AN ACT concerning regulation.

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

Section 5. The Department of Insurance Law of the Civil Administrative Code of Illinois is amended by changing Section 1405-50 as follows:

(20 ILCS 1405/1405-50)

Sec. 1405-50. Marketplace Director of the Illinois Health Benefits Exchange. The Governor shall appoint, with the advice and consent of the Senate, a person within the Department of Insurance to serve as the Marketplace Director of the Illinois Health Benefits Exchange. The Marketplace Director shall serve for a term of 2 years, and until a successor is appointed and qualified; except that the term of the first Marketplace Director appointed under this Law shall expire on the third Monday in January 2027. The Marketplace Director may serve for more than one term. The Governor may make a temporary appointment until the next meeting of the Senate. ~~This person may be an existing employee with other duties.~~ The Marketplace Director shall receive an annual salary as set by the Governor and shall be paid out of the appropriations to the Department. The Marketplace Director shall ~~not~~ be subject to the Personnel Code. The Marketplace Director, under the direction of the

Director, shall manage the operations and staff of the Illinois Health Benefits Exchange to ensure optimal exchange performance.

(Source: P.A. 103-103, eff. 6-27-23.)

Section 10. The Illinois Insurance Code is amended by adding Section 356z.40a as follows:

(215 ILCS 5/356z.40a new)

Sec. 356z.40a. Pregnancy as a qualifying life event for qualified health plans. Beginning with the operation of a State-based exchange in plan year 2026, a pregnant individual has the right to enroll in a qualified health plan through a special enrollment period within 60 days after any qualified health care professional, including a licensed certified professional midwife, licensed or certified under the laws of this State or any other state to provide pregnancy-related health care services certifies that the individual is pregnant. Upon enrollment, coverage shall be effective on and after the first day of the month in which the qualified health care professional certifies that the individual is pregnant, unless the individual elects to have coverage effective on the first day of the month following the date that the individual received certification of the pregnancy.

Section 15. The Illinois Health Insurance Portability and

Accountability Act is amended by changing Sections 30, 50, and 60 as follows:

(215 ILCS 97/30)

Sec. 30. Guaranteed renewability of coverage for employers in the group market.

(A) In general. Except as provided in this Section, if a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, the issuer must renew or continue in force such coverage at the option of the plan sponsor of the plan.

(B) General exceptions. A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of the following:

(1) Nonpayment of premiums. The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) Fraud. The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Violation of participation or contribution rules. The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group

participation rules, as permitted under Section 40(D) in the case of the small group market or pursuant to applicable State law in the case of the large group market.

(4) Termination of coverage. The issuer is ceasing to offer coverage in such market in accordance with subsection (C) and applicable State law.

(5) Movement outside service area. In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under Section 40(C)(1)(a).

(6) Association membership ceases. In the case of health insurance coverage that is made available in the small or large group market (as the case may be) only through one or more bona fide association, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

(C) Requirements for uniform termination of coverage.

(1) Particular type of coverage not offered. In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if:

(a) the issuer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(b) the issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan in such market; and

(c) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (b), the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries who may become eligible for such coverage.

(2) Discontinuance of all coverage.

(a) In general. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in Illinois, health insurance coverage may be discontinued by the issuer only in accordance with Illinois law and if:

(i) the issuer provides notice ~~to the Department and~~ to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage and to the Department as provided in Section 60 of this Act; and

(ii) all health insurance issued or delivered for issuance in Illinois in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(b) Prohibition on market reentry. In the case of a discontinuation under subparagraph (a) in a market, the issuer may not provide for the issuance of any health insurance coverage in the Illinois market involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(D) Exception for uniform modification of coverage. At the

time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan:

(1) in the large group market; or

(2) in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with State law and effective on a uniform basis among group health plans with that product.

(E) Application to coverage offered only through associations. In applying this Section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

(Source: P.A. 90-30, eff. 7-1-97.)

(215 ILCS 97/50)

Sec. 50. Guaranteed renewability of individual health insurance coverage.

(A) In general. Except as provided in this Section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

(B) General exceptions. A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) Nonpayment of premiums. The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) Fraud. The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Termination of plan. The issuer is ceasing to offer coverage in the individual market in accordance with subsection (C) of this Section and applicable Illinois law.

(4) Movement outside the service area. In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the issuer is authorized to do business), but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(5) Association membership ceases. In the case of

health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(C) Requirements for uniform termination of coverage.

(1) Particular type of coverage not offered. In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if:

(a) the issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(b) the issuer offers, to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

(c) in exercising the option to discontinue coverage of that type and in offering the option of coverage under subparagraph (b), the issuer acts uniformly without regard to any health status-related

factor of enrolled individuals or individuals who may become eligible for such coverage.

(2) Discontinuance of all coverage.

(a) In general. Subject to subparagraph (c), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in Illinois, health insurance coverage may be discontinued by the issuer only if:

(i) the issuer provides notice ~~to the Director and~~ to each individual of the discontinuation at least 180 days prior to the date of the expiration of such coverage and to the Director as provided in Section 60 of this Act;

(ii) all health insurance issued or delivered for issuance in Illinois in such market is discontinued and coverage under such health insurance coverage in such market is not renewed; and

(iii) in the case where the issuer has affiliates in the individual market, the issuer gives notice to each affected individual at least 180 days prior to the date of the expiration of the coverage of the individual's option to purchase all other individual health benefit plans currently offered by any affiliate of the carrier.

(b) Prohibition on market reentry. In the case of

a discontinuation under subparagraph (a) in the individual market, the issuer may not provide for the issuance of any health insurance coverage in Illinois involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(c) If an issuer elects to discontinue offering all health insurance coverage in the individual market under subparagraph (a), its affiliates that offer health insurance coverage in the individual market in Illinois shall offer individual health insurance coverage to all individuals who were covered by the discontinued health insurance coverage on the date of the notice provided to affected individuals under subdivision (iii) of subparagraph (a) of this item (2) if the individual applies for coverage no later than 63 days after the discontinuation of coverage.

(d) Subject to subparagraph (e) of this item (2), an affiliate that issues coverage under subparagraph (c) shall waive the preexisting condition exclusion period to the extent that the individual has satisfied the preexisting condition exclusion period under the individual's prior contract or policy.

(e) An affiliate that issues coverage under subparagraph (c) may require the individual to satisfy the remaining part of the preexisting condition

exclusion period, if any, under the individual's prior contract or policy that has not been satisfied, unless the coverage has a shorter preexisting condition exclusion period, and may include in any coverage issued under subparagraph (c) any waivers or limitations of coverage that were included in the individual's prior contract or policy.

(D) Exception for uniform modification of coverage. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as the modification is consistent with Illinois law and effective on a uniform basis among all individuals with that policy form.

(E) Application to coverage offered only through associations. In applying this Section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to such an association (of which the individual is a member).

The changes to this Section made by this amendatory Act of the 94th General Assembly apply only to discontinuances of coverage occurring on or after the effective date of this amendatory Act of the 94th General Assembly.

(Source: P.A. 94-502, eff. 8-8-05.)

(215 ILCS 97/60)

Sec. 60. Notice requirement. In any case where a health insurance issuer elects to uniformly modify coverage, uniformly terminate coverage, or discontinue coverage in a marketplace in accordance with Sections 30 and 50 of this Act, the issuer shall provide notice to the Department prior to notifying the plan sponsors, participants, beneficiaries, and covered individuals. The notice shall be sent by certified mail to the Department 45 ~~90~~ days in advance of any notification of the company's actions sent to plan sponsors, participants, beneficiaries, and covered individuals. The notice shall include: (i) a complete description of the action to be taken, (ii) a specific description of the type of coverage affected, (iii) the total number of covered lives affected, (iv) a sample draft of all letters being sent to the plan sponsors, participants, beneficiaries, or covered individuals, (v) time frames for the actions being taken, (vi) options the plans sponsors, participants, beneficiaries, or covered individuals may have available to them under this Act, and (vii) any other information as required by the Department. The Department may designate an email address or online platform to receive electronic notification in lieu of certified mail.

This Section applies only to discontinuances of coverage occurring on or after the effective date of this amendatory Act of the 94th General Assembly.

(Source: P.A. 94-502, eff. 8-8-05.)

Section 20. The Network Adequacy and Transparency Act is amended by changing Sections 3, 5, 10, and 25 as follows:

(215 ILCS 124/3)

Sec. 3. Applicability of Act. This Act applies to an individual or group policy of accident and health insurance with a network plan amended, delivered, issued, or renewed in this State on or after January 1, 2019. This Act does not apply to an individual or group policy for excepted benefits or short-term, limited-duration health insurance coverage ~~dental or vision insurance or a limited health service organization~~ with a network plan ~~amended, delivered, issued, or renewed in this State on or after January 1, 2019~~, except to the extent that federal law establishes network adequacy and transparency standards for stand-alone dental plans, which the Department shall enforce.

(Source: P.A. 100-502, eff. 9-15-17; 100-601, eff. 6-29-18.)

(215 ILCS 124/5)

Sec. 5. Definitions. In this Act:

"Authorized representative" means a person to whom a beneficiary has given express written consent to represent the beneficiary; a person authorized by law to provide substituted consent for a beneficiary; or the beneficiary's treating

provider only when the beneficiary or his or her family member is unable to provide consent.

"Beneficiary" means an individual, an enrollee, an insured, a participant, or any other person entitled to reimbursement for covered expenses of or the discounting of provider fees for health care services under a program in which the beneficiary has an incentive to utilize the services of a provider that has entered into an agreement or arrangement with an insurer.

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

"Excepted benefits" has the meaning given to that term in 42 U.S.C. 300gg-91(c).

"Family caregiver" means a relative, partner, friend, or neighbor who has a significant relationship with the patient and administers or assists the patient with activities of daily living, instrumental activities of daily living, or other medical or nursing tasks for the quality and welfare of that patient.

"Insurer" means any entity that offers individual or group accident and health insurance, including, but not limited to, health maintenance organizations, preferred provider organizations, exclusive provider organizations, and other plan structures requiring network participation, excluding the medical assistance program under the Illinois Public Aid Code, the State employees group health insurance program, workers

compensation insurance, and pharmacy benefit managers.

"Material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of 10% or more in a specific type of providers, the removal of a major health system that causes a network to be significantly different from the network when the beneficiary purchased the network plan, or any change that would cause the network to no longer satisfy the requirements of this Act or the Department's rules for network adequacy and transparency.

"Network" means the group or groups of preferred providers providing services to a network plan.

"Network plan" means an individual or group policy of accident and health insurance that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers managed, owned, under contract with, or employed by the insurer.

"Ongoing course of treatment" means (1) treatment for a life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits; (3) a course of treatment for a health condition that a treating provider attests that

discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes; or (4) the third trimester of pregnancy through the post-partum period.

"Preferred provider" means any provider who has entered, either directly or indirectly, into an agreement with an employer or risk-bearing entity relating to health care services that may be rendered to beneficiaries under a network plan.

"Providers" means physicians licensed to practice medicine in all its branches, other health care professionals, hospitals, or other health care institutions that provide health care services.

"Short-term, limited-duration health insurance coverage has the meaning given to that term in Section 5 of the Short-Term, Limited-Duration Health Insurance Coverage Act.

"Stand-alone dental plan" has the meaning given to that term in 45 CFR 156.400.

"Telehealth" has the meaning given to that term in Section 356z.22 of the Illinois Insurance Code.

"Telemedicine" has the meaning given to that term in Section 49.5 of the Medical Practice Act of 1987.

"Tiered network" means a network that identifies and groups some or all types of provider and facilities into specific groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

"Woman's principal health care provider" means a physician licensed to practice medicine in all of its branches specializing in obstetrics, gynecology, or family practice.

(Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22.)

(215 ILCS 124/10)

Sec. 10. Network adequacy.

(a) An insurer providing a network plan shall file a description of all of the following with the Director:

(1) The written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

(2) The written policies and procedures for making referrals within and outside the network.

(3) The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access to network-affiliated primary care, emergency services, and women's principal health care providers.

An insurer shall not prohibit a preferred provider from discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the insurer in accordance

with any rights or remedies available under applicable State or federal law.

(b) Insurers must file for review a description of the services to be offered through a network plan. The description shall include all of the following:

(1) A geographic map of the area proposed to be served by the plan by county service area and zip code, including marked locations for preferred providers.

(2) As deemed necessary by the Department, the names, addresses, phone numbers, and specialties of the providers who have entered into preferred provider agreements under the network plan.

(3) The number of beneficiaries anticipated to be covered by the network plan.

(4) An Internet website and toll-free telephone number for beneficiaries and prospective beneficiaries to access current and accurate lists of preferred providers, additional information about the plan, as well as any other information required by Department rule.

(5) A description of how health care services to be rendered under the network plan are reasonably accessible and available to beneficiaries. The description shall address all of the following:

(A) the type of health care services to be provided by the network plan;

(B) the ratio of physicians and other providers to

beneficiaries, by specialty and including primary care physicians and facility-based physicians when applicable under the contract, necessary to meet the health care needs and service demands of the currently enrolled population;

(C) the travel and distance standards for plan beneficiaries in county service areas; and

(D) a description of how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable.

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to insufficient number, type, unreasonable travel distance or delay, or preferred providers refusing to provide a covered service because it is contrary to the conscience of the preferred providers, as protected by the Health Care Right of Conscience Act, the insurer shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider.

This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply unless Section 356z.3a of the Illinois Insurance Code requires otherwise. In no event shall a beneficiary who receives care at a participating health care facility be required to search for participating providers under the circumstances described in subsection (b) or (b-5) of Section 356z.3a of the Illinois Insurance Code except under the circumstances described in paragraph (2) of subsection (b-5).

(7) A provision that the beneficiary shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the emergency services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider. For purposes of this paragraph (7), "the same benefit level" means that the beneficiary is provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This provision shall be consistent with Section 356z.3a of the Illinois Insurance Code.

(8) A limitation that, if the plan provides that the beneficiary will incur a penalty for failing to pre-certify inpatient hospital treatment, the penalty may not exceed $1,000 per occurrence in addition to the plan cost sharing provisions.

(c) The network plan shall demonstrate to the Director a minimum ratio of providers to plan beneficiaries as required by the Department.

(1) The ratio of physicians or other providers to plan beneficiaries shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits<u>, except to the extent provided under federal law for stand-alone dental plans</u>. The Department shall consider establishing ratios for the following physicians or other providers:

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

(F) Neurology;

(G) OB/GYN;

(H) Oncology/Radiation;

(I) Ophthalmology;

(J) Urology;

(K) Behavioral Health;

(L) Allergy/Immunology;

(M) Chiropractic;

(N) Dermatology;

(O) Endocrinology;

(P) Ears, Nose, and Throat (ENT)/Otolaryngology;

(Q) Infectious Disease;

(R) Nephrology;

(S) Neurosurgery;

(T) Orthopedic Surgery;

(U) Physiatry/Rehabilitative;

(V) Plastic Surgery;

(W) Pulmonary;

(X) Rheumatology;

(Y) Anesthesiology;

(Z) Pain Medicine;

(AA) Pediatric Specialty Services;

(BB) Outpatient Dialysis; and

(CC) HIV.

(2) The Director shall establish a process for the review of the adequacy of these standards, along with an assessment of additional specialties to be included in the list under this subsection (c).

(3) If the federal Centers for Medicare and Medicaid Services establishes minimum provider ratios for stand-alone dental plans in the type of exchange in use in this State for a given plan year, the Department shall enforce those standards for stand-alone dental plans for that plan year.

(d) The network plan shall demonstrate to the Director maximum travel and distance standards for plan beneficiaries, which shall be established annually by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. These standards shall consist of the maximum minutes or miles to be traveled by a plan beneficiary for each county type, such as large counties, metro counties, or rural counties as defined by Department rule.

The maximum travel time and distance standards must include standards for each physician and other provider category listed for which ratios have been established.

The Director shall establish a process for the review of the adequacy of these standards along with an assessment of additional specialties to be included in the list under this subsection (d).

If the federal Centers for Medicare and Medicaid Services establishes appointment wait-time standards for qualified health plans, including stand-alone dental plans, in the type of exchange in use in this State for a given plan year, the

Department shall enforce those standards for the same types of qualified health plans for that plan year. If the federal Centers for Medicare and Medicaid Services establishes time and distance standards for stand-alone dental plans in the type of exchange in use in this State for a given plan year, the Department shall enforce those standards for stand-alone dental plans for that plan year.

(d-5)(1) Every insurer shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. Insurers shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network

adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties

other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the

beneficiary's residence to receive inpatient or residential treatment for mental, emotional, nervous, or substance use disorders or conditions.

(3) If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the insurer shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(4) If the federal Centers for Medicare and Medicaid Services establishes a more stringent standard in any county than specified in paragraph (1) or (2) of this subsection (d-5) for qualified health plans in the type of exchange in use in this State for a given plan year, the federal standard shall apply in lieu of the standard in paragraph (1) or (2) of this subsection (d-5) for qualified health plans for that plan year.

(e) Except for network plans solely offered as a group health plan, these ratio and time and distance standards apply to the lowest cost-sharing tier of any tiered network.

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of

delivering care to partially meet the requirements set under this Section.

(g) Except for the requirements set forth in subsection (d-5), insurers who are not able to comply with the provider ratios, ~~and~~ time and distance standards, and appointment wait-time standards established under this Act or federal law ~~established by the Department~~ may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

(1) if no providers or facilities meet the specific time and distance standard in a specific service area and the insurer (i) discloses information on the distance and travel time points that beneficiaries would have to travel beyond the required criterion to reach the next closest contracted provider outside of the service area and (ii) provides contact information, including names, addresses, and phone numbers for the next closest contracted provider or facility;

(2) if patterns of care in the service area do not support the need for the requested number of provider or facility type and the insurer provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where the physicians currently refer beneficiaries, or both; or

(3) other circumstances deemed appropriate by the

Department consistent with the requirements of this Act.

(h) Insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23.)

(215 ILCS 124/25)

Sec. 25. Network transparency.

(a) A network plan shall post electronically an up-to-date, accurate, and complete provider directory for each of its network plans, with the information and search functions, as described in this Section.

(1) In making the directory available electronically, the network plans shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) The network plan shall update the online provider directory at least monthly. Providers shall notify the network plan electronically or in writing of any changes

to their information as listed in the provider directory, including the information required in subparagraph (K) of paragraph (1) of subsection (b). The network plan shall update its online provider directory in a manner consistent with the information provided by the provider within 10 business days after being notified of the change by the provider. Nothing in this paragraph (2) shall void any contractual relationship between the provider and the plan.

(3) The network plan shall audit periodically at least 25% of its provider directories for accuracy, make any corrections necessary, and retain documentation of the audit. The network plan shall submit the audit to the Director upon request. As part of these audits, the network plan shall contact any provider in its network that has not submitted a claim to the plan or otherwise communicated his or her intent to continue participation in the plan's network.

(4) A network plan shall provide a printed ~~print~~ copy of a current provider directory or a printed ~~print~~ copy of the requested directory information upon request of a beneficiary or a prospective beneficiary. Printed ~~Print~~ copies must be updated quarterly and an errata that reflects changes in the provider network must be updated quarterly.

(5) For each network plan, a network plan shall

include, in plain language in both the electronic and print directory, the following general information:

(A) in plain language, a description of the criteria the plan has used to build its provider network;

(B) if applicable, in plain language, a description of the criteria the insurer or network plan has used to create tiered networks;

(C) if applicable, in plain language, how the network plan designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example, by name, symbols, or grouping, in order for a beneficiary-covered person or a prospective beneficiary-covered person to be able to identify the provider tier; and

(D) if applicable, a notation that authorization or referral may be required to access some providers.

(6) A network plan shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this State. The network plan shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that

beneficiaries or the general public may use to notify the network plan of inaccurate provider directory information and contact information for the Department's Office of Consumer Health Insurance.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(b) For each network plan, a network plan shall make available through an electronic provider directory the following information in a searchable format:

(1) for health care professionals:

(A) name;

(B) gender;

(C) participating office locations;

(D) specialty, if applicable;

(E) medical group affiliations, if applicable;

(F) facility affiliations, if applicable;

(G) participating facility affiliations, if applicable;

(H) languages spoken other than English, if applicable;

(I) whether accepting new patients;

(J) board certifications, if applicable; and

(K) use of telehealth or telemedicine, including,

but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent;

(2) for hospitals:

(A) hospital name;

(B) hospital type (such as acute, rehabilitation, children's, or cancer);

(C) participating hospital location; and

(D) hospital accreditation status; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) types of services performed; and

(D) participating facility location or locations.

(c) For the electronic provider directories, for each network plan, a network plan shall make available all of the

following information in addition to the searchable information required in this Section:

(1) for health care professionals:

(A) contact information; and

(B) languages spoken other than English by clinical staff, if applicable;

(2) for hospitals, telephone number; and

(3) for facilities other than hospitals, telephone number.

(d) The insurer or network plan shall make available in print, upon request, the following provider directory information for the applicable network plan:

(1) for health care professionals:

(A) name;

(B) contact information;

(C) participating office location or locations;

(D) specialty, if applicable;

(E) languages spoken other than English, if applicable;

(F) whether accepting new patients; and

(G) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to patients for whom it would be clinically appropriate;

(ii) what modalities are used and what types of services may be provided via telehealth or telemedicine; and

(iii) whether the provider has the ability and willingness to include in a telehealth or telemedicine encounter a family caregiver who is in a separate location than the patient if the patient wishes and provides his or her consent;

(2) for hospitals:

(A) hospital name;

(B) hospital type (such as acute, rehabilitation, children's, or cancer); and

(C) participating hospital location and telephone number; and

(3) for facilities, other than hospitals, by type:

(A) facility name;

(B) facility type;

(C) types of services performed; and

(D) participating facility location or locations and telephone numbers.

(e) The network plan shall include a disclosure in the print format provider directory that the information included in the directory is accurate as of the date of printing and that beneficiaries or prospective beneficiaries should consult the insurer's electronic provider directory on its website and contact the provider. The network plan shall also include a

telephone number in the print format provider directory for a customer service representative where the beneficiary can obtain current provider directory information.

(f) The Director may conduct periodic audits of the accuracy of provider directories. A network plan shall not be subject to any fines or penalties for information required in this Section that a provider submits that is inaccurate or incomplete.

(g) This Section applies to network plans that are not otherwise exempt under Section 3, including stand-alone dental plans that are subject to provider directory requirements under federal law.

(Source: P.A. 102-92, eff. 7-9-21; revised 9-26-23.)

Section 25. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49, 355.2, 355.3, 355b, 355c, 356f, 356g.5-1, 356m, 356q, 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14,

356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.30a, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.65, 356z.67, 356z.68, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII

1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro

forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including, without limitation, the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health

Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff. 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;

102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

Section 30. The Managed Care Reform and Patient Rights Act is amended by changing Section 45.3 as follows:

(215 ILCS 134/45.3)

Sec. 45.3. Prescription drug benefits; plan choice.

(a) Notwithstanding any other provision of law, beginning January 1, 2023, every health insurance carrier that offers an individual health plan that provides coverage for prescription drugs shall ensure that at least 10% of individual health care plans offered in each applicable service area and at each level of coverage as defined in 42 U.S.C. 18022(d) apply a flat-dollar copayment structure to the entire drug benefit. Beginning January 1, 2024, every health insurance carrier that offers an individual health plan that provides coverage for prescription drugs shall ensure that at least 25% of individual health care plans offered in each applicable service area and at each level of coverage as defined in 42 U.S.C. 18022(d) apply a flat-dollar copayment structure to the entire drug benefit. If a health insurance carrier offers

fewer than 4 plans in a service area, then the health insurance carrier shall ensure that one plan applies a flat-dollar copayment structure to the entire drug benefit.

(b) ~~Beginning January 1, 2023, every health insurance carrier that offers a group health plan that provides coverage for prescription drugs shall offer at least one group health plan in each applicable service area and at each level of coverage as defined in 42 U.S.C. 18022 that applies a flat dollar copayment structure to the entire drug benefit.~~ Every ~~Beginning January 1, 2024, every~~ health insurance carrier that offers a small group health plan that provides coverage for prescription drugs shall offer at least 2 small group health plans in each applicable service area and at each level of coverage as defined in 42 U.S.C. 18022(d) that apply a flat-dollar copayment structure to the entire drug benefit.

(c) The flat-dollar copayment structure for prescription drugs under subsections (a) and (b) must be applied pre-deductible and be reasonably graduated and proportionately related in all tier levels such that the copayment structure as a whole does not discriminate against or discourage the enrollment of individuals with significant health care needs. Notwithstanding the other provisions of this subsection, beginning January 1, 2025, each level of coverage that a health insurance carrier offers of a standardized option in each applicable service area shall be deemed to satisfy the requirements for a flat-dollar copay structure in subsection

(a).

For purposes of this subsection, "standardized option" has the meaning given to that term in 45 CFR 155.20 or, when Illinois has a State-based exchange, a substantially similar definition to "standardized option" in 45 CFR 155.20 that substitutes the Illinois Health Benefits Exchange for the United States Department of Health and Human Services.

(d) A health insurance carrier that offers individual or small group health care plans shall clearly and appropriately name the plans described in subsections (a) and (b) to aid in the individual or small group plan selection process.

(e) A health insurance carrier shall market plans described in subsections (a) and (b) in the same manner as plans not described in subsections (a) and (b).

(f) The Department shall adopt rules necessary to implement and enforce the provisions of this Section.

(Source: P.A. 102-391, eff. 1-1-23.)

Section 99. Effective date. This Act takes effect upon becoming law, except that the changes to Sections 3, 5, 10, and 25 of the Network Adequacy and Transparency Act take effect January 1, 2025.