Illinois Department of Financial and Professional Regulation

Division of Insurance

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November 13, 2007

To: **COMPANY PRESIDENTS**
ALL COMPANIES WRITING HEALTH INSURANCE BUSINESS
ALL PREFERRED PROVIDER ADMINISTRATORS
ALL THIRD PARTY ADMINISTRATORS

From: **Michael T. McRaith, Director**

Re: **(CB #2007-04)** **Ancillary Providers - Reimbursement**

Reply To: **William McAndrew, Assistant Deputy Director**
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As the managed care market has matured in Illinois, so has its consumers. Through educational initiatives and experience, Illinois residents have become savvy in charting the critical path to securing appropriate and cost effective health care services. While once foreign concepts, Illinois residents have become comfortable in meeting payor expectations for using contracted providers, second opinions, precertification of care, referrals and determinations of medical appropriateness. What they do not expect is to be financially penalized when they have done everything "right".

Increasingly, Illinois consumers are experiencing unexpected and significant out-of-pocket expenses when using the services of ancillary providers. Repeatedly, the consumer will seek and receive an insurer's precertification for care, only to discover that the "on-call" radiologist, anesthesiologist, pathologist or other similar specialty provider, is not a contracted health care provider. The inability to coordinate preauthorized care with contracted ancillary providers, has not only taken the consumer by surprise, but has placed them in a position of considerable financial hardship for the difference between the insurer's contracted rate and the ancillary provider's usual and customary charge.

Under Illinois' Health Care Reimbursement Act, safeguards were put in place to protect consumers from being placed in this position. Under these standards, no contract, arrangement or agreement could contain terms or conditions that would operate to unreasonably restrict the access or availability of health care services for the insured (215 ILCS 5/370i). The implementing regulation (50 IAC 2051) elaborates further by addressing situations where: 1) covered services are not available from a contracted provider; and 2) the member has made a good faith effort to use the services of a contracted provider but such services are unavailable. In these instances, provider/payor agreements must contain a provision whereby the covered member will be provided a covered service at no greater cost than if such service had been provided by a contracted provider (50 IAC 2051.55 (e)(10)(A)).

To the extent that insurers provide access to providers through contractual arrangements with preferred provider administrators, it is the insurer’s responsibility to invoke and enforce the administrator’s responsibility under 50 IAC 2051.55 (e)(10)(A). To the extent that an insurer establishes its own provider network, the insured is to be held harmless in those instances where they have made a good faith effort to use the services of a contracted provider, but because of the lack of availability of ancillary providers, the insured's access to otherwise covered health care services is either inequitably restricted or simply not available (215 ILCS 5/370i).

In all situations where an Illinois insured has made a good faith effort to use the services of a contracted provider and where there is not equitable access to such provider(s), it is the insurer’s contractual and statutory responsibility to ensure that the covered person be provided covered services at no greater cost than if such services had been provided by a contracted provider.

This standard will guide all action taken on provider contracts, benefit contracts, payor agreements, consumer complaints and Market Conduct Examinations.