Illinois Health and Hospital Association

June 27, 2022

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

SUBJECT: Public Act 102-0901 State Surprise Billing Legislation

Public Act 102-0901/HB 4703, introduced by Rep. Bob Morgan and signed into law by the Governor on May 25, amends Illinois' surprise billing law to better align with the Federal No Surprises Act (NSA). The state law is effective July 1, 2022, with certain provisions effective Jan. 1, 2023. IHA's memos on the NSA can be found on our price transparency page.

Changes to the Illinois Insurance Code (effective July 1, 2022 unless otherwise noted)

Public Act 102-0901 amends the Illinois Insurance Code to mirror NSA protections that ban balance or surprise billing in certain situations. These protections are specific to insured individuals and fall into two categories: emergency services, and non-emergency services at participating health care facilities.

Emergency Services
Insured individuals that receive emergency services from a nonparticipating provider or at a nonparticipating emergency facility must be held to in-network cost-sharing requirements. Cost-sharing will be calculated based on the recognized amount (the lesser of the total billed amount or the qualifying payment amount defined below); or, if cost-sharing is typically a flat-dollar copayment, incurred cost-sharing shall be that amount unless the total billed amount is less than the flat-dollar copayment. Cost-sharing counts toward any deductible or out-of-pocket maximum applicable to in-network coverage.

The individual may not be billed beyond this cost-sharing amount by the health insurance issuer, nonparticipating provider or nonparticipating emergency facility. Any administrative requirements or limitations shall be no greater than those applicable to emergency services received from a participating provider or participating emergency facility.

Unless Notice and Consent criteria are satisfied (more information below), no referral requirement or any other provision contained in the policy or certificate of coverage may deny coverage, reduce benefits, or otherwise circumvent these billing protections for services that would have been covered with a participating provider.

Non-Emergency Services at Participating Health Care Facilities
Insured individuals receiving a covered ancillary service at a participating health care facility from a nonparticipating provider during or resulting from a non-emergency visit must be held

to in-network cost-sharing requirements. Cost-sharing will be calculated based on the recognized amount (the lesser of the total billed amount or the qualifying payment amount defined below); or, if cost-sharing it typically a flat-dollar copayment, incurred cost-sharing shall be that amount unless the total billed amount is less than the copayment. Cost-sharing will count toward any deductible or out-of-pocket maximum applicable to in-network coverage.

The individual may not be billed beyond this cost-sharing amount by the health insurance issuer, nonparticipating provider or nonparticipating emergency facility. Any administrative requirements or limitations shall be no greater than those applicable to emergency services received from a participating provider or participating emergency facility.

In addition to ancillary services, these balance billing protections also apply to covered items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the Notice and Consent criteria.

Unless Notice and Consent criteria are satisfied (more information below), no referral requirement or any other provision contained in the policy or certificate of coverage may deny coverage, reduce benefits, or otherwise circumvent the requirements outlined here for services that would have been covered with a participating provider.

Effective Jan. 1, 2023, these protections apply to limited benefit plans. Under the Illinois Insurance Code, non-participating providers may balance-bill patients with limited benefit plans up to billed charges after the plan pays its portion of the bill. However, Public Act 102-0901 amends Illinois Insurance Code Section 356z.3, excepting certain situations from balance billing allowances.

Specifically, if the patient receives covered services at a participating health care facility from a non-participating provider, non-participating providers may not balance bill the patient for ancillary services, unforeseen emergency items or services, or items or services when the facility or non-participating provider fails to satisfy the Notice and Consent criteria specified under Section 356z.3a of the Illinois Insurance Code. This provision is effective Jan. 1, 2023.

Notice and Consent

In certain limited instances, as outlined by the NSA and related regulations, nonparticipating providers may balance bill for typically protected items or services. To do this, the nonparticipating provider, or a participating facility acting on behalf of the provider, must fulfill the Notice and Consent criteria outlined in 42 U.S.C. 300gg-132 and related regulations. If the Notice and Consent criteria are not satisfied, then:

- Cost-sharing should reflect the amount owed as though the health care services were furnished by a participating provider, based on the recognized amount; and

- In no event shall the beneficiary, insured, enrollee, or any group policyholder or plan sponsor be liable to or billed by the health insurance issuer, the nonparticipating provider, or the participating health care facility for any amount beyond said cost-sharing amount.

For more information on the Notice and Consent process, see IHA's summary here.

Payment Process
In cases where the Notice and Consent process does not apply, Public Act 102-0901 amends the Illinois Insurance Code to outline the process payers and providers should use to agree to a payment amount. This process mirrors the process outlined by the NSA.

Upon receiving a provider or facility bill for items and services rendered, the payer must provide the nonparticipating provider or the facility with a written explanation of benefits. This explanation must specify the proposed reimbursement amount and the applicable deductible, copayment or coinsurance amounts owed by the patient. Any payment owed to the provider outside of the patient's cost-sharing obligation must go directly from the payer to the provider or facility.

The payer may pay the billed amount, or attempt to negotiate reimbursement with the nonparticipating provider or the facility. The payer has 30 calendar days from when the provider or facility transmits the bill, to make this initial payment or provide a notice of denial of payment. This must include a written explanation of benefits to the provider or facility. Should the provider or facility not accept the initial payment or notice of denial, the parties have 30 days to negotiate reimbursement. If negotiations are unsuccessful, either the payer or provider/facility may initiate binding arbitration to determine the final payment amount. **Health plans overseen by the Illinois Department of Insurance (IDOI) should proceed with the State arbitration process. Self-funded group health plans should go through the Federal Independent Dispute Resolution process.** For more information on the Federal Independent Dispute Resolution process, see IHA's summary here and updated guidance for disputing parties here.

Under the State process, the party requesting arbitration must notify the other party that arbitration has been initiated and state its final offer before arbitration. In response to this notice, the non-requesting party shall inform the requesting party of its final offer before arbitration occurs. Arbitration is initiated by filing a request with IDOI, and consists of a review of the written submissions by both parties. **Importantly, the arbiter is not allowed to assume that the qualifying payment amount, defined below, is the correct total payment amount owed to the provider or facility**.

The arbiter must provide a written decision within 45 days after the arbitration request is filed with IDOI, and the decision is binding. Any expenses and fees, not including attorney's fees, will be paid as stipulated in the written decision.

Changes to the Network Adequacy and Transparency Act (effective July 1, 2022)

The Network Adequacy and Transparency Act was amended to stipulate that an individual enrolled in a health plan receiving care at a participating health care facility will not be required to search for participating providers when it comes to items and services protected from balance billing and described in Section 356z.3a of the Illinois Insurance Code. The only exception is when Notice and Consent criteria are met.

Changes to the Health Maintenance Organization Act (effective Jan. 1, 2023)

Under the Health Maintenance Organization Act, non-participating providers may balance-bill patients with a point-of-service health plan up to billed charges, after the plan pays its portion of the bill. However, Public Act 102-0901 amends section 4.5-1, excepting certain situations, from balance billing allowances. Specifically, if the patient receives covered services at a participating health care facility from a non-participating provider, non-participating providers may not balance bill the patient for ancillary services, unforeseen emergency items or services, or items or services for which the facility or non-participating provider failed to satisfy the Notice and Consent criteria specified under Section 356z.3a of the Illinois Insurance Code.

Changes to the Managed Care Reform and Patient Rights Act (effective July 1, 2022)

Public Act 102-0901 amends the Managed Care Reform and Patient Rights Act, stipulating that prior authorization or approval by the plan is not required for post-stabilization services that are protected under Section 356z.3a of the Illinois Insurance Code.

Definitions

Exclusions: These protections do not apply to air ambulance or ground ambulance services. Additionally, these protections do not apply to any policy of excepted benefits or to short-term, limited-duration health insurance coverage.

Ancillary Services:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;

- Diagnostic services, including radiology and laboratory services, except for advanced diagnostic laboratory tests as identified by the U.S. Secretary of Health and Human Services (HHS);
- Items and services provided by other specialty practitioners as determined by the U.S. Secretary of HHS; and
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish the item or service at the facility.

Emergency Services: An emergency medical screening examination, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition, and additional medical examination and treatment as required to stabilize the patient, regardless of the department of the hospital or facility in which such further examination or treatment is furnished. This definition includes post-stabilization services as part of the outpatient observation or an inpatient or outpatient stay with respect to the emergency visit and services referenced above. Post-stabilization services cease to be emergency services only when all of the conditions of 42 USC 300gg-111(a)(3)(C)(ii)(II) and accompanying regulations are met.

Health Care Facility: A hospital (defined by 42 USC 1395x(e)); a hospital outpatient department; a critical access hospital (certified under 42 USC 1395i-4(e)); an ambulatory surgical treatment center (defined by Ambulatory Surgical Treatment Center Act); and any recipient of a license under the Hospital Licensing Act not otherwise described.

Emergency Facility: An emergency department of a hospital; a Freestanding Emergency Center; an ambulatory surgical treatment center (as defined by the Ambulatory Surgical Treatment Center Act); or a hospital furnishing emergency services.

Participating (Facility or Provider): A direct or indirect contractual relationship between a facility or provider and a health insurance issuer offering a group or individual health insurance policy that covers a relevant health care service provided to an insured, beneficiary or enrollee under that policy.

Nonparticipating (Facility or Provider): Lack of a direct or indirect contractual relationship between a facility or provider and a health insurance issuer offering a group or individual health insurance policy covering a relevant health care service provided to an insured, beneficiary or enrollee.

Qualifying Payment Amount: The median of contracted rates recognized by the plan or issuer as the total maximum payment, including cost-sharing and the amount paid by the plan or issuer, under such plans or coverage on Jan. 31, 2019 for the same or similar item or service, provided by a provider in the same or similar specialty, and provided in the geographic region in which

the item or service is furnished, increased by the percentage increase in the consumer price index for all urban consumers. See 42 USC 300gg-111(a)(3)(E) for additional details.

Recognized Amount: The lesser of the amount initially billed by the provider or the qualifying payment amount.

For more information on the NSA, please see IHA's Price Transparency website.

Please send questions to Cassie Yarbrough, Senior Director, Medicare policy at cyarbrough@team-iha.org.