Illinois Department of Insurance

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Governor

DANA POPISH SEVERINGHAUS
Director

TO: All Companies Writing Accident and Health Insurance and Managed Care Plans in Illinois

FROM: Dana Popish Severinghaus, Director dps

DATE: August 10, 2022

RE: Company Bulletin 2022-13 - Expanded State Enforcement of the Federal No Surprises Act

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This Company Bulletin supersedes Company Bulletin 2022-03 due to the passage of Public Act 102-0901, effective July 1, 2022.[1] This Company Bulletin primarily explains certain out of network health care service requirements for health insurance issuers that the Illinois Department of Insurance ("Department") now enforces.

Public Act 102-0901 amends the Illinois Insurance Code ("Code") and other insurance-related laws to fill gaps in Illinois' protections against balance billing and prior authorization so that Illinois law aligns with Section 2799A-1 of the Public Health Service Act, as amended by the federal No Surprises Act ("NSA") (Pub. L. 116-260, div. BB, tit. 1). The scope of services, providers, and facilities subject to Section 356z.3a has expanded under Public Act 102-0901. Please review the statute and incorporated federal provisions for details.

For all plans under the Director's jurisdiction that are major medical plans utilizing a preferred provider organization ("PPO"), health maintenance organization ("HMO") health care plans, or voluntary health services plans ("VHSP") comprising comprehensive health insurance coverage, Section 356z.3a of the Code now regulates billing and coverage for emergency services furnished by nonparticipating providers and/or nonparticipating emergency facilities. Under certain circumstances, post-stabilization services are considered emergency services under Section 356z.3a.

For major medical plans with a PPO, HMO health care plans, and comprehensive VHSPs, Section 356z.3a also regulates billing and coverage for non-emergency services furnished by nonparticipating providers at participating health care facilities when the services:

A. are ancillary services, as defined in the statute; or

B. are covered services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished; or

C. are furnished any time that the nonparticipating provider (or a participating health care facility acting on their behalf) fails to satisfy the notice and consent criteria established under 42 U.S.C. § 300gg-132.

The notice and consent criteria do not apply to nor may obtaining notice and consent be used to justify balance billing, or otherwise deviating from the requirements of Section 356z.3a, when the services are emergency services, ancillary services, or any covered service furnished as a result of unforeseen, urgent medical needs arising at the time an item or service is furnished.

[1] Changes to Section 356z.3 of the Illinois Insurance Code and Section 4.5-1 of the Health Maintenance Organization Act take effect January 1, 2023.

I. Determining Cost-Sharing Based on the "Recognized Amount"

For purposes of determining the insured, beneficiary, or enrollee's cost-sharing under a major medical plan with a PPO, an HMO health care plan, or a comprehensive VHSP, Section 356z.3a of the Code defines "recognized amount" as "the lesser of the amount initially billed by the provider or the qualifying payment amount." The definition of "qualifying payment amount" incorporates by reference the meaning given to that term in 42 U.S.C. § 300gg-111(a)(3)(E) and regulations promulgated thereunder. The qualifying payment amount often, but not always, will depend in part on the median of the contracted rates recognized by the issuer within all of the issuer's plans in the same insurance market for the same or similar service provided in the same geographic region by the same provider or facility type. Federal regulations specify the exact requirements to calculate the qualifying payment amount under any given circumstance at 45 C.F.R. § 149.140. This provision applies in Illinois. Cost-sharing in all situations subject to Section 356z.3a is based on and applied toward in-network requirements and limitations in the enrollee's coverage.

For a particular billing situation subject to Section 356z.3a, if the covered individual has not met an in-network deductible applicable to the covered item or service furnished, then the covered individual is responsible for the entire recognized amount or that portion of the recognized amount until the in-network deductible is met. Once the in-network deductible has been met, or if no in-network deductible applies to the item or service furnished, then the in-network flat-dollar copay or percentage coinsurance for the item or service, if any, shall be applied against the recognized amount (or any remainder thereof, if payment of the entire recognized amount would cause the covered individual to exceed the in-network deductible). This will determine the amount owed by the covered individual (or the remainder of the amount) until the in-network out-of-pocket maximum is reached. **Covered individuals are not liable to and shall not be billed** by the issuer, the nonparticipating provider, or the participating or nonparticipating provider or facility for amounts that exceed the cost-sharing requirements determined under Section 356z.3a(b) or (b-5), as applicable, regardless of the status of any dispute between the issuer and the provider or facility on the out-of-network rate.

II. Determining Total Amount Due to Provider - "Out of Network Rate"

Under the NSA, the total amount due from both the issuer and the covered individual combined to an out-of-network provider or facility for furnishing a covered item or service is the "out-of-network rate," which can differ from the "recognized amount." Section 356z.3a of the Code is a specified State law for the purpose of determining the out-of-network rate. For a major medical plan with a PPO, an HMO health care plan, or a comprehensive VHSP, Section 356z.3a provides that, initially, a nonparticipating provider may bill the health insurance issuer and the issuer may pay the billed amount or attempt to negotiate reimbursement. Within 30 calendar days after the provider transmits the bill to the issuer, the issuer must send an initial payment or notice of denial of payment with the written explanation of benefits to the provider. If attempts to negotiate reimbursement are not resolved within 30 days after receipt of written explanation of benefits, the issuer or the nonparticipating provider may initiate binding arbitration to determine payment. 215 ILCS 5/356z.3a(d).

For plans subject to the Code, the negotiation and arbitration provisions of Section 356z.3a apply rather than the federal independent dispute resolution ("IDR") process. Disputing parties should consult Company Bulletin 2011-07 for instructions on how to proceed with arbitration under Section 356z.3a. As provided in Company Bulletin 2011-07, the binding arbitration request **must** clearly state that it is being filed pursuant to 215 ILCS 5/356z.3a in order for the parties to avail themselves of the statute's benefits. Note that the American Health Lawyers Association ("AHLA") referred to in the statute (215 ILCS 5/356z.3a(e)) and in Company Bulletin 2011-07 is now known as the American Health Law Association (www.americanhealthlaw.org 1099 14th Street NW, Suite 925, Washington, DC 20005).

Additionally, parties filing a claim with either the AHLA or the American Arbitration Association ("AAA") should be aware that those entities require the use of a web-based electronic case management system when accessible. For AHLA, the system is located at https://drcases.americanhealthlaw.org/AppPages/Home.aspx. For the AAA, the system is located at https://www.adr.org/FileOnline. To start the 45-day statutory timeframe for the

arbitrator to issue the written decision, a party that files a claim through an electronic case management system must email a copy of their claim to doi.arbitrationrequest@illinois.gov after receiving confirmation of receipt by the case management system.

Also note that, unlike the IDR process outlined in initial federal rulemaking, the arbitrator in a State-regulated proceeding shall not establish a rebuttable presumption that the qualifying payment amount should be the total amount owed to the provider or facility by the combination of the issuer and the insured, beneficiary, or enrollee. 215 ILCS 5/356z.3a(e).

III. Post-Stabilization Services as Emergency Services

Under the NSA and Public Act 102-0901, post-stabilization services are sometimes considered "emergency services" for balance billing, cost-sharing, and prior authorization purposes even though they are not normally "emergency services" under the Managed Care Reform and Patient Rights Act.

A. Balance billing and cost-sharing protections for certain Post-Stabilization Services

The balance billing and cost-sharing protections in Section 356z.3a of the Code apply to post-stabilization services as emergency services when furnished by a nonparticipating provider or nonparticipating emergency facility, regardless of the department in which such items are furnished, as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the stabilizing emergency services are furnished. Pursuant to 45 C.F.R. § 149.410(b), covered services after stabilization cease to be emergency services **only** when **all** of the following are true:

1. The attending emergency physician or treating provider determines the individual is able to travel using nonmedical or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition;

2. The provider or facility satisfies the federal notice and consent criteria of 45 C.F.R. § 149.420(c)-(g), subject to further requirements under § 149.410(b)(2)(i) and (ii); and

3. The covered individual is in a condition to receive the information described above, as determined by the attending emergency physician or treating provider, and to provide informed consent; or informed consent is obtained from the individual's authorized representative, subject to further specifications under 45 C.F.R. § 149.410(b)(3) and applicable State law.

B. Prior authorization prohibited for certain Post-Stabilization Services

For plans subject to Section 70 of the Managed Care Reform and Patient Rights Act, prior authorization requirements are prohibited for post-stabilization services that constitute emergency services under Section 356z.3a. 215 ILCS 134/70(a-5). Only when post-stabilization services cease to be emergency services under the three criteria above may prior authorization requirements be imposed.

IV. Limitation on PPO-related Requirement to Search for In-Network Providers First and on HMO & VHSP Referral or Network Restrictions

PA 102-0901 codifies an exception to the search requirement under the Network Adequacy and Transparency Act (215 ILCS 124) to conform with the NSA. In addition to the existing protections for out-of-network emergency services under the NATA, a beneficiary cannot be required to make any effort to search for participating providers for non-emergency services before the service is covered at the in-network benefit level when both 1) the beneficiary receives care at a participating health care facility and 2) the balance billing protections in Section 356z.3a(b) or (b-5) of the Code apply to the situation. 215 ILCS 124/10(b)(6). Thus, for emergency services (including covered post-stabilization services described above), ancillary services, items or services furnished as a result of unforeseen, urgent medical needs that arise at the time another covered item or service is furnished, and instances when a provider fails to satisfy the notice and consent criteria, a beneficiary receiving care at a participating health care

facility cannot be required to search for participating providers before the service is covered at the in-network benefit level from an out-of-network provider with that facility. Only if the notice and consent criteria described in Section 356z.3a(b-5)(2) of the Code actually apply and are satisfied may the issuer impose a good faith effort search requirement under 215 ILCS 124/10(b)(6).

Similarly, HMOs and comprehensive VHSP issuers should take note that, notwithstanding any restrictions to participating providers or any referral requirements for out-of-network care that apply under other circumstances, for emergency services (including covered post-stabilization services described above), ancillary services, items or services furnished as a result of unforeseen, urgent medical needs that arise at the time another covered item or service is furnished, and instances when a provider fails to satisfy the notice and consent criteria, a beneficiary receiving services that would be covered from a participating provider must be covered at the in-network benefit level from an nonparticipating provider or nonparticipating emergency facility to the extent provided in Section 356z.3a(b) or (b-5) of the Code. 215 ILCS 5/356z.3a(k). Only if the notice and consent criteria described in Section 356z.3a(b-5)(2) actually apply and are satisfied may the issuer deny or limit coverage under usual HMO or VHSP restrictions to participating providers.

V. Policy Disclosure of Balance Billing Protections and Procedures

For a major medical plan with a PPO and for HMO point-of-service coverage issued, delivered, amended, or renewed on or after January 1, 2023, the disclosure of limited benefit contained in the policy form shall include new statutory language: "Non-participating providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill, except as provided in Section 356z.3a of the Illinois Insurance Code for covered services received at a participating health care facility from a nonparticipating provider that are: (a) ancillary services, (b) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is furnished, or (c) items or services received when the facility or the non-participating provider fails to satisfy the notice and consent criteria specified under Section 356z.3a." 215 ILCS 5/356z.3 and 215 ILCS 125/4.5-1(a)(7). All affected issuers must ensure that policy forms are filed with the Department with statutorily compliant language in time to issue the new language to insureds, beneficiaries, and enrollees. Nothing in this new requirement relieves issuers from otherwise applicable requirements to cover services from a nonparticipating provider at the in-network benefit level due to a network deficiency or as authorized from a referral by a primary care physician.

VI. Ground Ambulances and HMOs

For enrollees with HMO coverage, the consumer billing protection in the Health Maintenance Organization Act, 215 ILCS 125/4-15(b), related to ground ambulance services remains in effect without modification. The NSA has no provisions that apply.

The HMO Act provides: "Upon reasonable demand by a provider of emergency transportation by ambulance, a Health Maintenance Organization shall promptly pay to the provider, subject to coverage limitations stated in the contract or evidence of coverage, the charges for emergency transportation by ambulance provided to an enrollee in a health care plan arranged for by the Health Maintenance Organization. By accepting any such payment from the Health Maintenance Organization, the provider of emergency transportation by ambulance agrees not to seek any payment from the enrollee for services provided to the enrollee." 215 ILCS 125/4-15(b).

This protection, which applies regardless of whether the ground ambulance provider is a participating provider in the health care plan, will remain in force on and after July 1, 2022. This provision does not apply to voluntary health services plans.

VII. Air Ambulances

Currently, no Illinois law applies to balance billing by out-of-network air ambulance providers. Therefore, the federal Centers for Medicare and Medicaid Services ("CMS") will directly enforce the NSA and all implementing regulations for all plans that use participating or preferred provider networks.

VIII. Self-funded Plans of Individual Employers, Employee Organizations, and State or Local Governments

Self-funded plans of individual employers, employee organizations, and state or local governments are subject to the NSA default requirements enforced by the U.S. Department of Labor or Health and Human Services, as applicable, and they are not subject to Section 356z.3a. To the extent that any private or non-Federal governmental employer or employee organization offers fully-insured, network-based coverage to its employees, that coverage will be subject to Illinois insurance laws applicable to the health insurance issuer.

IX. Enforcement

With the exception of matters described in Sections VII and VIII, the Department will directly enforce the requirements described in this bulletin and otherwise incorporated under PA 102-0901 with respect to health insurance issuers. Regarding health care professionals, emergency facilities, and health care facilities, the allocation of responsibility described in CB 2022-03 remains unchanged. Please note that the CMS letter posted at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA has not yet been updated to reflect current Illinois law.

The Department may issue further guidance as issuers, providers, facilities, and consumers continue to adjust to the NSA and Illinois regulatory framework.

Questions regarding this Company Bulletin should be directed to DOI.InfoDesk@illinois.gov.