HB4703

LRB10224386BMS33620b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB4703

Introduced 1/27/2022, by Rep. Bob Morgan

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.3	
215 ILCS 5/356z.3a	
215 ILCS 124/10	
215 ILCS 125/4.5-1	
215 ILCS 125/5-3	from Ch. 111 1/2, par. 1411.2
215 ILCS 134/70	
215 ILCS 165/10	from Ch. 32, par. 604

Amends the Illinois Insurance Code. Provides that when an insured receives emergency services or covered ancillary services from a nonparticipating provider or a nonparticipating facility, the health insurance issuer shall ensure that cost-sharing requirements are applied as though the services had been received from a participating provider or facility, and that the insured or any group policyholder or plan sponsor shall not be liable to or billed by the health insurance issuer, the nonparticipating provider, or the facility beyond the cost-sharing amount. Contains provisions concerning a notice and consent process for out-of-network coverage; billing for reasonable administrative fees; assignment of benefits to nonparticipating providers; and cost-sharing amounts and deductibles. Amends the Illinois Insurance Code and the Health Maintenance Organization Act to make a change in provisions concerning disclosure of nonparticipating provider benefits. Amends the Network Adequacy and Transparency Act. Provides that a beneficiary who receives care at a participating health care facility shall not be required to search for participating providers under certain circumstances. Amends the Managed Care Reform and Patient Rights Act. Provides that prior authorization or approval by the plan shall not be required for post-stabilization services that constitute emergency services. Amends the Health Maintenance Organization Act and the Voluntary Health Services Plans Act to provide that health maintenance organizations and voluntary health services plans are subject to provisions of the Illinois Insurance Code concerning billing and cost sharing. Makes other changes. Effective July 1, 2022, except that certain changes take effect January 1, 2023.

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A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Illinois Insurance Code is amended by changing Sections 356z.3 and 356z.3a as follows:

(215 ILCS 5/356z.3)

Sec. 356z.3. Disclosure of limited benefit. An insurer that issues, delivers, amends, or renews an individual or group policy of accident and health insurance in this State after the effective date of this amendatory Act of the 92nd General Assembly and arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the

geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill, except as provided in Section 356z.3a of the Illinois Insurance Code for covered services received at a participating health care facility from a nonparticipating provider that are: (a) ancillary services, (b) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is furnished, or (c) items or services received when the facility or the non-participating provider fails to satisfy the notice and consent criteria specified under Section 356z.3a. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.".

(Source: P.A. 96-1523, eff. 6-1-11; 97-813, eff. 7-13-12.)

(215 ILCS 5/356z.3a)

Sec. 356z.3a. Billing; emergency services; nonparticipating providers ~~Nonparticipating facility based~~

~~physicians and providers~~.

(a) As used in this Section: ~~For purposes of this Section, "facility-based provider" means a physician or other provider who provide radiology, anesthesiology, pathology, neonatology, or emergency department services to insureds, beneficiaries, or enrollees in a participating hospital or participating ambulatory surgical treatment center.~~

"Ancillary services" means:

(1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology that are provided by any health care provider;

(2) items and services provided by assistant surgeons, hospitalists, and intensivists;

(3) diagnostic services, including radiology and laboratory services; and

(4) items and services provided by a nonparticipating provider if there is no participating provider who can furnish the item or service at the facility.

"Cost sharing" means the amount an insured, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the policy or certificate. "Cost sharing" includes copayments, coinsurance, and amounts paid toward deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under the policy or certificate.

"Emergency department of a hospital" means any hospital department that provides emergency services, including a hospital outpatient department.

"Emergency medical condition" has the meaning ascribed to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Emergency medical screening examination" has the meaning ascribed to that term in Section 10 of the Managed Care Reform and Patient Rights Act.

"Emergency services" means, with respect to an emergency medical condition:

(1) in general, an emergency medical screening examination, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment as would be required to stabilize the patient regardless of the department of the hospital or other facility in which such further examination or treatment is furnished; or

(2) additional items and services for which benefits are provided or covered under the coverage and that are furnished by a nonparticipating provider or nonparticipating emergency facility regardless of the department of the hospital or other facility in which such items are furnished after the insured, beneficiary, or enrollee is stabilized and as part of outpatient

observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (1) are furnished. Services after stabilization cease to be emergency services only when all the conditions of 42 U.S.C. 300gg-111(a)(3)(C)(ii)(II) and regulations thereunder are met.

"Freestanding Emergency Center" means a facility licensed under Section 32.5 of the Emergency Medical Services (EMS) Systems Act.

"Health care facility" means, in the context of non-emergency services, any of the following:

(1) a hospital as defined in 42 U.S.C. 1395x(e);

(2) a hospital outpatient department;

(3) a critical access hospital certified under 42 U.S.C. 1395i-4(e);

(4) an ambulatory surgical treatment center as defined in the Ambulatory Surgical Treatment Center Act; or

(5) any recipient of a license under the Hospital Licensing Act that is not otherwise described in this definition.

"Health care provider" means a provider as defined in subsection (d) of Section 370g. "Health care provider" does not include a provider of air ambulance or ground ambulance services.

"Health care services" has the meaning ascribed to that term in subsection (a) of Section 370g.

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

"Nonparticipating emergency facility" means, with respect to the furnishing of an item or service under a policy of group or individual health insurance coverage, any of the following facilities that does not have a contractual relationship directly or indirectly with a health insurance issuer in relation to the coverage:

(1) an emergency department of a hospital;

(2) a Freestanding Emergency Center;

(3) an ambulatory surgical treatment center as defined in the Ambulatory Surgical Treatment Center Act; or

(4) with respect to emergency services described in paragraph (2) of the definition of "emergency services", a hospital.

"Nonparticipating provider" means, with respect to the furnishing of an item or service under a policy of group or individual health insurance coverage, any health care provider who does not have a contractual relationship directly or indirectly with a health insurance issuer in relation to the coverage.

"Participating emergency facility" means any of the following facilities that has a contractual relationship directly or indirectly with a health insurance issuer offering group or individual health insurance coverage setting forth

the terms and conditions on which a relevant health care service is provided to an insured, beneficiary, or enrollee under the coverage:

(1) an emergency department of a hospital;

(2) a Freestanding Emergency Center;

(3) an ambulatory surgical treatment center as defined in the Ambulatory Surgical Treatment Center Act; or

(4) with respect to emergency services described in paragraph (2) of the definition of "emergency services", a hospital.

For purposes of this definition, a single case agreement between an emergency facility and an issuer that is used to address unique situations in which an insured, beneficiary, or enrollee requires services that typically occur out-of-network constitutes a contractual relationship and is limited to the parties to the agreement.

"Participating health care facility" means any health care facility that has a contractual relationship directly or indirectly with a health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant health care service is provided to an insured, beneficiary, or enrollee under the coverage. A single case agreement between an emergency facility and an issuer that is used to address unique situations in which an insured, beneficiary, or enrollee requires services that typically occur out-of-network

constitutes a contractual relationship for purposes of this definition and is limited to the parties to the agreement.

"Participating provider" means any health care provider that has a contractual relationship directly or indirectly with a health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant health care service is provided to an insured, beneficiary, or enrollee under the coverage.

"Recognized amount" means the lesser of:

(1) the amount billed by the provider;

(2) the amount negotiated under subsection (d); or

(3) the amount determined after arbitration under subsection (e).

"Stabilize" means "stabilization" as defined in Section 10 of the Managed Care Reform and Patient Rights Act.

"Treating provider" means a health care provider who has evaluated the individual.

"Visit" means, with respect to health care services furnished to an individual at a health care facility, health care services furnished by a provider at the facility, as well as equipment, devices, telehealth services, imaging services, laboratory services, and preoperative and postoperative services regardless of whether the provider furnishing such services is at the facility.

(b) Emergency services. When a beneficiary, insured, or enrollee receives emergency services from a nonparticipating

provider or a nonparticipating emergency facility, the health insurance issuer shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating provider or a participating emergency facility. Any cost-sharing requirements shall be applied as though the emergency services had been received from a participating provider or a participating facility. Cost sharing shall be calculated based on the recognized amount for the emergency services. In no event shall the beneficiary, insured, enrollee, or any group policyholder or plan sponsor be liable to or billed by the health insurance issuer, the nonparticipating provider, or the nonparticipating emergency facility for any amount beyond the cost sharing calculated in accordance with this subsection with respect to the emergency services delivered. Administrative requirements or limitations shall be no greater than those applicable to emergency services received from a participating provider or a participating emergency facility.

(b-5) Non-emergency services at participating health care facilities.

(1) When a beneficiary, insured, or enrollee utilizes a participating health care facility ~~network hospital or a participating network ambulatory surgery center~~ and, due to any reason, covered ancillary services ~~in network services for radiology, anesthesiology, pathology,~~

~~emergency physician, or neonatology are unavailable and~~ are provided by a nonparticipating ~~facility-based physician or~~ provider during or resulting from the visit, the health insurance issuer ~~insurer or health plan~~ shall ensure that the beneficiary, insured, or enrollee shall incur no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating ~~physician or~~ provider for the ancillary ~~covered~~ services. Any cost-sharing requirements shall be applied as though the ancillary services had been received from a participating provider. Cost sharing shall be calculated based on the recognized amount for the ancillary services. In no event shall the beneficiary, insured, enrollee, or any group policyholder or plan sponsor be liable to or billed by the health insurance issuer, the nonparticipating provider, or the participating health care facility for any amount beyond the cost sharing calculated in accordance with this subsection with respect to the ancillary services delivered. In addition to ancillary services, the requirements of this paragraph shall also apply with respect to covered items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent criteria under paragraph (2) of this subsection.

(2) When a beneficiary, insured, or enrollee utilizes a participating health care facility and receives non-emergency covered health care services other than those described in paragraph (1) of this subsection from a nonparticipating provider during or resulting from the visit, the health insurance issuer shall ensure that the beneficiary, insured, or enrollee incurs no greater out-of-pocket costs than the beneficiary, insured, or enrollee would have incurred with a participating provider unless the nonparticipating provider, or the participating health care facility on behalf of the nonparticipating provider, satisfies the notice and consent criteria provided in 42 U.S.C. 300gg-132 and regulations promulgated thereunder. If the notice and consent criteria are not satisfied, then:

(A) any cost-sharing requirements shall be applied as though the health care services had been received from a participating provider;

(B) cost sharing shall be calculated based on the recognized amount for the health care services; and

(C) in no event shall the beneficiary, insured, enrollee, or any group policyholder or plan sponsor be liable to or billed by the health insurance issuer, the nonparticipating provider, or the participating health care facility for any amount beyond the cost sharing calculated in accordance with this subsection

with respect to the health care services delivered.

(c) Notwithstanding ~~If a beneficiary, insured, or enrollee agrees in writing, notwithstanding~~ any other provision of this Code, except when the notice and consent criteria are satisfied for the situation in paragraph (2) of subsection (b-5), any benefits a beneficiary, insured, or enrollee receives for services under the situations ~~situation~~ in subsections ~~subsection~~ (b) or (b-5) are assigned to the nonparticipating ~~facility based~~ providers or the facility acting on their behalf. The health insurance issuer ~~insurer or health plan~~ shall provide the nonparticipating provider or the facility with a written explanation of benefits that specifies the proposed reimbursement and the applicable deductible, copayment or coinsurance amounts owed by the insured, beneficiary or enrollee. The health insurance issuer ~~insurer or health plan~~ shall pay any reimbursement subject to this Section directly to the nonparticipating ~~facility based~~ provider or the facility. ~~The nonparticipating facility based physician or provider shall not bill the beneficiary, insured, or enrollee, except for applicable deductible, copayment, or coinsurance amounts that would apply if the beneficiary, insured, or enrollee utilized a participating physician or provider for covered services. If a beneficiary, insured, or enrollee specifically rejects assignment under this Section in writing to the nonparticipating facility-based provider, then the nonparticipating facility based provider may bill the~~

~~beneficiary, insured, or enrollee for the services rendered.~~

(d) For bills assigned under subsection (c), the nonparticipating ~~facility-based~~ provider or the facility may bill the health insurance issuer ~~insurer or health plan~~ for the services rendered, and the health insurance issuer ~~insurer or health plan~~ may pay the billed amount or attempt to negotiate reimbursement with the nonparticipating ~~facility-based~~ provider or the facility. Within 30 calendar days after the provider or facility transmits the bill to the health insurance issuer, the issuer shall send an initial payment or notice of denial of payment with the written explanation of benefits to the provider or facility. If attempts to negotiate reimbursement for services provided by a nonparticipating ~~facility-based~~ provider do not result in a resolution of the payment dispute within 30 days after receipt of written explanation of benefits by the health insurance issuer ~~insurer or health plan~~, then the health insurance issuer ~~an insurer or health plan~~ or nonparticipating ~~facility-based physician or~~ provider or the facility may initiate binding arbitration to determine payment for services provided on a per bill basis. The party requesting arbitration shall notify the other party arbitration has been initiated and state its final offer before arbitration. In response to this notice, the nonrequesting party shall inform the requesting party of its final offer before the arbitration occurs. Arbitration shall be initiated by filing a request

with the Department of Insurance.

(e) The Department of Insurance shall publish a list of approved arbitrators or entities that shall provide binding arbitration. These arbitrators shall be American Arbitration Association or American Health Lawyers Association trained arbitrators. Both parties must agree on an arbitrator from the Department of Insurance's or its approved entity's list of arbitrators. If no agreement can be reached, then a list of 5 arbitrators shall be provided by the Department of Insurance or the approved entity. From the list of 5 arbitrators, the health insurance issuer ~~insurer~~ can veto 2 arbitrators and the provider or facility can veto 2 arbitrators. The remaining arbitrator shall be the chosen arbitrator. This arbitration shall consist of a review of the written submissions by both parties. Binding arbitration shall provide for a written decision within 45 days after the request is filed with the Department of Insurance. Both parties shall be bound by the arbitrator's decision. The arbitrator's expenses and fees, together with other expenses, not including attorney's fees, incurred in the conduct of the arbitration, shall be paid as provided in the decision.

(f) (Blank). ~~This Section 356z.3a does not apply to a beneficiary, insured, or enrollee who willfully chooses to access a nonparticipating facility-based physician or provider for health care services available through the insurer's or plan's network of participating physicians and providers. In~~

~~these circumstances, the contractual requirements for nonparticipating facility-based provider reimbursements will apply.~~

(g) Section 368a of this Act shall not apply during the pendency of a decision under subsection (d). Upon the issuance of the arbitrator's decision, Section 368a applies with respect to the amount, if any, by which the arbitrator's determination exceeds the issuer's initial payment under subsection (c), or the entire amount of the arbitrator's determination if initial payment was denied. Any ~~any~~ interest required to be paid a provider under Section 368a shall not accrue until after 30 days of an arbitrator's decision as provided in subsection (d), but in no circumstances longer than 150 days from date the nonparticipating facility-based provider billed for services rendered.

(h) Nothing in this Section shall be interpreted to change the prudent layperson provisions with respect to emergency services under the Managed Care Reform and Patient Rights Act.

(i) Nothing in this Section shall preclude a health care provider from billing a beneficiary, insured, or enrollee for reasonable administrative fees, such as service fees for checks returned for nonsufficient funds and missed appointments.

(j) Nothing in this Section shall preclude a beneficiary, insured, or enrollee from assigning benefits to a nonparticipating provider when the notice and consent criteria

are satisfied under paragraph (2) of subsection (b-5) or in any other situation not described in subsections (b) or (b-5).

(k) Except when the notice and consent criteria are satisfied under paragraph (2) of subsection (b-5), if an individual receives health care services under the situations described in subsections (b) or (b-5), no referral requirement or any other provision contained in the policy or certificate of coverage shall deny coverage, reduce benefits, or otherwise defeat the requirements of this Section for services that would have been covered with a participating provider. However, this subsection shall not be construed to preclude a provider contract with a health insurance issuer, or with an administrator or similar entity acting on the issuer's behalf, from imposing requirements on the participating provider, participating emergency facility, or participating health care facility relating to the referral of covered individuals to nonparticipating providers.

(l) Except if the notice and consent criteria are satisfied under paragraph (2) of subsection (b-5), cost-sharing amounts calculated in conformity with this Section shall count toward any deductible or out-of-pocket maximum applicable to in-network coverage.

(m) The Department has the authority to enforce the requirements of this Section in the situations described in subsections (b) and (b-5), and in any other situation for which 42 U.S.C. Chapter 6A, Subchapter XXV, Parts D or E and

regulations promulgated thereunder would prohibit an individual from being billed or liable for emergency services furnished by a nonparticipating provider or nonparticipating emergency facility or for non-emergency health care services furnished by a nonparticipating provider at a participating health care facility.

(n) This Section does not apply with respect to air ambulance or ground ambulance services. This Section does not apply to any policy of excepted benefits or to short-term, limited-duration health insurance coverage.

(Source: P.A. 98-154, eff. 8-2-13.)

Section 10. The Network Adequacy and Transparency Act is amended by changing Section 10 as follows:

(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 woman'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, or unreasonable travel distance or delay, 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 subsections (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. 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).

(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).

(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.

(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 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.)

Section 15. The Health Maintenance Organization Act is amended by changing Sections 4.5-1 and 5-3 as follows:

(215 ILCS 125/4.5-1)

Sec. 4.5-1. Point-of-service health service contracts.

(a) A health maintenance organization that offers a point-of-service contract:

(1) must include as in-plan covered services all services required by law to be provided by a health maintenance organization;

(2) must provide incentives, which shall include

financial incentives, for enrollees to use in-plan covered services;

(3) may not offer services out-of-plan without providing those services on an in-plan basis;

(4) may include annual out-of-pocket limits and lifetime maximum benefits allowances for out-of-plan services that are separate from any limits or allowances applied to in-plan services;

(5) may not consider emergency services, authorized referral services, or non-routine services obtained out of the service area to be point-of-service services;

(6) may treat as out-of-plan services those services that an enrollee obtains from a participating provider, but for which the proper authorization was not given by the health maintenance organization; and

(7) after the effective date of this amendatory Act of the 92nd General Assembly, must include the following disclosure on its point-of-service contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual

and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill, except as provided in Section 356z.3a of the Illinois Insurance Code for covered services received at a participating health care facility from a non-participating provider that are: (a) ancillary services, (b) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time the item or service is furnished, or (c) items or services received when the facility or the non-participating provider fails to satisfy the notice and consent criteria specified under Section 356z.3a. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.".

(b) A health maintenance organization offering a point-of-service contract is subject to all of the following

limitations:

(1) The health maintenance organization may not expend in any calendar quarter more than 20% of its total expenditures for all its members for out-of-plan covered services.

(2) If the amount specified in item (1) of this subsection is exceeded by 2% in a quarter, the health maintenance organization must effect compliance with item (1) of this subsection by the end of the following quarter.

(3) If compliance with the amount specified in item (1) of this subsection is not demonstrated in the health maintenance organization's next quarterly report, the health maintenance organization may not offer the point-of-service contract to new groups or include the point-of-service option in the renewal of an existing group until compliance with the amount specified in item (1) of this subsection is demonstrated or until otherwise allowed by the Director.

(4) A health maintenance organization failing, without just cause, to comply with the provisions of this subsection shall be required, after notice and hearing, to pay a penalty of $250 for each day out of compliance, to be recovered by the Director. Any penalty recovered shall be paid into the General Revenue Fund. The Director may reduce the penalty if the health maintenance organization

demonstrates to the Director that the imposition of the penalty would constitute a financial hardship to the health maintenance organization.

(c) A health maintenance organization that offers a point-of-service product must do all of the following:

(1) File a quarterly financial statement detailing compliance with the requirements of subsection (b).

(2) Track out-of-plan, point-of-service utilization separately from in-plan or non-point-of-service, out-of-plan emergency care, referral care, and urgent care out of the service area utilization.

(3) Record out-of-plan utilization in a manner that will permit such utilization and cost reporting as the Director may, by rule, require.

(4) Demonstrate to the Director's satisfaction that the health maintenance organization has the fiscal, administrative, and marketing capacity to control its point-of-service enrollment, utilization, and costs so as not to jeopardize the financial security of the health maintenance organization.

(5) Maintain, in addition to any other deposit required under this Act, the deposit required by Section 2-6.

(6) Maintain cash and cash equivalents of sufficient amount to fully liquidate 10 days' average claim payments, subject to review by the Director.

(7) Maintain and file with the Director, reinsurance coverage protecting against catastrophic losses on out of network point-of-service services. Deductibles may not exceed $100,000 per covered life per year, and the portion of risk retained by the health maintenance organization once deductibles have been satisfied may not exceed 20%. Reinsurance must be placed with licensed authorized reinsurers qualified to do business in this State.

(d) A health maintenance organization may not issue a point-of-service contract until it has filed and had approved by the Director a plan to comply with the provisions of this Section. The compliance plan must, at a minimum, include provisions demonstrating that the health maintenance organization will do all of the following:

(1) Design the benefit levels and conditions of coverage for in-plan covered services and out-of-plan covered services as required by this Article.

(2) Provide or arrange for the provision of adequate systems to:

(A) process and pay claims for all out-of-plan covered services;

(B) meet the requirements for point-of-service contracts set forth in this Section and any additional requirements that may be set forth by the Director; and

(C) generate accurate data and financial and

regulatory reports on a timely basis so that the Department of Insurance can evaluate the health maintenance organization's experience with the point-of-service contract and monitor compliance with point-of-service contract provisions.

(3) Comply with the requirements of subsections (b) and (c).

(Source: P.A. 92-135, eff. 1-1-02; 92-579, eff. 1-1-03.)

(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, 355.2, 355.3, 355b, 356g.5-1, 356m, 356q, 356v, 356w, 356x, 356y, 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.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.35, 356z.36, 356z.40, 356z.41, 356z.43, 356z.46, 356z.47, 356z.48, 356z.50, 356z.51, 364, 364.01, 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. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21; 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; revised 10-27-21.)

Section 20. The Managed Care Reform and Patient Rights Act is amended by changing Section 70 as follows:

(215 ILCS 134/70)

Sec. 70. Post-stabilization medical services.

(a) If prior authorization for covered post-stabilization services is required by the health care plan, the plan shall provide access 24 hours a day, 7 days a week to persons

designated by the plan to make such determinations, provided that any determination made under this Section must be made by a health care professional. The review shall be resolved in accordance with the provisions of Section 85 and the time requirements of this Section.

(a-5) Prior authorization or approval by the plan shall not be required for post-stabilization services that constitute emergency services under Section 356z.3a of the Illinois Insurance Code.

(b) The treating physician licensed to practice medicine in all its branches or health care provider shall contact the health care plan or delegated health care provider as designated on the enrollee's health insurance card to obtain authorization, denial, or arrangements for an alternate plan of treatment or transfer of the enrollee.

(c) The treating physician licensed to practice medicine in all its branches or health care provider shall document in the enrollee's medical record the enrollee's presenting symptoms; emergency medical condition; and time, phone number dialed, and result of the communication for request for authorization of post-stabilization medical services. The health care plan shall provide reimbursement for covered post-stabilization medical services if:

(1) authorization to render them is received from the health care plan or its delegated health care provider, or

(2) after 2 documented good faith efforts, the

treating health care provider has attempted to contact the enrollee's health care plan or its delegated health care provider, as designated on the enrollee's health insurance card, for prior authorization of post-stabilization medical services and neither the plan nor designated persons were accessible or the authorization was not denied within 60 minutes of the request. "Two documented good faith efforts" means the health care provider has called the telephone number on the enrollee's health insurance card or other available number either 2 times or one time and an additional call to any referral number provided. "Good faith" means honesty of purpose, freedom from intention to defraud, and being faithful to one's duty or obligation. For the purpose of this Act, good faith shall be presumed.

(d) After rendering any post-stabilization medical services, the treating physician licensed to practice medicine in all its branches or health care provider shall continue to make every reasonable effort to contact the health care plan or its delegated health care provider regarding authorization, denial, or arrangements for an alternate plan of treatment or transfer of the enrollee until the treating health care provider receives instructions from the health care plan or delegated health care provider for continued care or the care is transferred to another health care provider or the patient is discharged.

(e) Payment for covered post-stabilization services may be denied:

(1) if the treating health care provider does not meet the conditions outlined in subsection (c);

(2) upon determination that the post-stabilization services claimed were not performed;

(3) upon timely determination that the post-stabilization services rendered were contrary to the instructions of the health care plan or its delegated health care provider if contact was made between those parties prior to the service being rendered;

(4) upon determination that the patient receiving such services was not an enrollee of the health care plan; or

(5) upon material misrepresentation by the enrollee or health care provider; "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

(f) Nothing in this Section prohibits a health care plan from delegating tasks associated with the responsibilities enumerated in this Section to the health care plan's contracted health care providers or another entity. Only a clinical peer may make an adverse determination. However, the ultimate responsibility for coverage and payment decisions may not be delegated.

(g) Coverage and payment for post-stabilization medical services for which prior authorization or deemed approval is

received shall not be retrospectively denied.

(h) Nothing in this Section shall prohibit the imposition of deductibles, copayments, and co-insurance. Nothing in this Section alters the prohibition on billing enrollees contained in the Health Maintenance Organization Act.

(Source: P.A. 91-617, eff. 1-1-00.)

Section 25. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b, 356g, 356g.5, 356g.5-1, 356q, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 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.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.30a, 356z.32, 356z.33, 356z.40, 356z.41, 356z.46, 356z.47, 356z.51, ~~356z.43,~~ 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

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. 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-625, eff. 1-1-21; 102-30, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; revised 10-27-21.)

Section 99. Effective date. This Act takes effect July 1, 2022, except that the changes to Section 356z.3 of the Illinois Insurance Code and Section 4.5-1 of the Health Maintenance Organization Act take effect January 1, 2023.