SB0072

LRB09705652RPM45714b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

SB0072

Introduced 1/27/2011, by Sen. William R. Haine

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.3
215 ILCS 5/356z.3a new

Amends the Illinois Insurance Code. Makes changes to the provision concerning disclosure of limited benefits. Provides that when a beneficiary, insured, or enrollee utilizes a participating network hospital or a participating network ambulatory surgery center and, due to any reason, in network services for radiology, anesthesiology, pathology, emergency physician, or neonatology are unavailable and are provided by a nonparticipating facility-based physician or provider, the insurer or health plan shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating physician or provider for covered services. Sets forth provisions concerning written explanation of benefits, billing, assignment, negotiated reimbursement, arbitration, prudent laypersons, failure to make an offer of payment, and noncovered services.

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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 changing Section 356z.3 and by adding Section 356z.3a as follows:

(215 ILCS 5/356z.3)

Sec. 356z.3. Disclosure of limited benefit. An insurer that issues, delivers, amends, or renews an individual or group policy of accident and health insurance in this State after the effective date of this amendatory Act of the 92nd General Assembly and arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing

charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill as provided in Section 356z.3a of this Code. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.".

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 5/356z.3a new)

Sec. 356z.3a. Nonparticipating facility-based physicians and providers.

(a) For purposes of this Section only, "facility-based physician or provider" means a physician or other provider who provides radiology, anesthesiology, pathology, neonatology, or emergency department services to insureds, beneficiaries, or enrollees in a participating hospital or participating ambulatory surgical treatment center.

(b) When a beneficiary, insured, or enrollee utilizes a

participating network hospital or a participating network ambulatory surgery center and, due to any reason, in network services for radiology, anesthesiology, pathology, emergency physician, or neonatology are unavailable and are provided by a nonparticipating facility-based physician or provider, the insurer or health plan shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating physician or provider for covered services.

For the purposes of this Section, "out-of-pocket costs" means all costs paid by a beneficiary, insured, or enrollee to a participating or non-participating physician or provider, as applicable, for covered services including copayments, deductibles, and coinsurance amounts.

(c) If a beneficiary, insured, or enrollee agrees in writing, notwithstanding any other provision of this Code, then any benefits a beneficiary, insured, or enrollee receives for services under the situation described in subsection (b) are assigned to the nonparticipating facility-based physicians or providers. The insurer or health plan shall provide the nonparticipating physician or provider with a written explanation of benefits within 30 days after receipt of due proof of loss that specifies the applicable deductible, copayment, or coinsurance amounts owed by the insured, beneficiary, or enrollee. The nonparticipating facility-based

physician or provider shall not bill the beneficiary, insured, or enrollee, except for applicable deductible, copayment, or coinsurance amounts that would apply if the beneficiary, insured, or enrollee utilized a participating physician or provider for covered services. If a beneficiary, insured, or enrollee specifically rejects assignment under this Section in writing to the nonparticipating facility-based physician or provider, then the nonparticipating facility-based physician or provider may bill the beneficiary, insured, or enrollee for the services rendered.

(d) For bills assigned under subsection (c), the nonparticipating facility-based physician or provider may bill the insurer or health plan for the services rendered, and the insurer or health plan may pay the billed amount, minus any copayments, coinsurance, or deductibles, or attempt to negotiate reimbursement with the nonparticipating facility-based physician or provider. Payment shall be made directly to the nonparticipating facility-based physician or provider and, in the case of a negotiated payment, shall not be made without the written agreement of the nonparticipating facility-based physician or provider. If both parties agree on a reimbursement amount for a nonparticipating facility-based physician or provider, then the agreed upon amount shall be paid in full within 30 days after the agreement to the nonparticipating facility-based physician or provider. Any initial payment from an insurer or health plan without written

agreement from the nonparticipating facility-based physician or provider shall not waive the right to additional payment. If attempts to negotiate reimbursement for services provided by a nonparticipating facility-based physician or provider do not result in a resolution of the payment dispute within 30 days after receipt of written explanation of benefits from the insurer or health plan, then an insurer or health plan shall initiate binding arbitration to determine payment for services provided on a per bill basis no more than 45 days after sending the written explanation of benefits. Failure to file for arbitration shall require payment of the billed charges minus any copayment, deductible, or coinsurance amount. The insurer or health plan shall notify the nonparticipating facility-based physician or provider in writing that arbitration shall be initiated and state its final offer before arbitration. In response to this notice, the nonparticipating facility-based physician or provider shall inform the requesting party of its final offer before the arbitration occurs.

(e) Any payment dispute an insurer or health plan chooses to arbitrate shall be submitted for arbitration to the American Arbitration Association and be subject to its rules for the conduct of commercial arbitration. This arbitration shall consist solely of a review of the written submissions by both parties. An arbitrators written decision shall be provided to the parties within 45 days after the request is filed. Both

parties shall be bound by the arbitrator's decision. The arbitrator's expenses and fees, together with other expenses, not including attorney's fees, incurred in the conduct of the arbitration, shall be paid as provided in the decision.

(f) This Section does not apply to a beneficiary, insured, or enrollee who willfully chooses to access a nonparticipating facility-based physician or provider for health care services available through the insurer's or plan's network of participating physicians and providers. In these circumstances, the contractual requirements for nonparticipating facility-based physician or provider reimbursements shall apply.

(g) Section 368a of this Act shall not apply during the pendency of a decision under subsection (d) of this Section. Any interest required to be paid a provider under Section 368a shall not accrue until after 30 days of an arbitrator's decision as provided in subsection (d) of this Section, but in no circumstances longer than 150 days after date the nonparticipating facility-based physician or provider billed for services rendered.

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

(i) It shall be a violation of this Section for any insurer or health plan to make no offer of payment for any covered service rendered by a provider or fail to provide monetary

compensation for such service.

(j) Nothing in this Section shall apply to charges for a service by a nonparticipating facility-based physician or provider that are denied as a noncovered service under an explanation of benefits provided by an insurer or health plan.