, insured, enrollee, or health insurance issuer when prohibited by any other law, rule, ordinance, contract, or agreement. Limits home rule powers. Changes the definition of "emergency services" and "health care provider". Amends the Health Maintenance Organization Act. Removes language providing that upon reasonable demand by a provider of emergency transportation by ambulance, a health maintenance organization shall promptly pay to the provider, subject to coverage limitations stated in the contract or evidence of coverage, the charges for emergency transportation by ambulance provided to an enrollee in a health care plan arranged for by the health maintenance organization.

LRB104 09860 BAB 19928 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 Sections 356z.3a and 370g 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

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

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

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

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

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

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

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

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

(1) in general, any health care service provided to a person to evaluate or treat a condition that requires immediate unscheduled medical care, an emergency medical screening examination, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment as would be required to stabilize the patient regardless of the department of the hospital, ground ambulance, or other facility in which such further examination or treatment is furnished, including any covered service for transportation of a patient by a health care provider to a participating or nonparticipating emergency facility for an emergency medical condition; or

(2) additional items and services for which benefits are provided or covered under the coverage and that are furnished by a nonparticipating provider or nonparticipating emergency facility regardless of the department of the hospital or other facility in which such items are furnished after the insured, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (1) are furnished. Services after stabilization

cease to be emergency services only when all the conditions of 42 U.S.C. 300gg-111(a)(3)(C)(ii)(II) and regulations thereunder are met.

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

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

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

(2) a hospital outpatient department;

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

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

(5) any recipient of a license under the Hospital Licensing Act that is not otherwise described in this definition.

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

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

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

1 "Nonparticipating emergency facility" means, with respect
2 to the furnishing of an item or service under a policy of group
3 or individual health insurance coverage, any of the following
4 facilities that does not have a contractual relationship
5 directly or indirectly with a health insurance issuer in
6 relation to the coverage:
7 (1) an emergency department of a hospital;
8 (2) a Freestanding Emergency Center;
9 (3) an ambulatory surgical treatment center as defined
10 in the Ambulatory Surgical Treatment Center Act; or
11 (4) with respect to emergency services described in
12 paragraph (2) of the definition of "emergency services", a
13 hospital.
14 "Nonparticipating provider" means, with respect to the
15 furnishing of an item or service under a policy of group or
16 individual health insurance coverage, any health care provider
17 who does not have a contractual relationship directly or
18 indirectly with a health insurance issuer in relation to the
19 coverage.
20 "Participating emergency facility" means any of the
21 following facilities that has a contractual relationship
22 directly or indirectly with a health insurance issuer offering
23 group or individual health insurance coverage setting forth
24 the terms and conditions on which a relevant health care
25 service is provided to an insured, beneficiary, or enrollee
26 under the coverage:

(1) an emergency department of a hospital;

(2) a Freestanding Emergency Center;

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

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

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

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

"Participating provider" means any health care provider

1 that has a contractual relationship directly or indirectly
2 with a health insurance issuer offering group or individual
3 health insurance coverage setting forth the terms and
4 conditions on which a relevant health care service is provided
5 to an insured, beneficiary, or enrollee under the coverage.
6 "Qualifying payment amount" has the meaning given to that
7 term in 42 U.S.C. 300gg-111(a)(3)(E) and the regulations
8 promulgated thereunder.
9 "Recognized amount" means the lesser of the amount
10 initially billed by the provider or the qualifying payment
11 amount.
12 "Stabilize" means "stabilization" as defined in Section 10
13 of the Managed Care Reform and Patient Rights Act.
14 "Treating provider" means a health care provider who has
15 evaluated the individual.
16 "Visit" means, with respect to health care services
17 furnished to an individual at a health care facility, health
18 care services furnished by a provider at the facility, as well
19 as equipment, devices, telehealth services, imaging services,
20 laboratory services, and preoperative and postoperative
21 services regardless of whether the provider furnishing such
22 services is at the facility.
23 (b) Emergency services. When a beneficiary, insured, or
24 enrollee receives emergency services from a nonparticipating
25 provider or a nonparticipating emergency facility, the health
26 insurance issuer shall ensure that the beneficiary, insured,

or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating provider or a participating emergency facility. Any cost-sharing requirements shall be applied as though the emergency services had been received from a participating provider or a participating facility. Cost sharing shall be calculated based on the recognized amount for the emergency services. If the cost sharing for the same item or service furnished by a participating provider would have been a flat-dollar copayment, that amount shall be the cost-sharing amount unless the provider has billed a lesser total amount. In no event shall the beneficiary, insured, enrollee, or any group policyholder or plan sponsor be liable to or billed by the health insurance issuer, the nonparticipating provider, or the nonparticipating emergency facility for any amount beyond the cost sharing calculated in accordance with this subsection with respect to the emergency services delivered. Administrative requirements or limitations shall be no greater than those applicable to emergency services received from a participating provider or a participating emergency facility.

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

(1) When a beneficiary, insured, or enrollee utilizes a participating health care facility and, due to any reason, covered ancillary services are provided by a

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

criteria under paragraph (2) of this subsection.

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

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

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

(C) in no event shall the beneficiary, insured, enrollee, or any group policyholder or plan sponsor be liable to or billed by the health insurance issuer, the nonparticipating provider, or the participating health care facility for any amount beyond the cost

1 sharing calculated in accordance with this subsection
2 with respect to the health care services delivered.
3 (c) Notwithstanding any other provision of this Code,
4 except when the notice and consent criteria are satisfied for
5 the situation in paragraph (2) of subsection (b-5), any
6 benefits a beneficiary, insured, or enrollee receives for
7 services under the situations in subsection (b) or (b-5) are
8 assigned to the nonparticipating providers or the facility
9 acting on their behalf. Upon receipt of the provider's bill or
10 facility's bill, the health insurance issuer shall provide the
11 nonparticipating provider or the facility with a written
12 explanation of benefits that specifies the proposed
13 reimbursement and the applicable deductible, copayment, or
14 coinsurance amounts owed by the insured, beneficiary, or
15 enrollee. The health insurance issuer shall pay any
16 reimbursement subject to this Section directly to the
17 nonparticipating provider or the facility.
18 (d) For bills assigned under subsection (c), the
19 nonparticipating provider or the facility may bill the health
20 insurance issuer for the services rendered, and the health
21 insurance issuer may pay the billed amount or attempt to
22 negotiate reimbursement with the nonparticipating provider or
23 the facility. Within 30 calendar days after the provider or
24 facility transmits the bill to the health insurance issuer,
25 the issuer shall send an initial payment or notice of denial of
26 payment with the written explanation of benefits to the

1 provider or facility. If attempts to negotiate reimbursement
2 for services provided by a nonparticipating provider do not
3 result in a resolution of the payment dispute within 30 days
4 after receipt of written explanation of benefits by the health
5 insurance issuer, then the health insurance issuer or
6 nonparticipating provider or the facility may initiate binding
7 arbitration to determine payment for services provided on a
8 per-bill or batched-bill basis, in accordance with Section
9 300gg-111 of the Public Health Service Act and the regulations
10 promulgated thereunder. The party requesting arbitration shall
11 notify the other party arbitration has been initiated and
12 state its final offer before arbitration. In response to this
13 notice, the nonrequesting party shall inform the requesting
14 party of its final offer before the arbitration occurs.
15 Arbitration shall be initiated by filing a request with the
16 Department of Insurance.
17 (e) The Department of Insurance shall publish a list of
18 approved arbitrators or entities that shall provide binding
19 arbitration. These arbitrators shall be American Arbitration
20 Association or American Health Lawyers Association trained
21 arbitrators. Both parties must agree on an arbitrator from the
22 Department of Insurance's or its approved entity's list of
23 arbitrators. If no agreement can be reached, then a list of 5
24 arbitrators shall be provided by the Department of Insurance
25 or the approved entity. From the list of 5 arbitrators, the
26 health insurance issuer can veto 2 arbitrators and the

provider or facility can veto 2 arbitrators. The remaining arbitrator shall be the chosen arbitrator. This arbitration shall consist of a review of the written submissions by both parties. The arbitrator shall not establish a rebuttable presumption that the qualifying payment amount should be the total amount owed to the provider or facility by the combination of the issuer and the insured, beneficiary, or enrollee. Binding arbitration shall provide for a written decision within 45 days after the request is filed with the Department of Insurance. Both parties shall be bound by the arbitrator's decision. The arbitrator's expenses and fees, together with other expenses, not including attorney's fees, incurred in the conduct of the arbitration, shall be paid as provided in the decision.

(f) (Blank).

(g) Section 368a of this Act shall not apply during the pendency of a decision under subsection (d). Upon the issuance of the arbitrator's decision, Section 368a applies with respect to the amount, if any, by which the arbitrator's determination exceeds the issuer's initial payment under subsection (c), or the entire amount of the arbitrator's determination if initial payment was denied. Any interest required to be paid to a provider under Section 368a shall not accrue until after 30 days of an arbitrator's decision as provided in subsection (d), but in no circumstances longer than 150 days from the date the nonparticipating

1 facility-based provider billed for services rendered.
2 (h) Nothing in this Section shall be interpreted to change
3 the prudent layperson provisions with respect to emergency
4 services under the Managed Care Reform and Patient Rights Act.
5 (i) Nothing in this Section shall preclude a health care
6 provider from billing a beneficiary, insured, or enrollee for
7 reasonable administrative fees, such as service fees for
8 checks returned for nonsufficient funds and missed
9 appointments.
10 (j) Nothing in this Section shall preclude a beneficiary,
11 insured, or enrollee from assigning benefits to a
12 nonparticipating provider when the notice and consent criteria
13 are satisfied under paragraph (2) of subsection (b-5) or in
14 any other situation not described in subsection (b) or (b-5).
15 (k) Except when the notice and consent criteria are
16 satisfied under paragraph (2) of subsection (b-5), if an
17 individual receives health care services under the situations
18 described in subsection (b) or (b-5), no referral requirement
19 or any other provision contained in the policy or certificate
20 of coverage shall deny coverage, reduce benefits, or otherwise
21 defeat the requirements of this Section for services that
22 would have been covered with a participating provider.
23 However, this subsection shall not be construed to preclude a
24 provider contract with a health insurance issuer, or with an
25 administrator or similar entity acting on the issuer's behalf,
26 from imposing requirements on the participating provider,

participating emergency facility, or participating health care facility relating to the referral of covered individuals to nonparticipating providers.

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

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

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

(o) Nothing in this Section shall require an ambulance provider to bill a beneficiary, insured, enrollee, or health insurance issuer when prohibited by any other law, rule, ordinance, contract, or agreement. If an ambulance provider

1 other than an air ambulance provider is a nonparticipating
2 provider when it furnishes emergency services under a contract
3 with a unit of local government of this State, and if the unit
4 of local government is permitted or required to bill a
5 beneficiary, insured, enrollee, or health insurance issuer for
6 the services furnished by the ambulance provider, this Section
7 applies to the unit of local government as though it were the
8 ambulance provider. This Section also applies when a unit of
9 local government directly operates the ambulance provider that
10 furnished emergency services to a beneficiary, insured, or
11 enrollee.
12 (p) A home rule unit may not regulate ambulance providers
13 in a manner inconsistent with this Section. This Section is a
14 limitation under subsection (i) of Section 6 of Article VII of
15 the Illinois Constitution on the concurrent exercise by home
16 rule units of powers and functions exercised by the State.
17 (Source: P.A. 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23;
18 103-440, eff. 1-1-24.)

19 (215 ILCS 5/370g) (from Ch. 73, par. 982g)
20 Sec. 370g. Definitions. As used in this Article, the
21 following definitions apply:
22 (a) "Health care services" means health care services or
23 products rendered or sold by a provider within the scope of the
24 provider's license or legal authorization. The term includes,
25 but is not limited to, hospital, medical, surgical, dental,

1 vision, ground ambulance, and pharmaceutical services or
2 products.
3 (b) "Insurer" means an insurance company or a health
4 service corporation authorized in this State to issue policies
5 or subscriber contracts which reimburse for expenses of health
6 care services.
7 (c) "Insured" means an individual entitled to
8 reimbursement for expenses of health care services under a
9 policy or subscriber contract issued or administered by an
10 insurer.
11 (d) "Provider" means an individual or entity duly licensed
12 or legally authorized to provide health care services.
13 (e) "Noninstitutional provider" means any person licensed
14 under the Medical Practice Act of 1987, as now or hereafter
15 amended.
16 (f) "Beneficiary" means an individual entitled to
17 reimbursement for expenses of or the discount of provider fees
18 for health care services under a program where the beneficiary
19 has an incentive to utilize the services of a provider which
20 has entered into an agreement or arrangement with an
21 administrator.
22 (g) "Administrator" means any person, partnership or
23 corporation, other than an insurer or health maintenance
24 organization holding a certificate of authority under the
25 "Health Maintenance Organization Act", as now or hereafter
26 amended, that arranges, contracts with, or administers

contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider.

(h) "Emergency medical condition" has the meaning given to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

(Source: P.A. 102-409, eff. 1-1-22.)

Section 10. The Health Maintenance Organization Act is amended by changing Section 4-15 as follows:

(215 ILCS 125/4-15) (from Ch. 111 1/2, par. 1409.8)

Sec. 4-15. (a) No contract or evidence of coverage for basic health care services delivered, issued for delivery, renewed or amended by a Health Maintenance Organization shall exclude coverage for emergency transportation by ambulance. For the purposes of this Section, the term "emergency" means a need for immediate medical attention resulting from a life threatening condition or situation or a need for immediate medical attention as otherwise reasonably determined by a physician, public safety official or other emergency medical personnel.

(b) (Blank). ~~Upon reasonable demand by a provider of emergency transportation by ambulance, a Health Maintenance Organization shall promptly pay to the provider, subject to coverage limitations stated in the contract or evidence of coverage, the charges for emergency transportation by~~

1 ~~ambulance provided to an enrollee in a health care plan~~
2 ~~arranged for by the Health Maintenance Organization. By~~
3 ~~accepting any such payment from the Health Maintenance~~
4 ~~Organization, the provider of emergency transportation by~~
5 ~~ambulance agrees not to seek any payment from the enrollee for~~
6 ~~services provided to the enrollee.~~
7 (Source: P.A. 86-833; 86-1028.)