HB5801

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB5801

Introduced 4/2/2024, by Rep. Lindsey LaPointe

SYNOPSIS AS INTRODUCED:

215 ILCS 124/10

Amends the Network Adequacy and Transparency Act. Provides that the Department of Insurance shall consider establishing ratios for providers of genetic medicine and genetic counseling.

LRB103 39930 RPS 70997 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 Network Adequacy and Transparency Act is
5 amended by changing Section 10 as follows:

6 (215 ILCS 124/10)
7 Sec. 10. Network adequacy.
8 (a) An insurer providing a network plan shall file a
9 description of all of the following with the Director:
10 (1) The written policies and procedures for adding
11 providers to meet patient needs based on increases in the
12 number of beneficiaries, changes in the
13 patient-to-provider ratio, changes in medical and health
14 care capabilities, and increased demand for services.
15 (2) The written policies and procedures for making
16 referrals within and outside the network.
17 (3) The written policies and procedures on how the
18 network plan will provide 24-hour, 7-day per week access
19 to network-affiliated primary care, emergency services,
20 and women's principal health care providers.
21 An insurer shall not prohibit a preferred provider from
22 discussing any specific or all treatment options with
23 beneficiaries irrespective of the insurer's position on those

1 treatment options or from advocating on behalf of
2 beneficiaries within the utilization review, grievance, or
3 appeals processes established by the insurer in accordance
4 with any rights or remedies available under applicable State
5 or federal law.

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

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

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

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

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

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

1 (A) the type of health care services to be
2 provided by the network plan;
3 (B) the ratio of physicians and other providers to
4 beneficiaries, by specialty and including primary care
5 physicians and facility-based physicians when
6 applicable under the contract, necessary to meet the
7 health care needs and service demands of the currently
8 enrolled population;
9 (C) the travel and distance standards for plan
10 beneficiaries in county service areas; and
11 (D) a description of how the use of telemedicine,
12 telehealth, or mobile care services may be used to
13 partially meet the network adequacy standards, if
14 applicable.
15 (6) A provision ensuring that whenever a beneficiary
16 has made a good faith effort, as evidenced by accessing
17 the provider directory, calling the network plan, and
18 calling the provider, to utilize preferred providers for a
19 covered service and it is determined the insurer does not
20 have the appropriate preferred providers due to
21 insufficient number, type, unreasonable travel distance or
22 delay, or preferred providers refusing to provide a
23 covered service because it is contrary to the conscience
24 of the preferred providers, as protected by the Health
25 Care Right of Conscience Act, the insurer shall ensure,
26 directly or indirectly, by terms contained in the payer

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

18 (7) A provision that the beneficiary shall receive
19 emergency care coverage such that payment for this
20 coverage is not dependent upon whether the emergency
21 services are performed by a preferred or non-preferred
22 provider and the coverage shall be at the same benefit
23 level as if the service or treatment had been rendered by a
24 preferred provider. For purposes of this paragraph (7),
25 "the same benefit level" means that the beneficiary is
26 provided the covered service at no greater cost to the

1 beneficiary than if the service had been provided by a
2 preferred provider. This provision shall be consistent
3 with Section 356z.3a of the Illinois Insurance Code.
4 (8) A limitation that, if the plan provides that the
5 beneficiary will incur a penalty for failing to
6 pre-certify inpatient hospital treatment, the penalty may
7 not exceed $1,000 per occurrence in addition to the plan
8 cost sharing provisions.
9 (c) The network plan shall demonstrate to the Director a
10 minimum ratio of providers to plan beneficiaries as required
11 by the Department.
12 (1) The ratio of physicians or other providers to plan
13 beneficiaries shall be established annually by the
14 Department in consultation with the Department of Public
15 Health based upon the guidance from the federal Centers
16 for Medicare and Medicaid Services. The Department shall
17 not establish ratios for vision or dental providers who
18 provide services under dental-specific or vision-specific
19 benefits. The Department shall consider establishing
20 ratios for the following physicians or other providers:
21 (A) Primary Care;
22 (B) Pediatrics;
23 (C) Cardiology;
24 (D) Gastroenterology;
25 (E) General Surgery;
26 (F) Neurology;

1 (G) OB/GYN;
2 (H) Oncology/Radiation;
3 (I) Ophthalmology;
4 (J) Urology;
5 (K) Behavioral Health;
6 (L) Allergy/Immunology;
7 (M) Chiropractic;
8 (N) Dermatology;
9 (O) Endocrinology;
10 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
11 (Q) Infectious Disease;
12 (R) Nephrology;
13 (S) Neurosurgery;
14 (T) Orthopedic Surgery;
15 (U) Physiatry/Rehabilitative;
16 (V) Plastic Surgery;
17 (W) Pulmonary;
18 (X) Rheumatology;
19 (Y) Anesthesiology;
20 (Z) Pain Medicine;
21 (AA) Pediatric Specialty Services;
22 (BB) Outpatient Dialysis; ~~and~~
23 (CC) HIV<u>; and</u> ~~.~~
24 <u>(DD) Genetic Medicine and Genetic Counseling.</u>
25 (2) The Director shall establish a process for the
26 review of the adequacy of these standards, along with an

1 assessment of additional specialties to be included in the
2 list under this subsection (c).
3 (d) The network plan shall demonstrate to the Director
4 maximum travel and distance standards for plan beneficiaries,
5 which shall be established annually by the Department in
6 consultation with the Department of Public Health based upon
7 the guidance from the federal Centers for Medicare and
8 Medicaid Services. These standards shall consist of the
9 maximum minutes or miles to be traveled by a plan beneficiary
10 for each county type, such as large counties, metro counties,
11 or rural counties as defined by Department rule.
12 The maximum travel time and distance standards must
13 include standards for each physician and other provider
14 category listed for which ratios have been established.
15 The Director shall establish a process for the review of
16 the adequacy of these standards along with an assessment of
17 additional specialties to be included in the list under this
18 subsection (d).
19 (d-5)(1) Every insurer shall ensure that beneficiaries
20 have timely and proximate access to treatment for mental,
21 emotional, nervous, or substance use disorders or conditions
22 in accordance with the provisions of paragraph (4) of
23 subsection (a) of Section 370c of the Illinois Insurance Code.
24 Insurers shall use a comparable process, strategy, evidentiary
25 standard, and other factors in the development and application
26 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

1 mental, emotional, nervous, or substance use disorders or
2 conditions for outpatient treatment or to wait longer than
3 20 business days between requesting a repeat or follow-up
4 appointment and being seen by the facility or provider of
5 mental, emotional, nervous, or substance use disorders or
6 conditions for outpatient treatment; however, subject to
7 the protections of paragraph (3) of this subsection, a
8 network plan shall not be held responsible if the
9 beneficiary or provider voluntarily chooses to schedule an
10 appointment outside of these required time frames.

11 (B) For beneficiaries residing in Illinois counties
12 other than those counties listed in subparagraph (A) of
13 this paragraph, network adequacy standards for timely and
14 proximate access to treatment for mental, emotional,
15 nervous, or substance use disorders or conditions means a
16 beneficiary shall not have to travel longer than 60
17 minutes or 60 miles from the beneficiary's residence to
18 receive outpatient treatment for mental, emotional,
19 nervous, or substance use disorders or conditions.
20 Beneficiaries shall not be required to wait longer than 10
21 business days between requesting an initial appointment
22 and being seen by the facility or provider of mental,
23 emotional, nervous, or substance use disorders or
24 conditions for outpatient treatment or to wait longer than
25 20 business days between requesting a repeat or follow-up
26 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.

1 (f) The network plan may consider use of other health care
2 service delivery options, such as telemedicine or telehealth,
3 mobile clinics, and centers of excellence, or other ways of
4 delivering care to partially meet the requirements set under
5 this Section.
6 (g) Except for the requirements set forth in subsection
7 (d-5), insurers who are not able to comply with the provider
8 ratios and time and distance standards established by the
9 Department may request an exception to these requirements from
10 the Department. The Department may grant an exception in the
11 following circumstances:
12 (1) if no providers or facilities meet the specific
13 time and distance standard in a specific service area and
14 the insurer (i) discloses information on the distance and
15 travel time points that beneficiaries would have to travel
16 beyond the required criterion to reach the next closest
17 contracted provider outside of the service area and (ii)
18 provides contact information, including names, addresses,
19 and phone numbers for the next closest contracted provider
20 or facility;
21 (2) if patterns of care in the service area do not
22 support the need for the requested number of provider or
23 facility type and the insurer provides data on local
24 patterns of care, such as claims data, referral patterns,
25 or local provider interviews, indicating where the
26 beneficiaries currently seek this type of care or where

1 the physicians currently refer beneficiaries, or both; or
2 (3) other circumstances deemed appropriate by the
3 Department consistent with the requirements of this Act.
4 (h) Insurers are required to report to the Director any
5 material change to an approved network plan within 15 days
6 after the change occurs and any change that would result in
7 failure to meet the requirements of this Act. Upon notice from
8 the insurer, the Director shall reevaluate the network plan's
9 compliance with the network adequacy and transparency
10 standards of this Act.
11 (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22;
12 102-1117, eff. 1-13-23.)