SB3233

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97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

SB3233

Introduced 2/1/2012, by Sen. William R. Haine

SYNOPSIS AS INTRODUCED:

20 ILCS 1405/1405-40 new
215 ILCS 5/356z.3a

Amends the Department of Insurance Law of the Civil Administrative Code of Illinois. Provides that the Department of Insurance shall study the frequency and economic impact of nonparticipating facility-based physician and provider claims concerning the issue of when a beneficiary, insured, or enrollee utilizes a participating network hospital or a participating network ambulatory surgery center and, due to any reason, in-network services for radiology, anesthesiology, pathology, emergency physician, or neonatology are unavailable and are provided by a nonparticipating facility-based physician or provider and the insurer's or health plan's responsibility to 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 physician or provider for covered services. Provides that the Department shall report its findings and recommendations to the General Assembly no later than October 1, 2012. Amends the Illinois Insurance Code to provide that nothing in the provision concerning nonparticipating facility-based physicians and providers shall be interpreted to change the prudent layperson provisions with respect to emergency services under the Managed Care Reform and Patient Rights Act. Effective immediately.

LRB097 19652 RPM 64906 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning insurance.

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

Section 5. The Department of Insurance Law of the Civil Administrative Code of Illinois is amended by adding Section 1405-40 as follows:

(20 ILCS 1405/1405-40 new)

Sec. 1405-40. Study of out-of-network facility-based physician and provider claims.

(a) For purposes of this Section only, "facility-based provider" means a physician or other provider who provides radiology, anesthesiology, pathology, neonatology, or emergency department services to insureds, beneficiaries, or enrollees in a participating hospital or participating ambulatory surgical treatment center.

(b) The Department shall study the frequency and economic impact of nonparticipating facility-based physician and provider claims addressed in subsection (c) of this Section. The Department shall have the authority to request insurers, health plans, and applicable nonparticipating facility-based physician and provider trade associations to assemble and submit information for the purposes of this study to the extent permitted by law.

1 (c) The Department shall study the issue of when a
2 beneficiary, insured, or enrollee utilizes a participating
3 network hospital or a participating network ambulatory surgery
4 center and, due to any reason, in-network services for
5 radiology, anesthesiology, pathology, emergency physician, or
6 neonatology are unavailable and are provided by a
7 nonparticipating facility-based physician or provider and the
8 insurer's or health plan's responsibility to ensure that the
9 beneficiary, insured, or enrollee incurs no greater
10 out-of-pocket costs than the beneficiary, insured, or enrollee
11 would have incurred with a participating physician or provider
12 for covered services.
13 (d) The Department shall report its findings and
14 recommendations to the General Assembly no later than October
15 1, 2012.

16 Section 10. The Illinois Insurance Code is amended by
17 changing Section 356z.3a as follows:

18 (215 ILCS 5/356z.3a)
19 Sec. 356z.3a. Nonparticipating facility-based physicians
20 and providers.
21 (a) For purposes of this Section, "facility-based
22 provider" means a physician or other provider who provide
23 radiology, anesthesiology, pathology, neonatology, or
24 emergency department services to insureds, beneficiaries, or

1 enrollees in a participating hospital or participating
2 ambulatory surgical treatment center.
3 (b) When a beneficiary, insured, or enrollee utilizes a
4 participating network hospital or a participating network
5 ambulatory surgery center and, due to any reason, in network
6 services for radiology, anesthesiology, pathology, emergency
7 physician, or neonatology are unavailable and are provided by a
8 nonparticipating facility-based physician or provider, the
9 insurer or health plan shall ensure that the beneficiary,
10 insured, or enrollee shall incur no greater out-of-pocket costs
11 than the beneficiary, insured, or enrollee would have incurred
12 with a participating physician or provider for covered
13 services.
14 (c) If a beneficiary, insured, or enrollee agrees in
15 writing, notwithstanding any other provision of this Code, any
16 benefits a beneficiary, insured, or enrollee receives for
17 services under the situation in subsection (b) are assigned to
18 the nonparticipating facility-based providers. The insurer or
19 health plan shall provide the nonparticipating provider with a
20 written explanation of benefits that specifies the proposed
21 reimbursement and the applicable deductible, copayment or
22 coinsurance amounts owed by the insured, beneficiary or
23 enrollee. The insurer or health plan shall pay any
24 reimbursement directly to the nonparticipating facility-based
25 provider. The nonparticipating facility-based physician or
26 provider shall not bill the beneficiary, insured, or enrollee,

1 except for applicable deductible, copayment, or coinsurance
2 amounts that would apply if the beneficiary, insured, or
3 enrollee utilized a participating physician or provider for
4 covered services. If a beneficiary, insured, or enrollee
5 specifically rejects assignment under this Section in writing
6 to the nonparticipating facility-based provider, then the
7 nonparticipating facility-based provider may bill the
8 beneficiary, insured, or enrollee for the services rendered.
9 (d) For bills assigned under subsection (c), the
10 nonparticipating facility-based provider may bill the insurer
11 or health plan for the services rendered, and the insurer or
12 health plan may pay the billed amount or attempt to negotiate
13 reimbursement with the nonparticipating facility-based
14 provider. If attempts to negotiate reimbursement for services
15 provided by a nonparticipating facility-based provider do not
16 result in a resolution of the payment dispute within 30 days
17 after receipt of written explanation of benefits by the insurer
18 or health plan, then an insurer or health plan or
19 nonparticipating facility-based physician or provider may
20 initiate binding arbitration to determine payment for services
21 provided on a per bill basis. The party requesting arbitration
22 shall notify the other party arbitration has been initiated and
23 state its final offer before arbitration. In response to this
24 notice, the nonrequesting party shall inform the requesting
25 party of its final offer before the arbitration occurs.
26 Arbitration shall be initiated by filing a request with the

1 Department of Insurance.
2 (e) The Department of Insurance shall publish a list of
3 approved arbitrators or entities that shall provide binding
4 arbitration. These arbitrators shall be American Arbitration
5 Association or American Health Lawyers Association trained
6 arbitrators. Both parties must agree on an arbitrator from the
7 Department of Insurance's list of arbitrators. If no agreement
8 can be reached, then a list of 5 arbitrators shall be provided
9 by the Department of Insurance. From the list of 5 arbitrators,
10 the insurer can veto 2 arbitrators and the provider can veto 2
11 arbitrators. The remaining arbitrator shall be the chosen
12 arbitrator. This arbitration shall consist of a review of the
13 written submissions by both parties. Binding arbitration shall
14 provide for a written decision within 45 days after the request
15 is filed with the Department of Insurance. Both parties shall
16 be bound by the arbitrator's decision. The arbitrator's
17 expenses and fees, together with other expenses, not including
18 attorney's fees, incurred in the conduct of the arbitration,
19 shall be paid as provided in the decision.
20 (f) This Section 356z.3a does not apply to a beneficiary,
21 insured, or enrollee who willfully chooses to access a
22 nonparticipating facility-based physician or provider for
23 health care services available through the insurer's or plan's
24 network of participating physicians and providers. In these
25 circumstances, the contractual requirements for
26 nonparticipating facility-based provider reimbursements will

1 apply.
2 (g) Section 368a of this Act shall not apply during the
3 pendency of a decision under subsection (d) any interest
4 required to be paid a provider under Section 368a shall not
5 accrue until after 30 days of an arbitrator's decision as
6 provided in subsection (d), but in no circumstances longer than
7 150 days from date the nonparticipating facility-based
8 provider billed for services rendered.
9 (h) Nothing in this Section shall be interpreted to change
10 the prudent layperson provisions with respect to emergency
11 services under the Managed Care Reform and Patient Rights Act.
12 (Source: P.A. 96-1523, eff. 6-1-11.)

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