SB3739

LRB10339496RPS69693b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB3739

Introduced 2/9/2024, by Sen. Robert Peters

SYNOPSIS AS INTRODUCED:

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

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

LRB103 39496 RPS 69693 b

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 Administrative Procedure Act is amended by adding Section 5-45.55 as follows:

(5 ILCS 100/5-45.55 new)

Sec. 5-45.55. Emergency rulemaking; Network Adequacy and Transparency Act. To provide for the expeditious and timely implementation of the Network Adequacy and Transparency Act, emergency rules implementing federal standards for provider ratios, travel time and distance, and appointment wait times if such standards apply to health insurance coverage regulated by the Department of Insurance and are more stringent than the State standards extant at the time the final federal standards are published may be adopted in accordance with Section 5-45 by the Department of Insurance. The adoption of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed one year after the effective date of this amendatory Act of the 103rd General Assembly.

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

by adding Sections 35, 40, and 50 as follows:

(215 ILCS 124/3)

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

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

(215 ILCS 124/5)

Sec. 5. Definitions. In this Act:

"Authorized representative" means a person to whom a beneficiary has given express written consent to represent the beneficiary; a person authorized by law to provide substituted consent for a beneficiary; or the beneficiary's treating provider only when the beneficiary or his or her family member is unable to provide consent.

"Beneficiary" means an individual, an enrollee, an

insured, a participant, or any other person entitled to reimbursement for covered expenses of or the discounting of provider fees for health care services under a program in which the beneficiary has an incentive to utilize the services of a provider that has entered into an agreement or arrangement with an issuer ~~insurer~~.

"Department" means the Department of Insurance.

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

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

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

"Director" means the Director of Insurance.

"Family caregiver" means a relative, partner, friend, or neighbor who has a significant relationship with the patient and administers or assists the patient with activities of daily living, instrumental activities of daily living, or other medical or nursing tasks for the quality and welfare of that patient.

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

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

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

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

~~"Insurer" means any entity that offers individual or group accident and health insurance, including, but not limited to, health maintenance organizations, preferred provider organizations, exclusive provider organizations, and other plan structures requiring network participation, excluding the medical assistance program under the Illinois Public Aid Code, the State employees group health insurance program, workers compensation insurance, and pharmacy benefit managers.~~

"Material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of 10% or more in a specific type of providers within any county, the removal of a major health system that causes a network to be significantly different within any county from the network when the beneficiary purchased the network plan, or any change that would cause the network to no longer satisfy the requirements of this Act or the Department's rules for network adequacy and transparency.

"Network" means the group or groups of preferred providers providing services to a network plan.

"Network plan" means an individual or group policy of ~~accident and~~ health insurance coverage that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers managed, owned, under contract with, or employed by the issuer or by a third party contracted to arrange, contract for, or administer such provider-related incentives for the issuer ~~insurer~~.

"Ongoing course of treatment" means (1) treatment for a life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, radiation therapy, ~~or~~ post-operative visits, or a serious and complex condition as defined under 42 U.S.C. 300gg-113(b)(2); (3) a course of treatment for a health condition that a treating provider attests that discontinuing care by that provider would worsen the condition or interfere with anticipated outcomes; ~~or~~ (4) the third trimester of pregnancy through the post-partum period; (5) undergoing a course of institutional or inpatient care from the provider within the meaning of 42 U.S.C. 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective surgery from the provider, including receipt of preoperative or postoperative care from such provider with respect to such

a surgery; (7) being determined to be terminally ill, as determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving treatment for such illness from such provider; or (8) any other treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a provider because of the potential for changes in the therapeutic regimen.

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

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

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

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

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

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

"Tiered network" means a network that identifies and

groups some or all types of provider and facilities into specific groups to which different provider reimbursement, covered person cost-sharing or provider access requirements, or any combination thereof, apply for the same services.

"Woman's principal health care provider" means a physician licensed to practice medicine in all of its branches specializing in obstetrics, gynecology, or family practice.

(Source: P.A. 102-92, eff. 7-9-21; 102-813, eff. 5-13-22.)

(215 ILCS 124/10)

Sec. 10. Network adequacy.

(a) Before issuing, delivering, or renewing a network plan, an issuer ~~An insurer~~ providing a network plan shall file a description of all of the following with the Director:

(1) The written policies and procedures for adding providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient-to-provider ratio, changes in medical and health care capabilities, and increased demand for services.

(2) The written policies and procedures for making referrals within and outside the network.

(3) The written policies and procedures on how the network plan will provide 24-hour, 7-day per week access to network-affiliated primary care, emergency services, and women's principal health care providers.

An issuer ~~insurer~~ shall not prohibit a preferred provider

from discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the issuer ~~insurer~~ in accordance with any rights or remedies available under applicable State or federal law.

(b) Before issuing, delivering, or renewing a network plan, an issuer ~~Insurers~~ must file for review a description of the services to be offered through a network plan. The description shall include all of the following:

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

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

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

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

(5) A description of how health care services to be

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, 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 issuer ~~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 subsection (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.

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

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

(1) The minimum ratio of physicians or other providers to plan beneficiaries shall be established ~~annually~~ by the Department in consultation with the Department of Public Health based upon the guidance from the federal Centers for Medicare and Medicaid Services. The Department shall

not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits, except to the extent provided under federal law for stand-alone dental plans. 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).

(3) Notwithstanding any other law or rule, the minimum ratio for each provider type shall be no less than any such ratio established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than

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

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

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

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

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

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

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

(d-5)(1) Every issuer ~~insurer~~ shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. Issuers ~~Insurers~~ shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental,

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 issuer ~~insurer~~ shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(4) If the federal Centers for Medicare and Medicaid Services establishes or law requires more stringent standards for qualified health plans in the Federally-Facilitated Exchanges, the federal standards shall control for all network

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

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

(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section.

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

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

names, addresses, and phone numbers for the next closest contracted provider or facility;

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

(3) other circumstances deemed appropriate by the Department consistent with the requirements of this Act.

(h) Issuers ~~Insurers~~ are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that would result in failure to meet the requirements of this Act. The issuer shall submit a revised version of the portions of the network adequacy filing affected by the material change, as determined by the Director by rule, and the issuer shall attach versions with the changes indicated for each document that was revised from the previous version of the filing. Upon notice from the issuer ~~insurer~~, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act. For every day past 15 days that the issuer fails to submit a revised network adequacy filing to the Director, the Director may order a fine of $1,000

per day.

(i) If a network plan is inadequate under this Act with respect to a provider type in a county, and if the network plan does not have an approved exception for that provider type in that county pursuant to subsection (g), an issuer shall process out-of-network claims for covered health care services received from that provider type within that county at the in-network benefit level and shall retroactively adjudicate and reimburse beneficiaries to achieve that objective if their claims were processed at the out-of-network level contrary to this subsection.

(j) If the Director determines that a network is inadequate in any county and no exception has been granted under subsection (g) and the issuer does not have a process in place to comply with subsection (d-5), the Director may prohibit the network plan from being issued or renewed within that county until the Director determines that the network is adequate apart from processes and exceptions described in subsections (d-5) and (g). Nothing in this subsection shall be construed to terminate any beneficiary's health insurance coverage under a network plan before the expiration of the beneficiary's policy period if the Director makes a determination under this subsection after the issuance or renewal of the beneficiary's policy or certificate because of a material change. Policies or certificates issued or renewed in violation of this subsection may subject the issuer to a

civil penalty of $1,000 per policy.

(Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22; 102-1117, eff. 1-13-23.)

(215 ILCS 124/15)

Sec. 15. Notice of nonrenewal or termination.

(a) A network plan must give at least 60 days' notice of nonrenewal or termination of a provider to the provider and to the beneficiaries served by the provider. The notice shall include a name and address to which a beneficiary or provider may direct comments and concerns regarding the nonrenewal or termination and the telephone number maintained by the Department for consumer complaints. Immediate written notice may be provided without 60 days' notice when a provider's license has been disciplined by a State licensing board or when the network plan reasonably believes direct imminent physical harm to patients under the provider's ~~providers~~ care may occur. The notice to the beneficiary shall provide the individual with an opportunity to notify the issuer of the individual's need for transitional care.

(b) Primary care providers must notify active affected patients of nonrenewal or termination of the provider from the network plan, except in the case of incapacitation.

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

(215 ILCS 124/20)

Sec. 20. Transition of services.

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

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

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

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

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

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

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

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

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

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

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

for new beneficiaries as follows:

(1) If a new beneficiary whose provider is not a member of the network plan's provider network, but is within the network plan's service area, enrolls in the network plan, the network plan shall permit the beneficiary to continue an ongoing course of treatment with the beneficiary's current physician during a transitional period:

(A) of 90 days from the effective date of enrollment if the beneficiary has an ongoing course of treatment; or

(B) if the beneficiary has entered the third trimester of pregnancy at the effective date of enrollment, that includes the provision of post-partum care directly related to the delivery.

(2) If a beneficiary, or a beneficiary's authorized representative, elects in writing to continue to receive care from such provider pursuant to paragraph (1) of this subsection (b), such care shall be authorized by the network plan for the transitional period in accordance with the following:

(A) the provider receives reimbursement from the network plan at rates established by the network plan;

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

related to such care; and

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

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

(c) In no event shall this Section be construed to require a network plan to provide coverage for benefits not otherwise covered or to diminish or impair preexisting condition limitations contained in the beneficiary's contract.

(d) A provider shall comply with the requirements of 42 U.S.C. 300gg-138.

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

(215 ILCS 124/25)

Sec. 25. Network transparency.

(a) A network plan shall post electronically an up-to-date, accurate, and complete provider directory for each of its network plans, with the information and search functions, as described in this Section.

(1) In making the directory available electronically, the network plans shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2) The network plan shall update the online provider directory at least monthly. An issuer's failure to update a network plan's directory shall subject the issuer to a civil penalty of $5,000 per month. Providers shall notify the network plan electronically or in writing of any changes to their information as listed in the provider directory, including the information required in subparagraph (K) of paragraph (1) of subsection (b). If a provider is no longer accepting new patients, the provider must give notice to the issuer within 10 business days after deciding to cease accepting new patients, or within 10 business days after the effective date of this amendatory Act of the 103rd General Assembly, whichever is later. The network plan shall update its online provider directory in a manner consistent with the information provided by the provider within 2 ~~10~~ business days after being notified of the change by the provider. Nothing in this paragraph (2) shall void any contractual relationship between the provider and the plan.

(3) At least once every 90 days, the ~~The~~ network plan

shall audit each ~~periodically at least 25%~~ of its print and online provider directories for accuracy, make any corrections necessary, and retain documentation of the audit. The network plan shall submit the audit to the Director upon request. As part of these audits, the network plan shall contact any provider in its network that has not submitted a claim to the plan or otherwise communicated his or her intent to continue participation in the plan's network. The audits shall comply with 42 U.S.C. 300gg-115(a)(2), except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Act.

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

(5) For each network plan, a network plan shall include, in plain language in both the electronic and print directory, the following general information:

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

(B) if applicable, in plain language, a description of the criteria the issuer ~~insurer~~ or

network plan has used to create tiered networks;

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

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

(6) A network plan shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this State. The network plan shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that beneficiaries or the general public may use to notify the network plan of inaccurate provider directory information and contact information for the Department's Office of Consumer Health Insurance.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or

information regarding available assistance for persons with limited English proficiency.

(b) For each network plan, a network plan shall make available through an electronic provider directory the following information in a searchable format:

(1) for health care professionals:

(A) name;

(B) gender;

(C) participating office locations;

(D) specialty, if applicable;

(E) medical group affiliations, if applicable;

(F) facility affiliations, if applicable;

(G) participating facility affiliations, if applicable;

(H) languages spoken other than English, if applicable;

(I) whether accepting new patients;

(J) board certifications, if applicable; ~~and~~

(K) use of telehealth or telemedicine, including, but not limited to:

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

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

telemedicine; and

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

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

(2) for hospitals:

(A) hospital name;

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

(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 following information in addition to the searchable information required in this Section:

(1) for health care professionals:

(A) contact information, including both a

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

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

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

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

(d) The issuer ~~insurer~~ or network plan shall make available in print, upon request, the following provider directory information for the applicable network plan:

(1) for health care professionals:

(A) name;

(B) contact information, including a telephone number and digital contact information if the provider has supplied digital contact information;

(C) participating office location or locations;

(D) specialty, if applicable;

(E) languages spoken other than English, if applicable;

(F) whether accepting new patients; ~~and~~

(G) use of telehealth or telemedicine, including, but not limited to:

(i) whether the provider offers the use of telehealth or telemedicine to deliver services to

patients for whom it would be clinically appropriate;

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

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

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

(2) for hospitals:

(A) hospital name;

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

(C) participating hospital location, ~~and~~ telephone number, and digital contact information; and

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

(A) facility name;

(B) facility type;

(C) types of services performed; and

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

(e) The network plan shall include a disclosure in the print format provider directory that the information included in the directory is accurate as of the date of printing and that beneficiaries or prospective beneficiaries should consult the issuer's ~~insurer's~~ electronic provider directory on its website and contact the provider. The network plan shall also include a telephone number in the print format provider directory for a customer service representative where the beneficiary can obtain current provider directory information.

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

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

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

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

(215 ILCS 124/30)

Sec. 30. Administration and enforcement.

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

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

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

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

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

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

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

(215 ILCS 124/35 new)

Sec. 35. Provider requirements. Providers shall comply

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

(215 ILCS 124/40 new)

Sec. 40. Confidentiality.

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

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

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

(2) actual or projected time and distance between network providers and beneficiaries or actual or projected waiting times for a beneficiary to see a network provider;

(3) geographic maps of network providers;

(4) requests for exceptions under subsection (g) of Section 10, except with respect to any discussion of ongoing or planned contractual negotiations with providers that the issuer requests to be treated as confidential;

(5) provider directories and provider lists; and

(6) insurer or Department statements of determination as to whether a network plan has satisfied the Act's requirements regarding the information described in this subsection.

(c) An issuer's work papers and reports on the results of a self-audit of its provider directories shall remain confidential unless expressly waived by the insurer or unless deemed public information under federal law.

(d) The filings required under Section 10 of this Act shall be confidential while they remain under the Department's review but shall become open to public inspection and copying upon completion of the review, except as provided in this Section or under other applicable law.

(e) Nothing in this Section shall supersede the statutory requirement that work papers obtained during a market conduct examination be deemed confidential.

(215 ILCS 124/50 new)

Sec. 50. Funds for enforcement. Moneys from fines and penalties collected from issuers for violations of this Act shall be deposited into the Insurance Producer Administration Fund for appropriation by the General Assembly to the Department to be used for providing financial support of the Department's enforcement of this Act.

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

(215 ILCS 134/20)

Sec. 20. Notice of nonrenewal or termination. A health care plan must give at least 60 days notice of nonrenewal or termination of a health care provider to the health care provider and to the enrollees served by the health care provider. The notice shall include a name and address to which an enrollee or health care provider may direct comments and concerns regarding the nonrenewal or termination. Immediate written notice may be provided without 60 days notice when a health care provider's license has been disciplined by a State licensing board. The notice to the enrollee shall provide the individual with an opportunity to notify the health care plan of the individual's need for transitional care.

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

(215 ILCS 134/25)

Sec. 25. Transition of services.

(a) A health care plan shall provide for continuity of care for its enrollees as follows:

(1) If an enrollee's health care provider ~~physician~~ leaves the health care plan's network of health care providers for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board and the provider ~~physician~~ remains within the health care plan's service area, or if benefits provided under such health care plan with respect to such provider are terminated because of a change in the terms of the participation of such provider in such plan, or if a contract between a group health plan, as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act, and a health care plan offered in connection with the group health plan is terminated and results in a loss of benefits provided under such plan with respect to such provider, the health care plan shall permit the enrollee to continue an ongoing course of treatment with that provider ~~physician~~ during a transitional period:

(A) of 90 days from the date of the notice of provider's ~~physician's~~ termination from the health care plan to the enrollee of the provider's

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

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

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

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

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

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

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

care plan:

(A) provides general notification of the change in its formulary to current and prospective enrollees;

(B) directly notifies enrollees currently receiving coverage for the drug, including information on the specific drugs involved and the steps they may take to request coverage determinations and exceptions, including a statement that a certification of medical necessity by the enrollee's prescribing provider will result in continuation of coverage at the existing level; and

(C) directly notifies by first class mail and through an electronic transmission, if available, the prescribing provider of all health care plan enrollees currently prescribed the drug affected by the proposed change; the notice shall include a one-page form by which the prescribing provider can notify the health care plan by first class mail that coverage of the drug for the enrollee is medically necessary.

The notification in paragraph (C) may direct the prescribing provider to an electronic portal through which the prescribing provider may electronically file a certification to the health care plan that coverage of the drug for the enrollee is medically necessary. The prescribing provider may make a secure electronic signature beside the words "certification of medical

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

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

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

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

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

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

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

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

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

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

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

the health care plan's service area, enrolls in the health care plan, the health care plan shall permit the enrollee to continue an ongoing course of treatment with the enrollee's current physician during a transitional period:

(A) of 90 days from the effective date of enrollment if the enrollee has an ongoing course of treatment; or

(B) if the enrollee has entered the third trimester of pregnancy at the effective date of enrollment, that includes the provision of post-partum care directly related to the delivery.

(2) If an enrollee elects to continue to receive care from such physician pursuant to item (1) of this subsection, such care shall be authorized by the health care plan for the transitional period only if the physician agrees:

(A) to accept reimbursement from the health care plan at rates established by the health care plan; such rates shall be the level of reimbursement applicable to similar physicians within the health care plan for such services;

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

(C) to otherwise adhere to the health care plan's

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

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

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

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

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

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