SB1658 Enrolled

1 AN ACT concerning insurance.

2 Be it enacted by the People of the State of Illinois, 3 represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by
changing Section 356z.3a as follows:

6 (215 ILCS 5/356z.3a)

Sec. 356z.3a. Nonparticipating facility-based physiciansand providers.

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

(b) When a beneficiary, insured, or enrollee utilizes a 15 participating network hospital or a participating network 16 17 ambulatory surgery center and, due to any reason, in network services for radiology, anesthesiology, pathology, emergency 18 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 than the beneficiary, insured, or enrollee would have incurred 23

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

If a beneficiary, insured, or enrollee agrees in 3 (C) writing, notwithstanding any other provision of this Code, any 4 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 health plan shall or 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 enrollee utilized a participating physician or provider for 18 covered services. If a beneficiary, insured, or enrollee 19 20 specifically rejects assignment under this Section in writing to the nonparticipating facility-based provider, then the 21 22 nonparticipating facility-based provider bill mav the 23 beneficiary, insured, or enrollee for the services rendered.

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

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health plan may pay the billed amount or attempt to negotiate 1 2 reimbursement with the nonparticipating facility-based provider. If attempts to negotiate reimbursement for services 3 provided by a nonparticipating facility-based provider do not 4 5 result in a resolution of the payment dispute within 30 days 6 after receipt of written explanation of benefits by the insurer 7 health plan, then an insurer or health plan or 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 party of its final offer before the arbitration occurs. 14 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 approved arbitrators or entities that shall provide binding 18 arbitration. These arbitrators shall be American Arbitration 19 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 by the Department of Insurance. From the list of 5 arbitrators, 24 25 the insurer can veto 2 arbitrators and the provider can veto 2 26 arbitrators. The remaining arbitrator shall be the chosen

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arbitrator. This arbitration shall consist of a review of the 1 2 written submissions by both parties. Binding arbitration shall provide for a written decision within 45 days after the request 3 is filed with the Department of Insurance. Both parties shall 4 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 contractual 14 circumstances. the requirements for 15 nonparticipating facility-based provider reimbursements will 16 apply.

(g) Section 368a of this Act shall not apply during the pendency of a decision under subsection (d) 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), but in no circumstances longer than 150 days from date the nonparticipating facility-based provider billed for services rendered.

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

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

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