HB5395

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB5395

Introduced 2/9/2024, by Rep. Anna Moeller

SYNOPSIS AS INTRODUCED:

5 ILCS 100/5-45.55 new
215 ILCS 124/3
215 ILCS 124/5
215 ILCS 124/10
215 ILCS 124/15
215 ILCS 124/20
215 ILCS 124/25
215 ILCS 124/30
215 ILCS 124/35 new
215 ILCS 124/40 new
215 ILCS 124/50 new
215 ILCS 134/20
215 ILCS 134/25

Amends the Network Adequacy and Transparency Act. Adds definitions. Provides that the minimum ratio for each provider type shall be no less than any such ratio established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services. Provides that the maximum travel time and distance standards and appointment wait time standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services. Makes changes to provisions concerning network adequacy, notice of nonrenewal or termination, transition of services, network transparency, administration and enforcement, provider requirements, and provider directory information. Amends the Managed Care Reform and Patient Rights Act. Makes changes to provisions concerning notice of nonrenewal or termination and transition of services. Amends the Illinois Administrative Procedure Act to authorize the Department of Insurance to adopt emergency rules implementing federal standards for provider ratios, time and distance, or appointment wait times when such standards apply to health insurance coverage regulated by the Department of Insurance and are more stringent than the State standards extant at the time the final federal standards are published. Amends the Illinois Administrative Procedure Act to make a conforming change. Effective immediately.

LRB103 37071 RPS 67189 b

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Administrative Procedure Act is
5 amended by adding Section 5-45.55 as follows:

6 (5 ILCS 100/5-45.55 new)
7 Sec. 5-45.55. Emergency rulemaking; Network Adequacy and
8 Transparency Act. To provide for the expeditious and timely
9 implementation of the Network Adequacy and Transparency Act,
10 emergency rules implementing federal standards for provider
11 ratios, travel time and distance, and appointment wait times
12 if such standards apply to health insurance coverage regulated
13 by the Department of Insurance and are more stringent than the
14 State standards extant at the time the final federal standards
15 are published may be adopted in accordance with Section 5-45
16 by the Department of Insurance. The adoption of emergency
17 rules authorized by Section 5-45 and this Section is deemed to
18 be necessary for the public interest, safety, and welfare.
19 This Section is repealed one year after the effective date
20 of this amendatory Act of the 103rd General Assembly.

21 Section 15. The Network Adequacy and Transparency Act is
22 amended by changing Sections 3, 5, 10, 15, 20, 25, and 30 and

by adding Sections 35, 40, and 50 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 coverage 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 issuer ~~insurer~~.

"Department" means the Department of Insurance.

"Essential community provider" has the meaning ascribed to that term in 45 CFR 156.235.

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

"Exchange" has the meaning ascribed to that term in 45 CFR 155.20.

"Director" means the Director of Insurance.

"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.

"Group health plan" has the meaning ascribed to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Health insurance coverage" has the meaning ascribed to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act. "Health insurance

coverage" does not include any coverage or benefits under Medicare or under the medical assistance program established under Article V of the Illinois Public Aid Code.

"Issuer" means a "health insurance issuer" as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"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 within any county, the removal of a major health system that causes a network to be significantly different within any county 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.

1 "Network plan" means an individual or group policy of
2 ~~accident and~~ health insurance coverage that either requires a
3 covered person to use or creates incentives, including
4 financial incentives, for a covered person to use providers
5 managed, owned, under contract with, or employed by the issuer
6 or by a third party contracted to arrange, contract for, or
7 administer such provider-related incentives for the issuer
8 ~~insurer~~.
9 "Ongoing course of treatment" means (1) treatment for a
10 life-threatening condition, which is a disease or condition
11 for which likelihood of death is probable unless the course of
12 the disease or condition is interrupted; (2) treatment for a
13 serious acute condition, defined as a disease or condition
14 requiring complex ongoing care that the covered person is
15 currently receiving, such as chemotherapy, radiation therapy,
16 ~~or~~ post-operative visits, or a serious and complex condition
17 as defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of
18 treatment for a health condition that a treating provider
19 attests that discontinuing care by that provider would worsen
20 the condition or interfere with anticipated outcomes; ~~or~~ (4)
21 the third trimester of pregnancy through the post-partum
22 period; (5) undergoing a course of institutional or inpatient
23 care from the provider within the meaning of 42 U.S.C.
24 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective
25 surgery from the provider, including receipt of preoperative
26 or postoperative care from such provider with respect to such

1 a surgery; (7) being determined to be terminally ill, as
2 determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving
3 treatment for such illness from such provider; or (8) any
4 other treatment of a condition or disease that requires
5 repeated health care services pursuant to a plan of treatment
6 by a provider because of the potential for changes in the
7 therapeutic regimen.
8 "Preferred provider" means any provider who has entered,
9 either directly or indirectly, into an agreement with an
10 employer or risk-bearing entity relating to health care
11 services that may be rendered to beneficiaries under a network
12 plan.
13 "Providers" means physicians licensed to practice medicine
14 in all its branches, other health care professionals,
15 hospitals, or other health care institutions or facilities
16 that provide health care services.
17 "Short-term, limited-duration health insurance coverage"
18 has the meaning ascribed to that term in Section 5 of the
19 Short-Term, Limited-Duration Health Insurance Coverage Act.
20 "Stand-alone dental plan" has the meaning ascribed to that
21 term in 45 CFR 156.400.
22 "Telehealth" has the meaning given to that term in Section
23 356z.22 of the Illinois Insurance Code.
24 "Telemedicine" has the meaning given to that term in
25 Section 49.5 of the Medical Practice Act of 1987.
26 "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) Before issuing, delivering, or renewing a network plan, an issuer ~~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 issuer ~~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 issuer ~~insurer~~ in accordance with any rights or remedies available under applicable State or federal law.

(b) Before issuing, delivering, or renewing a network plan, an issuer ~~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 in each plan, 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

1 rendered under the network plan are reasonably accessible
2 and available to beneficiaries. The description shall
3 address all of the following:

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

6 (B) the ratio of physicians and other providers to
7 beneficiaries, by specialty and including primary care
8 physicians and facility-based physicians when
9 applicable under the contract, necessary to meet the
10 health care needs and service demands of the currently
11 enrolled population;

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

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

18 (6) A provision ensuring that whenever a beneficiary
19 has made a good faith effort, as evidenced by accessing
20 the provider directory, calling the network plan, and
21 calling the provider, to utilize preferred providers for a
22 covered service and it is determined the insurer does not
23 have the appropriate preferred providers due to
24 insufficient number, type, unreasonable travel distance or
25 delay, or preferred providers refusing to provide a
26 covered service because it is contrary to the conscience

1 of the preferred providers, as protected by the Health
2 Care Right of Conscience Act, the issuer ~~insurer~~ shall
3 ensure, directly or indirectly, by terms contained in the
4 payer contract, that the beneficiary will be provided the
5 covered service at no greater cost to the beneficiary than
6 if the service had been provided by a preferred provider.
7 This paragraph (6) does not apply to: (A) a beneficiary
8 who willfully chooses to access a non-preferred provider
9 for health care services available through the panel of
10 preferred providers, or (B) a beneficiary enrolled in a
11 health maintenance organization. In these circumstances,
12 the contractual requirements for non-preferred provider
13 reimbursements shall apply unless Section 356z.3a of the
14 Illinois Insurance Code requires otherwise. In no event
15 shall a beneficiary who receives care at a participating
16 health care facility be required to search for
17 participating providers under the circumstances described
18 in subsection (b) or (b-5) of Section 356z.3a of the
19 Illinois Insurance Code except under the circumstances
20 described in paragraph (2) of subsection (b-5).

21 (7) A provision that the beneficiary shall receive
22 emergency care coverage such that payment for this
23 coverage is not dependent upon whether the emergency
24 services are performed by a preferred or non-preferred
25 provider and the coverage shall be at the same benefit
26 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.

(9) For a network plan to be offered through the Exchange in the individual or small group market, as well as any off-Exchange mirror of such a network plan, evidence that the network plan includes essential community providers in accordance with rules established by the Exchange that will operate in this State for the applicable plan year.

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

(1) The minimum 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

1 not establish ratios for vision or dental providers who
2 provide services under dental-specific or vision-specific
3 benefits, except to the extent provided under federal law
4 for stand-alone dental plans. The Department shall
5 consider establishing ratios for the following physicians
6 or other providers:
7 (A) Primary Care;
8 (B) Pediatrics;
9 (C) Cardiology;
10 (D) Gastroenterology;
11 (E) General Surgery;
12 (F) Neurology;
13 (G) OB/GYN;
14 (H) Oncology/Radiation;
15 (I) Ophthalmology;
16 (J) Urology;
17 (K) Behavioral Health;
18 (L) Allergy/Immunology;
19 (M) Chiropractic;
20 (N) Dermatology;
21 (O) Endocrinology;
22 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
23 (Q) Infectious Disease;
24 (R) Nephrology;
25 (S) Neurosurgery;
26 (T) Orthopedic Surgery;

1 (U) Physiatry/Rehabilitative;
2 (V) Plastic Surgery;
3 (W) Pulmonary;
4 (X) Rheumatology;
5 (Y) Anesthesiology;
6 (Z) Pain Medicine;
7 (AA) Pediatric Specialty Services;
8 (BB) Outpatient Dialysis; and
9 (CC) HIV.
10 (2) The Director shall establish a process for the
11 review of the adequacy of these standards, along with an
12 assessment of additional specialties to be included in the
13 list under this subsection (c).
14 (3) Notwithstanding any other law or rule, the minimum
15 ratio for each provider type shall be no less than any such
16 ratio established for qualified health plans in
17 Federally-Facilitated Exchanges by federal law or by the
18 federal Centers for Medicare and Medicaid Services, even
19 if the network plan is issued in the large group market or
20 is otherwise not issued through an exchange. Federal
21 standards for stand-alone dental plans shall only apply to
22 such network plans. In the absence of an applicable
23 Department rule, the federal standards shall apply for the
24 time period specified in the federal law, regulation, or
25 guidance. If the Centers for Medicare and Medicaid
26 Services establish standards that are more stringent than

the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

(d) The network plan shall demonstrate to the Director maximum travel and distance standards and appointment wait time 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).

Notwithstanding any other law or Department rule, the maximum travel time and distance standards and appointment wait time standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if

the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

If the federal area designations for the maximum time or distance or appointment wait time standards required are changed by the most recent Letter to Issuers in the Federally-facilitated Marketplaces, the Department shall post on its website notice of such changes and may amend its rules to conform to those designations if the Director deems appropriate.

(d-5)(1) Every issuer ~~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. Issuers ~~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,

1 emotional, nervous, or substance use disorders or conditions
2 and those for the access to treatment for medical and surgical
3 conditions. As such, the network adequacy standards for timely
4 and proximate access shall equally be applied to treatment
5 facilities and providers for mental, emotional, nervous, or
6 substance use disorders or conditions and specialists
7 providing medical or surgical benefits pursuant to the parity
8 requirements of Section 370c.1 of the Illinois Insurance Code
9 and the federal Paul Wellstone and Pete Domenici Mental Health
10 Parity and Addiction Equity Act of 2008. Notwithstanding the
11 foregoing, the network adequacy standards for timely and
12 proximate access to treatment for mental, emotional, nervous,
13 or substance use disorders or conditions shall, at a minimum,
14 satisfy the following requirements:
15 (A) For beneficiaries residing in the metropolitan
16 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
17 network adequacy standards for timely and proximate access
18 to treatment for mental, emotional, nervous, or substance
19 use disorders or conditions means a beneficiary shall not
20 have to travel longer than 30 minutes or 30 miles from the
21 beneficiary's residence to receive outpatient treatment
22 for mental, emotional, nervous, or substance use disorders
23 or conditions. Beneficiaries shall not be required to wait
24 longer than 10 business days between requesting an initial
25 appointment and being seen by the facility or provider of
26 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 issuer ~~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 or law requires more stringent standards for qualified health plans in the Federally-Facilitated Exchanges, the federal standards shall control for all network

plans for the time period specified in the federal law, regulation, or guidance, even if the network plan is issued in the large group market, is issued through a different type of Exchange, or is otherwise not issued through an Exchange.

(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), issuers ~~insurers~~ who are not able to comply with the provider ratios and time and distance or appointment wait time standards established under this Act or federal law ~~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 issuer ~~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 issuer ~~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) Issuers ~~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. The issuer shall submit a revised version of the portions of the network adequacy filing affected by the material change, as determined by the Director by rule, and the issuer shall attach versions with the changes indicated for each document that was revised from the previous version of the filing. Upon notice from the issuer ~~insurer~~, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act. For every day past 15 days that the issuer fails to submit a revised network adequacy filing to the Director, the Director may order a fine of $1,000

1 per day.
2 (i) If a network plan is inadequate under this Act with
3 respect to a provider type in a county, and if the network plan
4 does not have an approved exception for that provider type in
5 that county pursuant to subsection (g), an issuer shall
6 process out-of-network claims for covered health care services
7 received from that provider type within that county at the
8 in-network benefit level and shall retroactively adjudicate
9 and reimburse beneficiaries to achieve that objective if their
10 claims were processed at the out-of-network level contrary to
11 this subsection.
12 (j) If the Director determines that a network is
13 inadequate in any county and no exception has been granted
14 under subsection (g) and the issuer does not have a process in
15 place to comply with subsection (d-5), the Director may
16 prohibit the network plan from being issued or renewed within
17 that county until the Director determines that the network is
18 adequate apart from processes and exceptions described in
19 subsections (d-5) and (g). Nothing in this subsection shall be
20 construed to terminate any beneficiary's health insurance
21 coverage under a network plan before the expiration of the
22 beneficiary's policy period if the Director makes a
23 determination under this subsection after the issuance or
24 renewal of the beneficiary's policy or certificate because of
25 a material change. Policies or certificates issued or renewed
26 in violation of this subsection may subject the issuer to a

1 civil penalty of $1,000 per policy.
2 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
3 102-1117, eff. 1-13-23.)

4 (215 ILCS 124/15)
5 Sec. 15. Notice of nonrenewal or termination.
6 (a) A network plan must give at least 60 days' notice of
7 nonrenewal or termination of a provider to the provider and to
8 the beneficiaries served by the provider. The notice shall
9 include a name and address to which a beneficiary or provider
10 may direct comments and concerns regarding the nonrenewal or
11 termination and the telephone number maintained by the
12 Department for consumer complaints. Immediate written notice
13 may be provided without 60 days' notice when a provider's
14 license has been disciplined by a State licensing board or
15 when the network plan reasonably believes direct imminent
16 physical harm to patients under the provider's ~~providers~~ care
17 may occur. The notice to the beneficiary shall provide the
18 individual with an opportunity to notify the issuer of the
19 individual's need for transitional care.
20 (b) Primary care providers must notify active affected
21 patients of nonrenewal or termination of the provider from the
22 network plan, except in the case of incapacitation.
23 (Source: P.A. 100-502, eff. 9-15-17.)

24 (215 ILCS 124/20)

Sec. 20. Transition of services.

(a) A network plan shall provide for continuity of care for its beneficiaries as follows:

(1) If a beneficiary's ~~physician or hospital~~ provider leaves the network plan's network of providers for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board and the provider remains within the network plan's service area, if benefits provided under such network plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan, or if a contract between a group health plan and a health insurance issuer offering a network plan in connection with the group health plan is terminated and results in a loss of benefits provided under such plan with respect to such provider, then the network plan shall permit the beneficiary to continue an ongoing course of treatment with that provider during a transitional period for the following duration:

(A) 90 days from the date of the notice to the beneficiary of the provider's disaffiliation from the network plan if the beneficiary has an ongoing course of treatment; or

(B) if the beneficiary has entered the third trimester of pregnancy at the time of the provider's

disaffiliation, a period that includes the provision of post-partum care directly related to the delivery.

(2) Notwithstanding the provisions of paragraph (1) of this subsection (a), such care shall be authorized by the network plan during the transitional period in accordance with the following:

(A) the provider receives continued reimbursement from the network plan at the rates and terms and conditions applicable under the terminated contract prior to the start of the transitional period;

(B) the provider adheres to the network plan's quality assurance requirements, including provision to the network plan of necessary medical information related to such care; and

(C) the provider otherwise adheres to the network plan's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining preauthorizations for treatment.

(3) The provisions of this Section governing health care provided during the transition period do not apply if the beneficiary has successfully transitioned to another provider participating in the network plan, if the beneficiary has already met or exceeded the benefit limitations of the plan, or if the care provided is not medically necessary.

(b) A network plan shall provide for continuity of care

1 for new beneficiaries as follows:
2 (1) If a new beneficiary whose provider is not a
3 member of the network plan's provider network, but is
4 within the network plan's service area, enrolls in the
5 network plan, the network plan shall permit the
6 beneficiary to continue an ongoing course of treatment
7 with the beneficiary's current physician during a
8 transitional period:
9 (A) of 90 days from the effective date of
10 enrollment if the beneficiary has an ongoing course of
11 treatment; or
12 (B) if the beneficiary has entered the third
13 trimester of pregnancy at the effective date of
14 enrollment, that includes the provision of post-partum
15 care directly related to the delivery.
16 (2) If a beneficiary, or a beneficiary's authorized
17 representative, elects in writing to continue to receive
18 care from such provider pursuant to paragraph (1) of this
19 subsection (b), such care shall be authorized by the
20 network plan for the transitional period in accordance
21 with the following:
22 (A) the provider receives reimbursement from the
23 network plan at rates established by the network plan;
24 (B) the provider adheres to the network plan's
25 quality assurance requirements, including provision to
26 the network plan of necessary medical information

1 related to such care; and
2 (C) the provider otherwise adheres to the network
3 plan's policies and procedures, including, but not
4 limited to, procedures regarding referrals and
5 obtaining preauthorization for treatment.
6 (3) The provisions of this Section governing health
7 care provided during the transition period do not apply if
8 the beneficiary has successfully transitioned to another
9 provider participating in the network plan, if the
10 beneficiary has already met or exceeded the benefit
11 limitations of the plan, or if the care provided is not
12 medically necessary.
13 (c) In no event shall this Section be construed to require
14 a network plan to provide coverage for benefits not otherwise
15 covered or to diminish or impair preexisting condition
16 limitations contained in the beneficiary's contract.
17 (d) A provider shall comply with the requirements of 42
18 U.S.C. 300gg-138.
19 (Source: P.A. 100-502, eff. 9-15-17.)

20 (215 ILCS 124/25)
21 Sec. 25. Network transparency.
22 (a) A network plan shall post electronically an
23 up-to-date, accurate, and complete provider directory for each
24 of its network plans, with the information and search
25 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. An issuer's failure to update a network plan's directory shall subject the issuer to a civil penalty of $5,000 per month. 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). If a provider is no longer accepting new patients, the provider must give notice to the issuer within 10 business days after deciding to cease accepting new patients, or within 10 business days after the effective date of this amendatory Act of the 103rd General Assembly, whichever is later. The network plan shall update its online provider directory in a manner consistent with the information provided by the provider within 2 ~~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) At least once every 90 days, the ~~The~~ network plan

shall audit each ~~periodically at least 25%~~ of its print and online 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. The audits shall comply with 42 U.S.C. 300gg-115(a)(2), except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Act.

(4) A network plan shall provide a print copy of a current provider directory or a print copy of the requested directory information upon request of a beneficiary or a prospective beneficiary. 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 issuer ~~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

1 telemedicine; and
2 (iii) whether the provider has the ability and
3 willingness to include in a telehealth or
4 telemedicine encounter a family caregiver who is
5 in a separate location than the patient if the
6 patient wishes and provides his or her consent;
7 and
8 (L) whether patients can make an appointment to
9 visit the health care professional.
10 (2) for hospitals:
11 (A) hospital name;
12 (B) hospital type (such as acute, rehabilitation,
13 children's, or cancer);
14 (C) participating hospital location; and
15 (D) hospital accreditation status; and
16 (3) for facilities, other than hospitals, by type:
17 (A) facility name;
18 (B) facility type;
19 (C) types of services performed; and
20 (D) participating facility location or locations.
21 (c) For the electronic provider directories, for each
22 network plan, a network plan shall make available all of the
23 following information in addition to the searchable
24 information required in this Section:
25 (1) for health care professionals:
26 (A) contact information, including both a

telephone number and digital contact information if the provider has supplied digital contact information; and

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

(2) for hospitals, telephone number and digital contact information; and

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

(d) The issuer ~~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, including a telephone number and digital contact information if the provider has supplied digital 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; and

(H) whether patients can make an appointment to visit the health care professional.

(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 digital contact information; 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, and digital contact information for each location.

(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 issuer's ~~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) To the extent not otherwise provided in this Act, an issuer shall comply with the requirements of 42 U.S.C. 300gg-115, except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Section.

(h) This Section applies to network plans not otherwise exempt under Section 3, including stand-alone dental plans.

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

(215 ILCS 124/30)

Sec. 30. Administration and enforcement.

(a) Issuers ~~Insurers~~, as defined in this Act, have a

continuing obligation to comply with the requirements of this Act. Other than the duties specifically created in this Act, nothing in this Act is intended to preclude, prevent, or require the adoption, modification, or termination of any utilization management, quality management, or claims processing methodologies of an issuer ~~insurer~~.

(b) Nothing in this Act precludes, prevents, or requires the adoption, modification, or termination of any network plan term, benefit, coverage or eligibility provision, or payment methodology.

(c) The Director shall enforce the provisions of this Act pursuant to the enforcement powers granted to it by law.

(d) The Department shall adopt rules to enforce compliance with this Act to the extent necessary.

(e) In accordance with Section 5-45 of the Illinois Administrative Procedure Act, the Department may adopt emergency rules to implement federal standards for provider ratios, travel time and distance, and appointment wait times if such standards apply to health insurance coverage regulated by the Department and are more stringent than the State standards extant at the time the final federal standards are published.

(Source: P.A. 100-502, eff. 9-15-17.)

(215 ILCS 124/35 new)

Sec. 35. Provider requirements. Providers shall comply

with 42 U.S.C. 300gg-138 and 300gg-139 and the regulations promulgated thereunder, as well as Section 20 and paragraph (2) of subsection (a) of Section 25 of this Act, except that "provider directory information" includes all information required to be included in a provider directory pursuant to Section 25 of this Act. To the extent a provider is licensed by the Department of Financial and Professional Regulation or by the Department of Public Health, that agency shall have the authority to investigate, examine, process complaints, issue subpoenas, examine witnesses under oath, issue a fine, or take disciplinary action against the provider's license for violations of these requirements in accordance with the provider's applicable licensing statute.

(215 ILCS 124/40 new)

Sec. 40. Confidentiality.

(a) All records in the custody or possession of the Department are presumed to be open to public inspection or copying unless exempt from disclosure by Section 7 or 7.5 of the Freedom of Information Act. Except as otherwise provided in this Section or other applicable law, the filings required under this Act shall be open to public inspection or copying.

(b) The following information shall not be deemed confidential:

(1) actual or projected ratios of providers to beneficiaries;

1 (2) actual or projected time and distance between
2 network providers and beneficiaries or actual or projected
3 waiting times for a beneficiary to see a network provider;
4 (3) geographic maps of network providers;
5 (4) requests for exceptions under subsection (g) of
6 Section 10, except with respect to any discussion of
7 ongoing or planned contractual negotiations with providers
8 that the issuer requests to be treated as confidential;
9 (5) provider directories and provider lists; and
10 (6) insurer or Department statements of determination
11 as to whether a network plan has satisfied the Act's
12 requirements regarding the information described in this
13 subsection.
14 (c) An issuer's work papers and reports on the results of a
15 self-audit of its provider directories shall remain
16 confidential unless expressly waived by the insurer or unless
17 deemed public information under federal law.
18 (d) The filings required under Section 10 of this Act
19 shall be confidential while they remain under the Department's
20 review but shall become open to public inspection and copying
21 upon completion of the review, except as provided in this
22 Section or under other applicable law.
23 (e) Nothing in this Section shall supersede the statutory
24 requirement that work papers obtained during a market conduct
25 examination be deemed confidential.

1 (215 ILCS 124/50 new)
2 Sec. 50. Funds for enforcement. Moneys from fines and
3 penalties collected from issuers for violations of this Act
4 shall be deposited into the Insurance Producer Administration
5 Fund for appropriation by the General Assembly to the
6 Department to be used for providing financial support of the
7 Department's enforcement of this Act.

8 Section 20. The Managed Care Reform and Patient Rights Act
9 is amended by changing Sections 20 and 25 as follows:

10 (215 ILCS 134/20)
11 Sec. 20. Notice of nonrenewal or termination. A health
12 care plan must give at least 60 days notice of nonrenewal or
13 termination of a health care provider to the health care
14 provider and to the enrollees served by the health care
15 provider. The notice shall include a name and address to which
16 an enrollee or health care provider may direct comments and
17 concerns regarding the nonrenewal or termination. Immediate
18 written notice may be provided without 60 days notice when a
19 health care provider's license has been disciplined by a State
20 licensing board. The notice to the enrollee shall provide the
21 individual with an opportunity to notify the health care plan
22 of the individual's need for transitional care.
23 (Source: P.A. 91-617, eff. 1-1-00.)

1 (215 ILCS 134/25)
2 Sec. 25. Transition of services.
3 (a) A health care plan shall provide for continuity of
4 care for its enrollees as follows:
5 (1) If an enrollee's health care provider ~~physician~~
6 leaves the health care plan's network of health care
7 providers for reasons other than termination of a contract
8 in situations involving imminent harm to a patient or a
9 final disciplinary action by a State licensing board and
10 the provider ~~physician~~ remains within the health care
11 plan's service area, or if benefits provided under such
12 health care plan with respect to such provider are
13 terminated because of a change in the terms of the
14 participation of such provider in such plan, or if a
15 contract between a group health plan, as defined in
16 Section 5 of the Illinois Health Insurance Portability and
17 Accountability Act, and a health care plan offered in
18 connection with the group health plan is terminated and
19 results in a loss of benefits provided under such plan
20 with respect to such provider, the health care plan shall
21 permit the enrollee to continue an ongoing course of
22 treatment with that provider ~~physician~~ during a
23 transitional period:
24 (A) of 90 days from the date of the notice of
25 provider's ~~physician's~~ termination from the health
26 care plan to the enrollee of the provider's

~~physician's~~ disaffiliation from the health care plan if the enrollee has an ongoing course of treatment; or

(B) if the enrollee has entered the third trimester of pregnancy at the time of the provider's ~~physician's~~ disaffiliation, that includes the provision of post-partum care directly related to the delivery.

(2) Notwithstanding the provisions in item (1) of this subsection, such care shall be authorized by the health care plan during the transitional period only if the provider ~~physician~~ agrees:

(A) to continue to accept reimbursement from the health care plan at the rates applicable prior to the start of the transitional period;

(B) to adhere to the health care plan's quality assurance requirements and to provide to the health care plan necessary medical information related to such care; and

(C) to otherwise adhere to the health care plan's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorizations for treatment.

(3) During an enrollee's plan year, a health care plan shall not remove a drug from its formulary or negatively change its preferred or cost-tier sharing unless, at least 60 days before making the formulary change, the health

1 care plan:
2 (A) provides general notification of the change in
3 its formulary to current and prospective enrollees;
4 (B) directly notifies enrollees currently
5 receiving coverage for the drug, including information
6 on the specific drugs involved and the steps they may
7 take to request coverage determinations and
8 exceptions, including a statement that a certification
9 of medical necessity by the enrollee's prescribing
10 provider will result in continuation of coverage at
11 the existing level; and
12 (C) directly notifies by first class mail and
13 through an electronic transmission, if available, the
14 prescribing provider of all health care plan enrollees
15 currently prescribed the drug affected by the proposed
16 change; the notice shall include a one-page form by
17 which the prescribing provider can notify the health
18 care plan by first class mail that coverage of the drug
19 for the enrollee is medically necessary.
20 The notification in paragraph (C) may direct the
21 prescribing provider to an electronic portal through which
22 the prescribing provider may electronically file a
23 certification to the health care plan that coverage of the
24 drug for the enrollee is medically necessary. The
25 prescribing provider may make a secure electronic
26 signature beside the words "certification of medical

necessity", and this certification shall authorize continuation of coverage for the drug.

If the prescribing provider certifies to the health care plan either in writing or electronically that the drug is medically necessary for the enrollee as provided in paragraph (C), a health care plan shall authorize coverage for the drug prescribed based solely on the prescribing provider's assertion that coverage is medically necessary, and the health care plan is prohibited from making modifications to the coverage related to the covered drug, including, but not limited to:

(i) increasing the out-of-pocket costs for the covered drug;

(ii) moving the covered drug to a more restrictive tier; or

(iii) denying an enrollee coverage of the drug for which the enrollee has been previously approved for coverage by the health care plan.

Nothing in this item (3) prevents a health care plan from removing a drug from its formulary or denying an enrollee coverage if the United States Food and Drug Administration has issued a statement about the drug that calls into question the clinical safety of the drug, the drug manufacturer has notified the United States Food and Drug Administration of a manufacturing discontinuance or

potential discontinuance of the drug as required by Section 506C of the Federal Food, Drug, and Cosmetic Act, as codified in 21 U.S.C. 356c, or the drug manufacturer has removed the drug from the market.

Nothing in this item (3) prohibits a health care plan, by contract, written policy or procedure, or any other agreement or course of conduct, from requiring a pharmacist to effect substitutions of prescription drugs consistent with Section 19.5 of the Pharmacy Practice Act, under which a pharmacist may substitute an interchangeable biologic for a prescribed biologic product, and Section 25 of the Pharmacy Practice Act, under which a pharmacist may select a generic drug determined to be therapeutically equivalent by the United States Food and Drug Administration and in accordance with the Illinois Food, Drug and Cosmetic Act.

This item (3) applies to a policy or contract that is amended, delivered, issued, or renewed on or after January 1, 2019. This item (3) does not apply to a health plan as defined in the State Employees Group Insurance Act of 1971 or medical assistance under Article V of the Illinois Public Aid Code.

(b) A health care plan shall provide for continuity of care for new enrollees as follows:

(1) If a new enrollee whose physician is not a member of the health care plan's provider network, but is within

1 the health care plan's service area, enrolls in the health
2 care plan, the health care plan shall permit the enrollee
3 to continue an ongoing course of treatment with the
4 enrollee's current physician during a transitional period:
5 (A) of 90 days from the effective date of
6 enrollment if the enrollee has an ongoing course of
7 treatment; or
8 (B) if the enrollee has entered the third
9 trimester of pregnancy at the effective date of
10 enrollment, that includes the provision of post-partum
11 care directly related to the delivery.
12 (2) If an enrollee elects to continue to receive care
13 from such physician pursuant to item (1) of this
14 subsection, such care shall be authorized by the health
15 care plan for the transitional period only if the
16 physician agrees:
17 (A) to accept reimbursement from the health care
18 plan at rates established by the health care plan;
19 such rates shall be the level of reimbursement
20 applicable to similar physicians within the health
21 care plan for such services;
22 (B) to adhere to the health care plan's quality
23 assurance requirements and to provide to the health
24 care plan necessary medical information related to
25 such care; and
26 (C) to otherwise adhere to the health care plan's

policies and procedures including, but not limited to procedures regarding referrals and obtaining preauthorization for treatment.

(c) In no event shall this Section be construed to require a health care plan to provide coverage for benefits not otherwise covered or to diminish or impair preexisting condition limitations contained in the enrollee's contract. In no event shall this Section be construed to prohibit the addition of prescription drugs to a health care plan's list of covered drugs during the coverage year.

(d) In this Section, "ongoing course of treatment" has the meaning ascribed to that term in Section 5 of the Network Adequacy and Transparency Act.

(Source: P.A. 100-1052, eff. 8-24-18.)

Section 95. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

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