

SB3307



103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB3307

Introduced 2/7/2024, by Sen. Linda Holmes

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.3a

Amends the Illinois Insurance Code. In a provision concerning billing for services provided by nonparticipating providers or facilities, provides that when calculating an enrollee's contribution to the annual limitation on cost sharing set forth under specified federal law, a health insurance issuer or its subcontractors shall include expenditures for any item or health care service covered under the policy issued to the enrollee by the health insurance issuer or its subcontractors if that item or health care service is included within a category of essential health benefits and regardless of whether the health insurance issuer or its subcontractors classify that item or service as an essential health benefit. Effective immediately.

LRB103 35341 RPS 65405 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 (Text of Section before amendment by P.A. 103-440)

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

10 (a) As used in this Section:

11 "Ancillary services" means:

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

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

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

22 (4) items and services provided by other specialty
23 practitioners as the United States Secretary of Health and

1 Human Services specifies through rulemaking under 42
2 U.S.C. 300gg-132(b) (3);

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

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

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

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

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

25 "Emergency medical screening examination" has the meaning
26 ascribed to that term in Section 10 of the Managed Care Reform

1 and Patient Rights Act.

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

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

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

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

1 Systems Act.

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

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

5 (2) a hospital outpatient department;

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

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

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

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

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

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

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

1 relation to the coverage:

2 (1) an emergency department of a hospital;

3 (2) a Freestanding Emergency Center;

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

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

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

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

22 (1) an emergency department of a hospital;

23 (2) a Freestanding Emergency Center;

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

26 (4) with respect to emergency services described in

1 paragraph (2) of the definition of "emergency services", a
2 hospital.

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

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

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

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

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

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

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

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

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

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

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

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

1 for the ancillary services. Any cost-sharing requirements
2 shall be applied as though the ancillary services had been
3 received from a participating provider. Cost sharing shall
4 be calculated based on the recognized amount for the
5 ancillary services. If the cost sharing for the same item
6 or service furnished by a participating provider would
7 have been a flat-dollar copayment, that amount shall be
8 the cost-sharing amount unless the provider has billed a
9 lesser total amount. In no event shall the beneficiary,
10 insured, enrollee, or any group policyholder or plan
11 sponsor be liable to or billed by the health insurance
12 issuer, the nonparticipating provider, or the
13 participating health care facility for any amount beyond
14 the cost sharing calculated in accordance with this
15 subsection with respect to the ancillary services
16 delivered. In addition to ancillary services, the
17 requirements of this paragraph shall also apply with
18 respect to covered items or services furnished as a result
19 of unforeseen, urgent medical needs that arise at the time
20 an item or service is furnished, regardless of whether the
21 nonparticipating provider satisfied the notice and consent
22 criteria under paragraph (2) of this subsection. When
23 calculating an enrollee's contribution to the annual
24 limitation on cost sharing set forth in 42 U.S.C. 18022(c)
25 and 42 U.S.C. 300gg-6(b), a health insurance issuer or its
26 subcontractors shall include expenditures for any item or

1 health care service covered under the policy issued to the
2 enrollee by the health insurance issuer or its
3 subcontractors if that item or health care service is
4 included within a category of essential health benefits,
5 as described in 42 U.S.C. 18022(b)(1), and regardless of
6 whether the health insurance issuer or its subcontractors
7 classify that item or service as an essential health
8 benefit.

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

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

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

3 (C) in no event shall the beneficiary, insured,
4 enrollee, or any group policyholder or plan sponsor be
5 liable to or billed by the health insurance issuer,
6 the nonparticipating provider, or the participating
7 health care facility for any amount beyond the cost
8 sharing calculated in accordance with this subsection
9 with respect to the health care services delivered;
10 and -

11 (D) when calculating an enrollee's contribution to
12 the annual limitation on cost sharing set forth in 42
13 U.S.C. 18022(c) and 42 U.S.C. 300gg-6(b), a health
14 insurance issuer or its subcontractors shall include
15 expenditures for any item or health care service
16 covered under the policy issued to the enrollee by the
17 health insurance issuer or its subcontractors if that
18 item or health care service is included within a
19 category of essential health benefits, as described in
20 42 U.S.C. 18022(b)(1), and regardless of whether the
21 health insurance issuer or its subcontractors classify
22 that item or service as an essential health benefit.

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

16 (Text of Section after amendment by P.A. 103-440)

17 Sec. 356z.3a. Billing; emergency services;
18 nonparticipating providers.

19 (a) As used in this Section:

20 "Ancillary services" means:

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

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

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

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

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

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

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

26 "Emergency department of a hospital" means any hospital

1 department that provides emergency services, including a
2 hospital outpatient department.

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

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

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

11 (1) in general, an emergency medical screening
12 examination, including ancillary services routinely
13 available to the emergency department to evaluate such
14 emergency medical condition, and such further medical
15 examination and treatment as would be required to
16 stabilize the patient regardless of the department of the
17 hospital or other facility in which such further
18 examination or treatment is furnished; or

19 (2) additional items and services for which benefits
20 are provided or covered under the coverage and that are
21 furnished by a nonparticipating provider or
22 nonparticipating emergency facility regardless of the
23 department of the hospital or other facility in which such
24 items are furnished after the insured, beneficiary, or
25 enrollee is stabilized and as part of outpatient
26 observation or an inpatient or outpatient stay with

1 respect to the visit in which the services described in
2 paragraph (1) are furnished. Services after stabilization
3 cease to be emergency services only when all the
4 conditions of 42 U.S.C. 300gg-111(a)(3)(C)(ii)(II) and
5 regulations thereunder are met.

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

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

- 11 (1) a hospital as defined in 42 U.S.C. 1395x(e);
- 12 (2) a hospital outpatient department;
- 13 (3) a critical access hospital certified under 42
14 U.S.C. 1395i-4(e);
- 15 (4) an ambulatory surgical treatment center as defined
16 in the Ambulatory Surgical Treatment Center Act; or
- 17 (5) any recipient of a license under the Hospital
18 Licensing Act that is not otherwise described in this
19 definition.

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

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

26 "Health insurance issuer" has the meaning ascribed to that

1 term in Section 5 of the Illinois Health Insurance Portability
2 and Accountability Act.

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

9 (1) an emergency department of a hospital;

10 (2) a Freestanding Emergency Center;

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

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

16 "Nonparticipating provider" means, with respect to the
17 furnishing of an item or service under a policy of group or
18 individual health insurance coverage, any health care provider
19 who does not have a contractual relationship directly or
20 indirectly with a health insurance issuer in relation to the
21 coverage.

22 "Participating emergency facility" means any of the
23 following facilities that has a contractual relationship
24 directly or indirectly with a health insurance issuer offering
25 group or individual health insurance coverage setting forth
26 the terms and conditions on which a relevant health care

1 service is provided to an insured, beneficiary, or enrollee
2 under the coverage:

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

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

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

1 definition and is limited to the parties to the agreement.

2 "Participating provider" means any health care provider
3 that has a contractual relationship directly or indirectly
4 with a health insurance issuer offering group or individual
5 health insurance coverage setting forth the terms and
6 conditions on which a relevant health care service is provided
7 to an insured, beneficiary, or enrollee under the coverage.

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

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

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

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

18 "Visit" means, with respect to health care services
19 furnished to an individual at a health care facility, health
20 care services furnished by a provider at the facility, as well
21 as equipment, devices, telehealth services, imaging services,
22 laboratory services, and preoperative and postoperative
23 services regardless of whether the provider furnishing such
24 services is at the facility.

25 (b) Emergency services. When a beneficiary, insured, or
26 enrollee receives emergency services from a nonparticipating

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

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

26 (1) When a beneficiary, insured, or enrollee utilizes

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

1 an item or service is furnished, regardless of whether the
2 nonparticipating provider satisfied the notice and consent
3 criteria under paragraph (2) of this subsection. When
4 calculating an enrollee's contribution to the annual
5 limitation on cost sharing set forth in 42 U.S.C. 18022(c)
6 and 42 U.S.C. 300gg-6(b), a health insurance issuer or its
7 subcontractors shall include expenditures for any item or
8 health care service covered under the policy issued to the
9 enrollee by the health insurance issuer or its
10 subcontractors if that item or health care service is
11 included within a category of essential health benefits,
12 as described in 42 U.S.C. 18022(b)(1), and regardless of
13 whether the health insurance issuer or its subcontractors
14 classify that item or service as an essential health
15 benefit.

16 (2) When a beneficiary, insured, or enrollee utilizes
17 a participating health care facility and receives
18 non-emergency covered health care services other than
19 those described in paragraph (1) of this subsection from a
20 nonparticipating provider during or resulting from the
21 visit, the health insurance issuer shall ensure that the
22 beneficiary, insured, or enrollee incurs no greater
23 out-of-pocket costs than the beneficiary, insured, or
24 enrollee would have incurred with a participating provider
25 unless the nonparticipating provider or the participating
26 health care facility on behalf of the nonparticipating

1 provider satisfies the notice and consent criteria
2 provided in 42 U.S.C. 300gg-132 and regulations
3 promulgated thereunder. If the notice and consent criteria
4 are not satisfied, then:

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

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

10 (C) in no event shall the beneficiary, insured,
11 enrollee, or any group policyholder or plan sponsor be
12 liable to or billed by the health insurance issuer,
13 the nonparticipating provider, or the participating
14 health care facility for any amount beyond the cost
15 sharing calculated in accordance with this subsection
16 with respect to the health care services delivered;
17 and-

18 (D) when calculating an enrollee's contribution to
19 the annual limitation on cost sharing set forth in 42
20 U.S.C. 18022(c) and 42 U.S.C. 300gg-6(b), a health
21 insurance issuer or its subcontractors shall include
22 expenditures for any item or health care service
23 covered under the policy issued to the enrollee by the
24 health insurance issuer or its subcontractors if that
25 item or health care service is included within a
26 category of essential health benefits, as described in

1 42 U.S.C. 18022(b)(1), and regardless of whether the
2 health insurance issuer or its subcontractors classify
3 that item or service as an essential health benefit.

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

19 (d) For bills assigned under subsection (c), the
20 nonparticipating provider or the facility may bill the health
21 insurance issuer for the services rendered, and the health
22 insurance issuer may pay the billed amount or attempt to
23 negotiate reimbursement with the nonparticipating provider or
24 the facility. Within 30 calendar days after the provider or
25 facility transmits the bill to the health insurance issuer,
26 the issuer shall send an initial payment or notice of denial of

1 payment with the written explanation of benefits to the
2 provider or facility. If attempts to negotiate reimbursement
3 for services provided by a nonparticipating provider do not
4 result in a resolution of the payment dispute within 30 days
5 after receipt of written explanation of benefits by the health
6 insurance issuer, then the health insurance issuer or
7 nonparticipating provider or the facility may initiate binding
8 arbitration to determine payment for services provided on a
9 per-bill or batched-bill basis, in accordance with Section
10 300gg-111 of the Public Health Service Act and the regulations
11 promulgated thereunder. The party requesting arbitration shall
12 notify the other party arbitration has been initiated and
13 state its final offer before arbitration. In response to this
14 notice, the nonrequesting party shall inform the requesting
15 party of its final offer before the arbitration occurs.
16 Arbitration shall be initiated by filing a request with the
17 Department of Insurance.

18 (e) The Department of Insurance shall publish a list of
19 approved arbitrators or entities that shall provide binding
20 arbitration. These arbitrators shall be American Arbitration
21 Association or American Health Lawyers Association trained
22 arbitrators. Both parties must agree on an arbitrator from the
23 Department of Insurance's or its approved entity's list of
24 arbitrators. If no agreement can be reached, then a list of 5
25 arbitrators shall be provided by the Department of Insurance
26 or the approved entity. From the list of 5 arbitrators, the

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

16 (f) (Blank).

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

1 than 150 days from the date the nonparticipating
2 facility-based provider billed for services rendered.

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

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

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

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

1 from imposing requirements on the participating provider,
2 participating emergency facility, or participating health care
3 facility relating to the referral of covered individuals to
4 nonparticipating providers.

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

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

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

24 (Source: P.A. 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23;
25 103-440, eff. 1-1-24.)

1 Section 95. No acceleration or delay. Where this Act makes
2 changes in a statute that is represented in this Act by text
3 that is not yet or no longer in effect (for example, a Section
4 represented by multiple versions), the use of that text does
5 not accelerate or delay the taking effect of (i) the changes
6 made by this Act or (ii) provisions derived from any other
7 Public Act.

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