



## 103RD GENERAL ASSEMBLY

### State of Illinois

2023 and 2024

HB4931

Introduced 2/7/2024, by Rep. Margaret Croke

#### 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 35342 RPS 65406 b

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;

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12 in the Ambulatory Surgical Treatment Center Act; or

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19 who does not have a contractual relationship directly or  
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21 coverage.

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23 following facilities that has a contractual relationship  
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26 the terms and conditions on which a relevant health care

1 service is provided to an insured, beneficiary, or enrollee  
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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  
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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.