AN ACT concerning regulation.

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

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

(20 ILCS 1405/1405-50)

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

Director, shall manage the operations and staff of the Illinois Health Benefits Exchange to ensure optimal exchange performance.
(Source: P.A. 103-103, eff. 6-27-23.)

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

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

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

Section 15. The Illinois Health Insurance Portability and

1 Accountability Act is amended by changing Sections 30, 50, and
2 60 as follows:

3 (215 ILCS 97/30)
4 Sec. 30. Guaranteed renewability of coverage for employers
5 in the group market.
6 (A) In general. Except as provided in this Section, if a
7 health insurance issuer offers health insurance coverage in
8 the small or large group market in connection with a group
9 health plan, the issuer must renew or continue in force such
10 coverage at the option of the plan sponsor of the plan.
11 (B) General exceptions. A health insurance issuer may
12 nonrenew or discontinue health insurance coverage offered in
13 connection with a group health plan in the small or large group
14 market based only on one or more of the following:
15 (1) Nonpayment of premiums. The plan sponsor has
16 failed to pay premiums or contributions in accordance with
17 the terms of the health insurance coverage or the issuer
18 has not received timely premium payments.
19 (2) Fraud. The plan sponsor has performed an act or
20 practice that constitutes fraud or made an intentional
21 misrepresentation of material fact under the terms of the
22 coverage.
23 (3) Violation of participation or contribution rules.
24 The plan sponsor has failed to comply with a material plan
25 provision relating to employer contribution or group

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

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

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

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

26 (C) Requirements for uniform termination of coverage.

1 (1) Particular type of coverage not offered. In any
2 case in which an issuer decides to discontinue offering a
3 particular type of group health insurance coverage offered
4 in the small or large group market, coverage of such type
5 may be discontinued by the issuer in accordance with
6 applicable State law in such market only if:
7 (a) the issuer provides notice to each plan
8 sponsor provided coverage of this type in such market
9 (and participants and beneficiaries covered under such
10 coverage) of such discontinuation at least 90 days
11 prior to the date of the discontinuation of such
12 coverage;
13 (b) the issuer offers to each plan sponsor
14 provided coverage of this type in such market, the
15 option to purchase all (or, in the case of the large
16 group market, any) other health insurance coverage
17 currently being offered by the issuer to a group
18 health plan in such market; and
19 (c) in exercising the option to discontinue
20 coverage of this type and in offering the option of
21 coverage under subparagraph (b), the issuer acts
22 uniformly without regard to the claims experience of
23 those sponsors or any health status-related factor
24 relating to any participants or beneficiaries who may
25 become eligible for such coverage.
26 (2) Discontinuance of all coverage.

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

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

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

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

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

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

4 (1) in the large group market; or

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

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

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

19 (215 ILCS 97/50)

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

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

1 (B) General exceptions. A health insurance issuer may
2 nonrenew or discontinue health insurance coverage of an
3 individual in the individual market based only on one or more
4 of the following:
5 (1) Nonpayment of premiums. The individual has failed
6 to pay premiums or contributions in accordance with the
7 terms of the health insurance coverage or the issuer has
8 not received timely premium payments.
9 (2) Fraud. The individual has performed an act or
10 practice that constitutes fraud or made an intentional
11 misrepresentation of material fact under the terms of the
12 coverage.
13 (3) Termination of plan. The issuer is ceasing to
14 offer coverage in the individual market in accordance with
15 subsection (C) of this Section and applicable Illinois
16 law.
17 (4) Movement outside the service area. In the case of
18 a health insurance issuer that offers health insurance
19 coverage in the market through a network plan, the
20 individual no longer resides, lives, or works in the
21 service area (or in an area for which the issuer is
22 authorized to do business), but only if such coverage is
23 terminated under this paragraph uniformly without regard
24 to any health status-related factor of covered
25 individuals.
26 (5) Association membership ceases. In the case of

1 health insurance coverage that is made available in the
2 individual market only through one or more bona fide
3 associations, the membership of the individual in the
4 association (on the basis of which the coverage is
5 provided) ceases, but only if such coverage is terminated
6 under this paragraph uniformly without regard to any
7 health status-related factor of covered individuals.
8 (C) Requirements for uniform termination of coverage.
9 (1) Particular type of coverage not offered. In any
10 case in which an issuer decides to discontinue offering a
11 particular type of health insurance coverage offered in
12 the individual market, coverage of such type may be
13 discontinued by the issuer only if:
14 (a) the issuer provides notice to each covered
15 individual provided coverage of this type in such
16 market of such discontinuation at least 90 days prior
17 to the date of the discontinuation of such coverage;
18 (b) the issuer offers, to each individual in the
19 individual market provided coverage of this type, the
20 option to purchase any other individual health
21 insurance coverage currently being offered by the
22 issuer for individuals in such market; and
23 (c) in exercising the option to discontinue
24 coverage of that type and in offering the option of
25 coverage under subparagraph (b), the issuer acts
26 uniformly without regard to any health status-related

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

(2) Discontinuance of all coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(215 ILCS 97/60)

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

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

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

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

(215 ILCS 124/3)

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

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

(215 ILCS 124/5)

Sec. 5. Definitions. In this Act:

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

1 provider only when the beneficiary or his or her family member
2 is unable to provide consent.
3 "Beneficiary" means an individual, an enrollee, an
4 insured, a participant, or any other person entitled to
5 reimbursement for covered expenses of or the discounting of
6 provider fees for health care services under a program in
7 which the beneficiary has an incentive to utilize the services
8 of a provider that has entered into an agreement or
9 arrangement with an insurer.
10 "Department" means the Department of Insurance.
11 "Director" means the Director of Insurance.
12 "Excepted benefits" has the meaning given to that term in
13 42 U.S.C. 300gg-91(c).
14 "Family caregiver" means a relative, partner, friend, or
15 neighbor who has a significant relationship with the patient
16 and administers or assists the patient with activities of
17 daily living, instrumental activities of daily living, or
18 other medical or nursing tasks for the quality and welfare of
19 that patient.
20 "Insurer" means any entity that offers individual or group
21 accident and health insurance, including, but not limited to,
22 health maintenance organizations, preferred provider
23 organizations, exclusive provider organizations, and other
24 plan structures requiring network participation, excluding the
25 medical assistance program under the Illinois Public Aid Code,
26 the State employees group health insurance program, workers

1 compensation insurance, and pharmacy benefit managers.
2 "Material change" means a significant reduction in the
3 number of providers available in a network plan, including,
4 but not limited to, a reduction of 10% or more in a specific
5 type of providers, the removal of a major health system that
6 causes a network to be significantly different from the
7 network when the beneficiary purchased the network plan, or
8 any change that would cause the network to no longer satisfy
9 the requirements of this Act or the Department's rules for
10 network adequacy and transparency.
11 "Network" means the group or groups of preferred providers
12 providing services to a network plan.
13 "Network plan" means an individual or group policy of
14 accident and health insurance that either requires a covered
15 person to use or creates incentives, including financial
16 incentives, for a covered person to use providers managed,
17 owned, under contract with, or employed by the insurer.
18 "Ongoing course of treatment" means (1) treatment for a
19 life-threatening condition, which is a disease or condition
20 for which likelihood of death is probable unless the course of
21 the disease or condition is interrupted; (2) treatment for a
22 serious acute condition, defined as a disease or condition
23 requiring complex ongoing care that the covered person is
24 currently receiving, such as chemotherapy, radiation therapy,
25 or post-operative visits; (3) a course of treatment for a
26 health condition that a treating provider attests that

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

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

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

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

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

18 "Telehealth" has the meaning given to that term in Section
19 356z.22 of the Illinois Insurance Code.

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

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

1 "Woman's principal health care provider" means a physician
2 licensed to practice medicine in all of its branches
3 specializing in obstetrics, gynecology, or family practice.
4 (Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22.)

5 (215 ILCS 124/10)
6 Sec. 10. Network adequacy.
7 (a) An insurer providing a network plan shall file a
8 description of all of the following with the Director:
9 (1) The written policies and procedures for adding
10 providers to meet patient needs based on increases in the
11 number of beneficiaries, changes in the
12 patient-to-provider ratio, changes in medical and health
13 care capabilities, and increased demand for services.
14 (2) The written policies and procedures for making
15 referrals within and outside the network.
16 (3) The written policies and procedures on how the
17 network plan will provide 24-hour, 7-day per week access
18 to network-affiliated primary care, emergency services,
19 and women's principal health care providers.
20 An insurer shall not prohibit a preferred provider from
21 discussing any specific or all treatment options with
22 beneficiaries irrespective of the insurer's position on those
23 treatment options or from advocating on behalf of
24 beneficiaries within the utilization review, grievance, or
25 appeals processes established by the insurer in accordance

1 with any rights or remedies available under applicable State
2 or federal law.
3 (b) Insurers must file for review a description of the
4 services to be offered through a network plan. The description
5 shall include all of the following:
6 (1) A geographic map of the area proposed to be served
7 by the plan by county service area and zip code, including
8 marked locations for preferred providers.
9 (2) As deemed necessary by the Department, the names,
10 addresses, phone numbers, and specialties of the providers
11 who have entered into preferred provider agreements under
12 the network plan.
13 (3) The number of beneficiaries anticipated to be
14 covered by the network plan.
15 (4) An Internet website and toll-free telephone number
16 for beneficiaries and prospective beneficiaries to access
17 current and accurate lists of preferred providers,
18 additional information about the plan, as well as any
19 other information required by Department rule.
20 (5) A description of how health care services to be
21 rendered under the network plan are reasonably accessible
22 and available to beneficiaries. The description shall
23 address all of the following:
24 (A) the type of health care services to be
25 provided by the network plan;
26 (B) the ratio of physicians and other providers to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (A) For beneficiaries residing in the metropolitan
6 counties of Cook, DuPage, Kane, Lake, McHenry, and Will,
7 network adequacy standards for timely and proximate access
8 to treatment for mental, emotional, nervous, or substance
9 use disorders or conditions means a beneficiary shall not
10 have to travel longer than 30 minutes or 30 miles from the
11 beneficiary's residence to receive outpatient treatment
12 for mental, emotional, nervous, or substance use disorders
13 or conditions. Beneficiaries shall not be required to wait
14 longer than 10 business days between requesting an initial
15 appointment and being seen by the facility or provider of
16 mental, emotional, nervous, or substance use disorders or
17 conditions for outpatient treatment or to wait longer than
18 20 business days between requesting a repeat or follow-up
19 appointment and being seen by the facility or provider of
20 mental, emotional, nervous, or substance use disorders or
21 conditions for outpatient treatment; however, subject to
22 the protections of paragraph (3) of this subsection, a
23 network plan shall not be held responsible if the
24 beneficiary or provider voluntarily chooses to schedule an
25 appointment outside of these required time frames.

26 (B) For beneficiaries residing in Illinois counties

1 other than those counties listed in subparagraph (A) of
2 this paragraph, network adequacy standards for timely and
3 proximate access to treatment for mental, emotional,
4 nervous, or substance use disorders or conditions means a
5 beneficiary shall not have to travel longer than 60
6 minutes or 60 miles from the beneficiary's residence to
7 receive outpatient treatment for mental, emotional,
8 nervous, or substance use disorders or conditions.
9 Beneficiaries shall not be required to wait longer than 10
10 business days between requesting an initial appointment
11 and being seen by the facility or provider of mental,
12 emotional, nervous, or substance use disorders or
13 conditions for outpatient treatment or to wait longer than
14 20 business days between requesting a repeat or follow-up
15 appointment and being seen by the facility or provider of
16 mental, emotional, nervous, or substance use disorders or
17 conditions for outpatient treatment; however, subject to
18 the protections of paragraph (3) of this subsection, a
19 network plan shall not be held responsible if the
20 beneficiary or provider voluntarily chooses to schedule an
21 appointment outside of these required time frames.
22 (2) For beneficiaries residing in all Illinois counties,
23 network adequacy standards for timely and proximate access to
24 treatment for mental, emotional, nervous, or substance use
25 disorders or conditions means a beneficiary shall not have to
26 travel longer than 60 minutes or 60 miles from the

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

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

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

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

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

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

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

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

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

(3) other circumstances deemed appropriate by the

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

11 (215 ILCS 124/25)
12 Sec. 25. Network transparency.
13 (a) A network plan shall post electronically an
14 up-to-date, accurate, and complete provider directory for each
15 of its network plans, with the information and search
16 functions, as described in this Section.
17 (1) In making the directory available electronically,
18 the network plans shall ensure that the general public is
19 able to view all of the current providers for a plan
20 through a clearly identifiable link or tab and without
21 creating or accessing an account or entering a policy or
22 contract number.
23 (2) The network plan shall update the online provider
24 directory at least monthly. Providers shall notify the
25 network plan electronically or in writing of any changes

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

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

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

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

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

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

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

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

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

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

1 beneficiaries or the general public may use to notify the
2 network plan of inaccurate provider directory information
3 and contact information for the Department's Office of
4 Consumer Health Insurance.
5 (7) A provider directory, whether in electronic or
6 print format, shall accommodate the communication needs of
7 individuals with disabilities, and include a link to or
8 information regarding available assistance for persons
9 with limited English proficiency.
10 (b) For each network plan, a network plan shall make
11 available through an electronic provider directory the
12 following information in a searchable format:
13 (1) for health care professionals:
14 (A) name;
15 (B) gender;
16 (C) participating office locations;
17 (D) specialty, if applicable;
18 (E) medical group affiliations, if applicable;
19 (F) facility affiliations, if applicable;
20 (G) participating facility affiliations, if
21 applicable;
22 (H) languages spoken other than English, if
23 applicable;
24 (I) whether accepting new patients;
25 (J) board certifications, if applicable; and
26 (K) use of telehealth or telemedicine, including,

but not limited to:

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

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

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

(2) for hospitals:

(A) hospital name;

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

(C) participating hospital location; and

(D) hospital accreditation status; and

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

(A) facility name;

(B) facility type;

(C) types of services performed; and

(D) participating facility location or locations.

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

1 following information in addition to the searchable
2 information required in this Section:
3 (1) for health care professionals:
4 (A) contact information; and
5 (B) languages spoken other than English by
6 clinical staff, if applicable;
7 (2) for hospitals, telephone number; and
8 (3) for facilities other than hospitals, telephone
9 number.
10 (d) The insurer or network plan shall make available in
11 print, upon request, the following provider directory
12 information for the applicable network plan:
13 (1) for health care professionals:
14 (A) name;
15 (B) contact information;
16 (C) participating office location or locations;
17 (D) specialty, if applicable;
18 (E) languages spoken other than English, if
19 applicable;
20 (F) whether accepting new patients; and
21 (G) use of telehealth or telemedicine, including,
22 but not limited to:
23 (i) whether the provider offers the use of
24 telehealth or telemedicine to deliver services to
25 patients for whom it would be clinically
26 appropriate;

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

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

(2) for hospitals:

(A) hospital name;

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

(C) participating hospital location and telephone number; and

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

(A) facility name;

(B) facility type;

(C) types of services performed; and

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

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

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

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

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

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

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

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

Sec. 5-3. Insurance Code provisions.

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

1 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21, 356z.22,
2 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29, 356z.30,
3 356z.30a, 356z.31, 356z.32, 356z.33, 356z.34, 356z.35,
4 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.40a,
5 356z.41, 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49,
6 356z.50, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57,
7 356z.58, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.65,
8 356z.67, 356z.68, 364, 364.01, 364.3, 367.2, 367.2-5, 367i,
9 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402,
10 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c)
11 of subsection (2) of Section 367, and Articles IIA, VIII 1/2,
12 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
13 Illinois Insurance Code.

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

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

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

22 (3) a corporation organized under the laws of another
23 state, 30% or more of the enrollees of which are residents
24 of this State, except a corporation subject to
25 substantially the same requirements in its state of
26 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

1 Insurance Act and except for medicare supplement policies as
2 defined in Section 363 of the Illinois Insurance Code, a
3 Health Maintenance Organization may by contract agree with a
4 group or other enrollment unit to effect refunds or charge
5 additional premiums under the following terms and conditions:
6 (i) the amount of, and other terms and conditions with
7 respect to, the refund or additional premium are set forth
8 in the group or enrollment unit contract agreed in advance
9 of the period for which a refund is to be paid or
10 additional premium is to be charged (which period shall
11 not be less than one year); and
12 (ii) the amount of the refund or additional premium
13 shall not exceed 20% of the Health Maintenance
14 Organization's profitable or unprofitable experience with
15 respect to the group or other enrollment unit for the
16 period (and, for purposes of a refund or additional
17 premium, the profitable or unprofitable experience shall
18 be calculated taking into account a pro rata share of the
19 Health Maintenance Organization's administrative and
20 marketing expenses, but shall not include any refund to be
21 made or additional premium to be paid pursuant to this
22 subsection (f)). The Health Maintenance Organization and
23 the group or enrollment unit may agree that the profitable
24 or unprofitable experience may be calculated taking into
25 account the refund period and the immediately preceding 2
26 plan years.

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

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

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

23 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
24 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
25 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
26 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;

1 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
2 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
3 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
4 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
5 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
6 eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

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

9 (215 ILCS 134/45.3)
10 Sec. 45.3. Prescription drug benefits; plan choice.
11 (a) Notwithstanding any other provision of law, beginning
12 January 1, 2023, every health insurance carrier that offers an
13 individual health plan that provides coverage for prescription
14 drugs shall ensure that at least 10% of individual health care
15 plans offered in each applicable service area and at each
16 level of coverage as defined in 42 U.S.C. 18022(d) apply a
17 flat-dollar copayment structure to the entire drug benefit.
18 Beginning January 1, 2024, every health insurance carrier that
19 offers an individual health plan that provides coverage for
20 prescription drugs shall ensure that at least 25% of
21 individual health care plans offered in each applicable
22 service area and at each level of coverage as defined in 42
23 U.S.C. 18022(d) apply a flat-dollar copayment structure to the
24 entire drug benefit. If a health insurance carrier offers

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

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

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

1 (a).

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

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

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

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

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

18 Section 99. Effective date. This Act takes effect upon
19 becoming law, except that the changes to Sections 3, 5, 10, and
20 25 of the Network Adequacy and Transparency Act take effect
21 January 1, 2025.