Rep. Margaret Croke

Filed: 4/12/2024

AMENDMENT TO HOUSE BILL 5313

AMENDMENT NO. _____. Amend House Bill 5313 by replacing everything after the enacting clause with the following:

"Section 5. The Network Adequacy and Transparency Act is amended by changing Section 25 and by adding Section 35 as follows:

(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 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) The network plan shall, at least every 90 days, audit each ~~periodically at least 25%~~ of its provider directories for accuracy, make any corrections necessary, and retain documentation of the audit. If inaccurate information for a provider is found in any provider directory, the health carrier, as defined in Section 10 of the Health Carrier External Review Act shall check all its network plan directories to identify and correct all inaccuracies associated with that provider. The network plan shall submit the audit to the Department, and the Department shall make a summary of each audit publicly available ~~Director upon request~~. The Department shall

specify the requirements of the summary. 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 audit shall comply with 42 U.S.C. 300gg-115(a)(2), except that "provider directory information" shall include all information required under this Act.

(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 at least every 90 days ~~quarterly~~, and ~~an~~ errata that reflect ~~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; and~~.~~

(E) a detailed description of the process to dispute charges for out-of-network providers or facilities that were incorrectly listed as in-network prior to the provision of care and a telephone number and email address to dispute such charges.

(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) patient population served (such as pediatric, adult, elderly, or women) and specialty or subspecialty, 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; and

(L) the anticipated date the provider will leave the network, if applicable, which shall be included not more than 10 days after the network confirms that the provider is scheduled to leave the network in accordance with Section 15 of this Act; and

(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; and~~.~~

(E) the anticipated date the facility will leave the network, if applicable, which shall be included not more than 10 days after the network confirms the facility is scheduled to leave the network.

(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, including a telephone number and any other digital contact information the provider has supplied; 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, including a telephone

number and any other digital contact information the provider has supplied;

(C) participating office location or locations;

(D) patient population (such as pediatric, adult, elderly, or women) and specialty or subspecialty, 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 digital contact information; and

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

(A) facility name;

(B) facility type;

(C) patient population (such as pediatric, adult, elderly, or women) served, if applicable, and types of services performed; and

(D) participating facility location or locations, ~~and~~ telephone numbers, and digital contact information.

(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 and email address in the print format provider directory for a customer service representative where the beneficiary can obtain current provider directory information or report directory inaccuracies. The network plan shall include in the print format provider directory a detailed description of the process to dispute charges for out-of-network providers or facilities that were incorrectly listed as in-network prior to the provision of care and a

telephone number and email address to dispute those charges.

(f) The Director may conduct periodic audits of the accuracy of provider directories and shall conduct audits of at least 10% of plans each year, with at least one plan from each health carrier under the Department's jurisdiction. The Director shall require a network plan to correct any inaccuracies found within 2 business days after the network plan is notified of an inaccuracy. If an audit of any health carrier's plan finds that more than 1% of providers listed in the audited directory are not participating providers, the Director shall require the health carrier to have an audit conducted of each of the health carrier's network plans by an unaffiliated independent firm qualified to conduct such audits at the health carrier's expense and shall provide all audits to the Director. The Director shall specify requirements, including qualifications of the auditor, relating to those audits and audit summaries. The Department shall make summaries of audits publicly available on its website. 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) If a nonparticipating provider listed in a network plan directory is identified by the network plan or Director, the health carrier shall do all of the following:

(1) Check each of the health carrier's network plan directories for the provider within 2 business days to

ascertain whether the provider is participating in that network plan and, if the provider is incorrectly listed as participating, remove the provider without delay.

(2) Identify the dates across each of the health carrier's network plan directories that the provider was listed when the provider was not a participating provider.

(3) For network plans with an out-of-network benefit, identify all claims for services provided by the provider on an out-of-network basis during the period which the provider was incorrectly listed as a participating provider in the network directory and reimburse each affected beneficiary the amount necessary to ensure the beneficiary is held harmless for all amounts exceeding the amount the beneficiary would have paid had the services been provided in-network. All out-of-pocket costs incurred by the beneficiary shall apply toward the in-network deductible and out-of-pocket maximum.

(4) For each beneficiary who had an in-network claim for services from the provider during the year prior to the date that the provider ceased to be a participating in the network plan, send mail and electronic communications to the beneficiary informing the beneficiary of the inaccurate listing, including the dates thereof, and the beneficiary's rights as described in subparagraph (F) of paragraph (5) of subsection (a) if the beneficiary received services from the provider on dates when the

provider was inaccurately listed in the directory as in-network. The Director may specify required language and additional content of such communications.

(h) Each network plan shall maintain records, for a minimum of 5 years, of all providers listed in its network directory, including the dates each provider was listed in the network, the information listed, and the date and content of any changes to directory information.

(i) If a network plan fails to provide notice to beneficiaries of a nonrenewal or termination of a provider pursuant to Section 15 of this Act and that nonrenewal or termination takes effect, services delivered by the provider shall be reimbursed as if the provider was in-network until the requirements, including any relevant notice period, of Section 15 have been met. In such cases, the network plan shall hold the beneficiary harmless for all amounts exceeding the amount the beneficiary would have paid had the services been provided in-network. The amounts paid by the beneficiary shall apply toward the in-network deductible and out-of-pocket maximum.

(j) If the Director determines that a network plan or any entity or person acting on the network plan's behalf has violated this Section, the Director may, after appropriate notice and opportunity for hearing, by order, assess a civil penalty up to $5,000 per violation, as adjusted under subsection (k), except for inaccurate contact information

given by the provider. If a network plan or any entity or person acting on the network plan's behalf knew or reasonably should have known that the action was in violation of this Section, the Director may, after appropriate notice and opportunity for hearing, by order, assess a civil penalty up to $25,000 per violation, as adjusted under subsection (k). The civil penalties available to the Director under this Section are not exclusive and may be sought and employed in combination with any other remedies available to the Director under this Act.

(k) Beginning January 1, 2030, and every 5 years thereafter, the penalty amounts specified in this Section shall be adjusted based on the average rate of change in premium rates for the individual and small group markets, and weighted by enrollment, since the previous adjustment.

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

(215 ILCS 124/35 new)

Sec. 35. Complaint of incorrect charges.

(a) A beneficiary who incurs a cost for inappropriate out-of-network charges for a provider, facility, or hospital that was listed as in-network prior to the provision of services may file a complaint with the Department. The Department shall conduct an investigation of any complaint and shall determine that the complaint is confirmed if the beneficiary was provided with inaccurate information provided

by the network plan.

(b) Upon a finding that a complaint is confirmed, a network plan shall reimburse the beneficiary the amount necessary to ensure the beneficiary is held harmless for all amounts exceeding the amount the beneficiary would have paid had the services been provided in-network. All out-of-pocket costs incurred by the beneficiary shall apply toward the in-network deductible and out-of-pocket maximum.

Section 99. Effective date. This Act takes effect January 1, 2025.".