

SB1658



98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

SB1658

Introduced 2/13/2013, by Sen. William R. Haine

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.3a

Amends the Illinois Insurance Code to provide that nothing in the provision concerning nonparticipating facility-based physicians and providers shall be interpreted to change the prudent layperson provisions with respect to emergency services under the Managed Care Reform and Patient Rights Act. Effective immediately.

LRB098 07934 RPM 38022 b

A BILL FOR

1 AN ACT concerning insurance.

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

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

15 (b) When a beneficiary, insured, or enrollee utilizes a
16 participating network hospital or a participating network
17 ambulatory surgery center and, due to any reason, in network
18 services for radiology, anesthesiology, pathology, emergency
19 physician, or neonatology are unavailable and are provided by a
20 nonparticipating facility-based physician or provider, the
21 insurer or health plan shall ensure that the beneficiary,
22 insured, or enrollee shall incur no greater out-of-pocket costs
23 than the beneficiary, insured, or enrollee would have incurred

1 with a participating physician or provider for covered
2 services.

3 (c) If a beneficiary, insured, or enrollee agrees in
4 writing, notwithstanding any other provision of this Code, any
5 benefits a beneficiary, insured, or enrollee receives for
6 services under the situation in subsection (b) are assigned to
7 the nonparticipating facility-based providers. The insurer or
8 health plan shall provide the nonparticipating provider with a
9 written explanation of benefits that specifies the proposed
10 reimbursement and the applicable deductible, copayment or
11 coinsurance amounts owed by the insured, beneficiary or
12 enrollee. The insurer or health plan shall pay any
13 reimbursement directly to the nonparticipating facility-based
14 provider. The nonparticipating facility-based physician or
15 provider shall not bill the beneficiary, insured, or enrollee,
16 except for applicable deductible, copayment, or coinsurance
17 amounts that would apply if the beneficiary, insured, or
18 enrollee utilized a participating physician or provider for
19 covered services. If a beneficiary, insured, or enrollee
20 specifically rejects assignment under this Section in writing
21 to the nonparticipating facility-based provider, then the
22 nonparticipating facility-based provider may bill the
23 beneficiary, insured, or enrollee for the services rendered.

24 (d) For bills assigned under subsection (c), the
25 nonparticipating facility-based provider may bill the insurer
26 or health plan for the services rendered, and the insurer or

1 health plan may pay the billed amount or attempt to negotiate
2 reimbursement with the nonparticipating facility-based
3 provider. If attempts to negotiate reimbursement for services
4 provided by a nonparticipating facility-based provider do not
5 result in a resolution of the payment dispute within 30 days
6 after receipt of written explanation of benefits by the insurer
7 or health plan, then an insurer or health plan or
8 nonparticipating facility-based physician or provider may
9 initiate binding arbitration to determine payment for services
10 provided on a per bill basis. The party requesting arbitration
11 shall notify the other party arbitration has been initiated and
12 state its final offer before arbitration. In response to this
13 notice, the nonrequesting party shall inform the requesting
14 party of its final offer before the arbitration occurs.
15 Arbitration shall be initiated by filing a request with the
16 Department of Insurance.

17 (e) The Department of Insurance shall publish a list of
18 approved arbitrators or entities that shall provide binding
19 arbitration. These arbitrators shall be American Arbitration
20 Association or American Health Lawyers Association trained
21 arbitrators. Both parties must agree on an arbitrator from the
22 Department of Insurance's list of arbitrators. If no agreement
23 can be reached, then a list of 5 arbitrators shall be provided
24 by the Department of Insurance. From the list of 5 arbitrators,
25 the insurer can veto 2 arbitrators and the provider can veto 2
26 arbitrators. The remaining arbitrator shall be the chosen

1 arbitrator. This arbitration shall consist of a review of the
2 written submissions by both parties. Binding arbitration shall
3 provide for a written decision within 45 days after the request
4 is filed with the Department of Insurance. Both parties shall
5 be bound by the arbitrator's decision. The arbitrator's
6 expenses and fees, together with other expenses, not including
7 attorney's fees, incurred in the conduct of the arbitration,
8 shall be paid as provided in the decision.

9 (f) This Section 356z.3a does not apply to a beneficiary,
10 insured, or enrollee who willfully chooses to access a
11 nonparticipating facility-based physician or provider for
12 health care services available through the insurer's or plan's
13 network of participating physicians and providers. In these
14 circumstances, the contractual requirements for
15 nonparticipating facility-based provider reimbursements will
16 apply.

17 (g) Section 368a of this Act shall not apply during the
18 pendency of a decision under subsection (d) any interest
19 required to be paid a provider under Section 368a shall not
20 accrue until after 30 days of an arbitrator's decision as
21 provided in subsection (d), but in no circumstances longer than
22 150 days from date the nonparticipating facility-based
23 provider billed for services rendered.

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

1 (Source: P.A. 96-1523, eff. 6-1-11.)

2 Section 99. Effective date. This Act takes effect upon
3 becoming law.