SB1762

LRB10305845BMS50865b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB1762

Introduced 2/9/2023, by Sen. Ann Gillespie

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.3
215 ILCS 5/356z.3a
215 ILCS 125/4.5-1

Amends the Illinois Insurance Code. In provisions concerning required disclosures on contracts and evidences of coverage of accident and health insurance, provides that insurers must notify beneficiaries that nonparticipating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill, except for specified services, including items or services provided to a Medicare beneficiary, insured, or enrollee. Provides that a health care provider shall not charge or collect from a Medicare beneficiary, insured, or enrollee any amount in excess of the Medicare-approved amount for any Medicare-covered item or service provided, and provides that the Department of Insurance has the authority to enforce that requirement. Defines terms. Makes a conforming change in the Health Maintenance Organization Act. Effective immediately.

LRB103 05845 BMS 50865 b

A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Illinois Insurance Code is amended by changing Sections 356z.3 and 356z.3a as follows:

(215 ILCS 5/356z.3)

Sec. 356z.3. Disclosure of limited benefit. An insurer that issues, delivers, amends, or renews an individual or group policy of accident and health insurance in this State after the effective date of this amendatory Act of the 92nd General Assembly and arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the

geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill, except as provided in Section 356z.3a of the Illinois Insurance Code for covered services received at a participating health care facility from a nonparticipating provider that are: (a) ancillary services, (b) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is furnished, ~~or~~ (c) items or services received when the facility or the non-participating provider fails to satisfy the notice and consent criteria specified under Section 356z.3a, or (d) items or services provided to a Medicare beneficiary, insured, or enrollee. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.".

(Source: P.A. 102-901, eff. 1-1-23.)

(215 ILCS 5/356z.3a)

Sec. 356z.3a. Billing; emergency services;

nonparticipating providers.

(a) As used in this Section:

"Ancillary services" means:

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

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

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

(4) items and services provided by other specialty practitioners as the United States Secretary of Health and Human Services specifies through rulemaking under 42 U.S.C. 300gg-132(b)(3); and

(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.

"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, 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 or other facility in which such further examination or treatment is furnished; 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.

"Medicare" means the health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

"Medicare-approved amount" means the total payment that Medicare has agreed to pay a health care provider for a service or item.

"Nonparticipating emergency facility" means, with respect to the furnishing of an item or service under a policy of group or individual health insurance coverage, any of the following facilities that does not have a contractual relationship directly or indirectly with a health insurance issuer in relation to 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.

"Nonparticipating provider" means, with respect to the furnishing of an item or service under a policy of group or individual health insurance coverage, any health care provider

who does not have a contractual relationship directly or indirectly with a health insurance issuer in relation to the coverage.

"Participating emergency facility" means any of the following facilities 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:

(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 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.

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

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

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

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

"Visit" means, with respect to health care services

furnished to an individual at a health care facility, health care services furnished by a provider at the facility, as well as equipment, devices, telehealth services, imaging services, laboratory services, and preoperative and postoperative services regardless of whether the provider furnishing such services is at the facility.

(b) Emergency services. When a beneficiary, insured, or enrollee receives emergency services from a nonparticipating provider or a nonparticipating emergency facility, the health 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 nonparticipating provider during or resulting from the visit, the health 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 for the ancillary services. Any cost-sharing requirements shall be applied as though the ancillary services had been received from a participating provider. Cost sharing shall be calculated based on the recognized amount for the ancillary 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 participating health care facility for any amount beyond the cost sharing calculated in accordance with this subsection with respect to the ancillary services delivered. In addition to ancillary services, the requirements of this paragraph shall also apply with respect to covered items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the 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 sharing calculated in accordance with this subsection with respect to the health care services delivered.

(c) Notwithstanding any other provision of this Code, except when the notice and consent criteria are satisfied for the situation in paragraph (2) of subsection (b-5), any benefits a beneficiary, insured, or enrollee receives for services under the situations in subsection ~~subsections~~ (b) or (b-5) are assigned to the nonparticipating providers or the facility acting on their behalf. Upon receipt of the provider's bill or facility's bill, the health insurance issuer shall provide the nonparticipating provider or the facility with a written explanation of benefits that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the insured, beneficiary, or enrollee. The health insurance issuer shall pay any reimbursement subject to this Section directly to the

nonparticipating provider or the facility.

(d) For bills assigned under subsection (c), the nonparticipating provider or the facility may bill the health insurance issuer for the services rendered, and the health insurance issuer may pay the billed amount or attempt to negotiate reimbursement with the nonparticipating provider or the facility. Within 30 calendar days after the provider or facility transmits the bill to the health insurance issuer, the issuer shall send an initial payment or notice of denial of payment with the written explanation of benefits to the provider or facility. If attempts to negotiate reimbursement for services provided by a nonparticipating provider do not result in a resolution of the payment dispute within 30 days after receipt of written explanation of benefits by the health insurance issuer, then the health insurance issuer or nonparticipating provider or the facility may initiate binding arbitration to determine payment for services provided on a per-bill ~~per bill~~ basis. The party requesting arbitration shall notify the other party arbitration has been initiated and state its final offer before arbitration. In response to this notice, the nonrequesting party shall inform the requesting party of its final offer before the arbitration occurs. Arbitration shall be initiated by filing a request with the Department of Insurance.

(e) The Department of Insurance shall publish a list of approved arbitrators or entities that shall provide binding

arbitration. These arbitrators shall be American Arbitration Association or American Health Lawyers Association trained arbitrators. Both parties must agree on an arbitrator from the Department of Insurance's or its approved entity's list of arbitrators. If no agreement can be reached, then a list of 5 arbitrators shall be provided by the Department of Insurance or the approved entity. From the list of 5 arbitrators, the 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).

(f-1) A health care provider shall not charge or collect from a Medicare beneficiary, insured, or enrollee any amount in excess of the Medicare-approved amount for any

Medicare-covered item or service provided.

(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 facility-based provider billed for services rendered.

(h) Nothing in this Section shall be interpreted to change the prudent layperson provisions with respect to emergency services under the Managed Care Reform and Patient Rights Act.

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

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

(b) or (b-5).

(k) Except when the notice and consent criteria are satisfied under paragraph (2) of subsection (b-5), if an individual receives health care services under the situations described in subsections (b) or (b-5), no referral requirement or any other provision contained in the policy or certificate of coverage shall deny coverage, reduce benefits, or otherwise defeat the requirements of this Section for services that would have been covered with a participating provider. However, this subsection shall not be construed to preclude a provider contract with a health insurance issuer, or with an administrator or similar entity acting on the issuer's behalf, 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)<u>,</u> ~~and~~ (b-5), <u>and (f-1),</u> 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.

(Source: P.A. 102-901, eff. 7-1-22; revised 8-19-22.)

Section 10. The Health Maintenance Organization Act is amended by changing Section 4.5-1 as follows:

(215 ILCS 125/4.5-1)

Sec. 4.5-1. Point-of-service health service contracts.

(a) A health maintenance organization that offers a point-of-service contract:

(1) must include as in-plan covered services all services required by law to be provided by a health maintenance organization;

(2) must provide incentives, which shall include financial incentives, for enrollees to use in-plan covered services;

(3) may not offer services out-of-plan without providing those services on an in-plan basis;

(4) may include annual out-of-pocket limits and lifetime maximum benefits allowances for out-of-plan services that are separate from any limits or allowances applied to in-plan services;

(5) may not consider emergency services, authorized referral services, or non-routine services obtained out of the service area to be point-of-service services;

(6) may treat as out-of-plan services those services that an enrollee obtains from a participating provider, but for which the proper authorization was not given by the health maintenance organization; and

(7) after January 1, 2003 (the effective date of Public Act 92-579) ~~this amendatory Act of the 92nd General Assembly~~, must include the following disclosure on its point-of-service contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as

defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill, except as provided in Section 356z.3a of the Illinois Insurance Code for covered services received at a participating health care facility from a non-participating provider that are: (a) ancillary services, (b) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is furnished, ~~or~~ (c) items or services received when the facility or the non-participating provider fails to satisfy the notice and consent criteria specified under Section 356z.3a, or (d) items or services provided to a Medicare beneficiary, insured, or enrollee. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.".

(b) A health maintenance organization offering a point-of-service contract is subject to all of the following limitations:

(1) The health maintenance organization may not expend

in any calendar quarter more than 20% of its total expenditures for all its members for out-of-plan covered services.

(2) If the amount specified in item (1) of this subsection is exceeded by 2% in a quarter, the health maintenance organization must effect compliance with item (1) of this subsection by the end of the following quarter.

(3) If compliance with the amount specified in item (1) of this subsection is not demonstrated in the health maintenance organization's next quarterly report, the health maintenance organization may not offer the point-of-service contract to new groups or include the point-of-service option in the renewal of an existing group until compliance with the amount specified in item (1) of this subsection is demonstrated or until otherwise allowed by the Director.

(4) A health maintenance organization failing, without just cause, to comply with the provisions of this subsection shall be required, after notice and hearing, to pay a penalty of $250 for each day out of compliance, to be recovered by the Director. Any penalty recovered shall be paid into the General Revenue Fund. The Director may reduce the penalty if the health maintenance organization demonstrates to the Director that the imposition of the penalty would constitute a financial hardship to the

health maintenance organization.

(c) A health maintenance organization that offers a point-of-service product must do all of the following:

(1) File a quarterly financial statement detailing compliance with the requirements of subsection (b).

(2) Track out-of-plan, point-of-service utilization separately from in-plan or non-point-of-service, out-of-plan emergency care, referral care, and urgent care out of the service area utilization.

(3) Record out-of-plan utilization in a manner that will permit such utilization and cost reporting as the Director may, by rule, require.

(4) Demonstrate to the Director's satisfaction that the health maintenance organization has the fiscal, administrative, and marketing capacity to control its point-of-service enrollment, utilization, and costs so as not to jeopardize the financial security of the health maintenance organization.

(5) Maintain, in addition to any other deposit required under this Act, the deposit required by Section 2-6.

(6) Maintain cash and cash equivalents of sufficient amount to fully liquidate 10 days' average claim payments, subject to review by the Director.

(7) Maintain and file with the Director, reinsurance coverage protecting against catastrophic losses on

out-of-network ~~out of network~~ point-of-service services. Deductibles may not exceed $100,000 per covered life per year, and the portion of risk retained by the health maintenance organization once deductibles have been satisfied may not exceed 20%. Reinsurance must be placed with licensed authorized reinsurers qualified to do business in this State.

(d) A health maintenance organization may not issue a point-of-service contract until it has filed and had approved by the Director a plan to comply with the provisions of this Section. The compliance plan must, at a minimum, include provisions demonstrating that the health maintenance organization will do all of the following:

(1) Design the benefit levels and conditions of coverage for in-plan covered services and out-of-plan covered services as required by this Article.

(2) Provide or arrange for the provision of adequate systems to:

(A) process and pay claims for all out-of-plan covered services;

(B) meet the requirements for point-of-service contracts set forth in this Section and any additional requirements that may be set forth by the Director; and

(C) generate accurate data and financial and regulatory reports on a timely basis so that the

Department of Insurance can evaluate the health maintenance organization's experience with the point-of-service contract and monitor compliance with point-of-service contract provisions.

(3) Comply with the requirements of subsections (b) and (c).

(Source: P.A. 102-901, eff. 1-1-23; revised 12-9-22.)

Section 99. Effective date. This Act takes effect upon becoming law.