SB3378

LRB09618501RPM33882b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

SB3378

Introduced 2/10/2010, by Sen. William R. Haine

SYNOPSIS AS INTRODUCED:

215 ILCS 5/370u new
215 ILCS 5/370v new

Amends the Illinois Insurance Code. Provides that every health insurer and health plan that provides incentives for insureds to seek services from a specific provider network must pay for out-of-network health care provided by out-of-network providers pursuant to the provisions concerning out-of-network providers. Sets forth the conditions under which an insured who utilizes an out-of-network provider shall not be charged a greater cost than if the service had been provided by a network provider. Provides that prior to the provision of any medical services by an out-of-network provider, the out-of-network provider shall give a written notice to the patient. Sets forth the circumstances under which a network hospital may enter into an exclusive arrangement with a provider or a group of providers with regard to the provision of certain medical services provided at a network hospital. Makes other changes.

LRB096 18501 RPM 33882 b

A BILL FOR

AN ACT concerning insurance.

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

Section 5. The Illinois Insurance Code is amended by adding Sections 370u and 370v as follows:

(215 ILCS 5/370u new)

Sec. 370u. Out-of-network health care provider.

(a) Every health insurer and health plan that provides incentives for insureds, beneficiaries, or enrollees to seek services from a specific provider network must pay for out-of-network health care provided by out-of-network providers pursuant to this Section.

(b) An insured, beneficiary, or enrollee who utilizes an out-of-network provider with whom the insured, beneficiary, or enrollee does not have a provider-patient relationship shall be provided a covered service at no greater cost to the insured, beneficiary, or enrollee than if the service had been provided by a network provider if:

(1) a network hospital is utilized;

(2) the insurer or health plan has been contacted in advance by the network hospital or the patient, beneficiary, or enrollee regarding the services to be provided; and

(3) due to any reason, in-network services are unavailable.

(c) The insurer or plan shall pay the out-of-network provider providing services in the network hospital the lesser of the actual charged amount or usual and customary amount, less any cost sharing that is the responsibility of the insured, beneficiary, or enrollee for similar in-network services.

(d) Prior to the provision of any medical services by an out-of-network provider, a notice from the out-of-network provider to the patient or prospective patient shall be given and shall include:

(1) a written good faith estimate of the provider's reasonably anticipated charges;

(2) a written statement of the provider's billing policies and practices; and

(3) a written statement of the business names of all insurers and health plans with which the provider participates and is under contract and from whom the provider accepts reimbursements as payment in full after payment by the insured, beneficiary, or enrollee of any deductibles, copayments, or coinsurance pursuant to the insured's, beneficiary's, or enrollee's contract with the insurer or health plan.

A network hospital shall require the out-of-network provider to obtain the patient's or a prospective patient's

signature acknowledging receipt of the notice prior to the provision of medical services. A copy of the signed acknowledgement shall be kept in the patient's file.

(e) Except for applicable copayments, deductibles, or coinsurance responsibilities of the insured or enrollee, a healthcare provider shall not bill or otherwise attempt to recover from the insured or enrollee the difference between the healthcare provider's charge and the amount paid by the insurer or plan as provided in this Section.

(f) This Section shall apply only to nonemergency services.

(215 ILCS 5/370v new)

Sec. 370v. Exclusive provider agreements. A network hospital shall not enter into an exclusive arrangement with a provider or a group of providers with regard to the provision of certain medical services provided at the network hospital unless:

(1) the provider or group of providers agrees to contract with an insurer or health plan that has contracted with the network hospital; or

(2) the provider or group of providers accepts as payment in full, after payment by the insured, beneficiary, or enrollee of any deductibles, copayments, or coinsurance pursuant to the insured's, beneficiary's, or enrollee's contract with the insurer or health plan, the usual and customary amount from the insurer or health plan.