

HB3251



103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB3251

Introduced 2/17/2023, by Rep. Robert "Bob" Rita

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.3a

Amends the Accident and Health Article of the Illinois Insurance Code. Provides that no health insurer may charge a patient out-of-network rates for neonatal care at any hospital.

LRB103 30989 BMS 57591 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.

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

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

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

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

- 1 (1) an emergency department of a hospital;
- 2 (2) a Freestanding Emergency Center;
- 3 (3) an ambulatory surgical treatment center as defined
- 4 in the Ambulatory Surgical Treatment Center Act; or
- 5 (4) with respect to emergency services described in
- 6 paragraph (2) of the definition of "emergency services", a
- 7 hospital.

8 "Nonparticipating provider" means, with respect to the

9 furnishing of an item or service under a policy of group or

10 individual health insurance coverage, any health care provider

11 who does not have a contractual relationship directly or

12 indirectly with a health insurance issuer in relation to the

13 coverage.

14 "Participating emergency facility" means any of the

15 following facilities that has a contractual relationship

16 directly or indirectly with a health insurance issuer offering

17 group or individual health insurance coverage setting forth

18 the terms and conditions on which a relevant health care

19 service is provided to an insured, beneficiary, or enrollee

20 under the coverage:

- 21 (1) an emergency department of a hospital;
- 22 (2) a Freestanding Emergency Center;
- 23 (3) an ambulatory surgical treatment center as defined
- 24 in the Ambulatory Surgical Treatment Center Act; or
- 25 (4) with respect to emergency services described in
- 26 paragraph (2) of the definition of "emergency services", a

1 hospital.

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

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

20 "Participating provider" means any health care provider
21 that has a contractual relationship directly or indirectly
22 with a health insurance issuer offering group or individual
23 health insurance coverage setting forth the terms and
24 conditions on which a relevant health care service is provided
25 to an insured, beneficiary, or enrollee under the coverage.

26 "Qualifying payment amount" has the meaning given to that

1 term in 42 U.S.C. 300gg-111(a)(3)(E) and the regulations
2 promulgated thereunder.

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

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

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

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

17 (b) Emergency services. When a beneficiary, insured, or
18 enrollee receives emergency services from a nonparticipating
19 provider or a nonparticipating emergency facility, the health
20 insurance issuer shall ensure that the beneficiary, insured,
21 or enrollee shall incur no greater out-of-pocket costs than
22 the beneficiary, insured, or enrollee would have incurred with
23 a participating provider or a participating emergency
24 facility. Any cost-sharing requirements shall be applied as
25 though the emergency services had been received from a
26 participating provider or a participating facility. Cost

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

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

18 (1) When a beneficiary, insured, or enrollee utilizes
19 a participating health care facility and, due to any
20 reason, covered ancillary services are provided by a
21 nonparticipating provider during or resulting from the
22 visit, the health insurance issuer shall ensure that the
23 beneficiary, insured, or enrollee shall incur no greater
24 out-of-pocket costs than the beneficiary, insured, or
25 enrollee would have incurred with a participating provider
26 for the ancillary services. Any cost-sharing requirements

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

22 (2) When a beneficiary, insured, or enrollee utilizes
23 a participating health care facility and receives
24 non-emergency covered health care services other than
25 those described in paragraph (1) of this subsection from a
26 nonparticipating provider during or resulting from the

1 visit, the health insurance issuer shall ensure that the
2 beneficiary, insured, or enrollee incurs no greater
3 out-of-pocket costs than the beneficiary, insured, or
4 enrollee would have incurred with a participating provider
5 unless the nonparticipating provider or the participating
6 health care facility on behalf of the nonparticipating
7 provider satisfies the notice and consent criteria
8 provided in 42 U.S.C. 300gg-132 and regulations
9 promulgated thereunder. If the notice and consent criteria
10 are not satisfied, then:

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

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

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

23 (c) Notwithstanding any other provision of this Code,
24 except when the notice and consent criteria are satisfied for
25 the situation in paragraph (2) of subsection (b-5), any
26 benefits a beneficiary, insured, or enrollee receives for

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

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

1 arbitration to determine payment for services provided on a
2 per-bill basis. The party requesting arbitration shall notify
3 the other party arbitration has been initiated and state its
4 final offer before arbitration. In response to this notice,
5 the nonrequesting party shall inform the requesting party of
6 its final offer before the arbitration occurs. Arbitration
7 shall be initiated by filing a request with the Department of
8 Insurance.

9 (e) The Department of Insurance shall publish a list of
10 approved arbitrators or entities that shall provide binding
11 arbitration. These arbitrators shall be American Arbitration
12 Association or American Health Lawyers Association trained
13 arbitrators. Both parties must agree on an arbitrator from the
14 Department of Insurance's or its approved entity's list of
15 arbitrators. If no agreement can be reached, then a list of 5
16 arbitrators shall be provided by the Department of Insurance
17 or the approved entity. From the list of 5 arbitrators, the
18 health insurance issuer can veto 2 arbitrators and the
19 provider or facility can veto 2 arbitrators. The remaining
20 arbitrator shall be the chosen arbitrator. This arbitration
21 shall consist of a review of the written submissions by both
22 parties. The arbitrator shall not establish a rebuttable
23 presumption that the qualifying payment amount should be the
24 total amount owed to the provider or facility by the
25 combination of the issuer and the insured, beneficiary, or
26 enrollee. Binding arbitration shall provide for a written

1 decision within 45 days after the request is filed with the
2 Department of Insurance. Both parties shall be bound by the
3 arbitrator's decision. The arbitrator's expenses and fees,
4 together with other expenses, not including attorney's fees,
5 incurred in the conduct of the arbitration, shall be paid as
6 provided in the decision.

7 (f) (Blank).

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

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

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

1 appointments.

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

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

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

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

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

15 (o) Notwithstanding any provisions to the contrary, no
16 health insurer may charge a patient out-of-network rates for
17 neonatal care at any hospital.

18 (Source: P.A. 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23.)