HB4679

LRB10017738SMS32911b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB4679

by Rep. Justin Slaughter

SYNOPSIS AS INTRODUCED:

215 ILCS 5/355.5 new

Amends the Illinois Insurance Code. Defines "surprise bill" to mean a bill for health care services received by certain out-of-network providers in which the enrollee did not knowingly elect to obtain those services from an out-of-network provider. Provides that a carrier shall require an enrollee to pay only certain expenses of a surprise bill that would be imposed for health care services if the services were rendered by a network provider. Provides for reimbursement to the out-of-network provider or enrollee at the average network rate, unless the carrier and out-of-network provider agree otherwise. Provides that if a carrier has an inadequate network, as determined by the Director of Insurance, the carrier shall ensure that the enrollee obtains covered service at no greater cost to the enrollee than if the service was obtained from a network provider or make other arrangements acceptable to the Director.

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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 adding Section 355.5 as follows:

(215 ILCS 5/355.5 new)

Sec. 355.5. Protection from surprise bills.

(a) As used in this Section:

"Carrier" means:

(1) an insurance company authorized to transact business in accordance with this Code to provide health insurance;

(2) a health maintenance organization as defined in the Health Maintenance Organization Act;

(3) a preferred provider organization;

(4) a fraternal benefit society;

(5) a nonprofit hospital or medical service organization or health plan;

(6) a multiple-employer welfare arrangement;

(7) a self-insured employer subject to State regulation; or

(8) notwithstanding any other provision of this Code, an entity offering coverage in this State that is subject

to the requirements of the federal Patient Protection and Affordable Care Act.

"Carrier" does not include an employer exempted from the applicability of this Code under the federal Employee Retirement Income Security Act of 1974.

"Enrollee" means an individual who is enrolled in a health plan or a managed care plan.

"Health plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan, other than a plan that provides only accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care, or other limited benefit coverage not subject to the requirements of the federal Patient Protection and Affordable Care Act. A plan that is subject to the requirements of the federal Patient Protection and Affordable Care Act and offered in this State by a carrier, including, but not limited to, a qualified health plan offered on an American Health Benefit Exchange or a SHOP Exchange established pursuant to the federal Patient Protection and Affordable Care Act, is a health plan for purposes of this Section.

"Provider" means a practitioner or facility licensed, accredited, or certified to perform specified health care services consistent with State law.

"Surprise bill" means a bill for health care services, other than emergency services, received by an enrollee for

covered services rendered by an out-of-network provider, when such services were rendered by that out-of-network provider at a network provider, during a service or procedure performed by a network provider, or during a service or procedure previously approved or authorized by the carrier and the enrollee did not knowingly elect to obtain such services from that out-of-network provider. "Surprise bill" does not include a bill for health care services received by an enrollee when a network provider was available to render the services and the enrollee knowingly elected to obtain the services from another provider who was an out-of-network provider.

(b) With respect to a surprise bill:

(1) a carrier shall require an enrollee to pay only the applicable coinsurance, copayment, deductible, or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a network provider;

(2) a carrier shall reimburse the out-of-network provider or enrollee, as applicable, for health care services rendered at the average network rate under the enrollee's health care plan as payment in full, unless the carrier and out-of-network provider agree otherwise; and

(3) notwithstanding paragraph (2), if a carrier has an inadequate network, as determined by the Director, the carrier shall ensure that the enrollee obtains the covered service at no greater cost to the enrollee than if the

service was obtained from a network provider or shall make other arrangements acceptable to the Director.