**Section 4540.40 Filing Procedures**

At least annually, an insurer shall file with the Director the description required under Section 10 of the Act for each network plan before the network plan is issued, delivered, or renewed in this State. Each filing shall be submitted through SERFF under the Supporting Documentation tab as searchable text PDFs unless the applicable template is an Excel spreadsheet. Filings must include the following information:

a) A complete list of network plan names, associated SERFF Tracking Numbers, and applicable form numbers that will use the network;

b) The following network information:

1. for HMOs, the approval letter from the Illinois Department of Public Health stating the county or counties, including any partial counties, in which the insurer has been granted the authority to operate;
2. for HMOs, a list of the MCOs, including but not limited to individual practice associations and physician-hospital organizations, used within the network. The list must include each MCO’s legal entity name, corporate address, point of contact at the entity, and point of contact’s phone number and email address;

3) for any insurer, a list of all Preferred Provider Program Administrators (PPPAs), if any, through which the insurer has contracted to include providers in the plan's network and each PPPA's corresponding Federal Employer Identification Number (FEIN). An insurer shall verify before filing that all PPPAs are registered with the Department and in good standing with the Secretary of State; and

4) the specific name of the network;

c) The print and electronic versions of the provider directories. The directories must include up-to-date, accurate, and complete provider/facility type, location, and contact information required under Section 25 of the Act. Providers available by telehealth or telemedicine must be clearly identified and include information required under the Act. The print directory, along with the errata, shall be a PDF of the most recent edition published no more than three months before the date of filing. Notwithstanding the above, if the insurer has never offered a network plan with the network described in the filing, the printed and electronic directories shall include all preferred providers that, as of the filing date, are under contract, agreement, or arrangement to service the beneficiaries of the network plan when it is issued;

d) Compliance with time and distance standards as follows:

1) Except as provided in subsection (d)(2), for any network plan issued, delivered, or renewed on or after January 1, 2023, the filing required under Section 10 of the Act shall demonstrate compliance with the federal time and distance standards established in Tables 3.1 and 3.2 of the 2023 Letter for each county in the service area. These standards prescribe the maximum limits of travel in minutes and miles that a beneficiary residing in a given county type may be expected to undertake to a preferred provider of a given provider specialty type. The Department will ensure that distance standards are measured no less stringently than straight-line distance (i.e., “how the crow flies”) between the beneficiary and the preferred provider, but an insurer may apply more stringent standards that measure distance based on travel along existing roads. Time standards shall be evaluated based on estimated driving time from the beneficiary to the preferred provider using mapping output data for travel along existing roads. Measurements of driving time must not be exclusively based on nor, if an average driving time is used, disproportionately weighted toward weekends, any day during the week of a federal or State holiday, or times outside the range of 8 am through 5 pm.

2) For time and distance standards related to outpatient, inpatient, or residential treatment for mental, emotional, nervous, or substance use disorders or conditions, the network plan's compliance with time and distance standards will be evaluated as follows:

A) the Department will enforce compliance with Section 10(d-5) of the Act for all network plans. The insurer shall provide evidence of its arrangements under which, if the network plan has no preferred provider available that meets the network adequacy standards of Section 10(d-5) in relation to a beneficiary, it will make the necessary exemptions to its network to ensure admission and treatment with a non-preferred provider or facility at no greater cost to the beneficiary than if the service or treatment had been provided by a preferred provider; and

B) nothing in this Part shall be construed to supersede, exempt, or waive the requirement under 45 CFR 156.230(a)(2) (May 6, 2022) (no later editions or amendments) that insurers offering QHPs demonstrate compliance with the quantitative time and distance standards in Tables 3.1 or 3.2 of the 2023 Letter for Outpatient Clinical Behavioral Health, Psychiatry, and Inpatient or Residential Behavioral Health Facility Services. The Department will defer to the U.S. Department of Health and Human Services to enforce those standards for QHPs, including the evaluation of an insurer's justifications for exceptions. However, for purposes of subsection (d)(1), an insurer may elect to demonstrate to the Department that the network plan actually complies with the federal time and distance standards without an exception in any county where the federal standards match or exceed the standards provided in Section 10(d-5) of the Act;

e) For any network plan to be issued, delivered, amended, or renewed on or after January 1, 2023, the filing required under Section 10 of the Act must demonstrate compliance with the following minimum provider ratios. For health care professionals, the provider ratios below are expressed in terms of preferred providers to beneficiaries. For facilities, the provider ratios are expressed in terms of the number of facilities per county:

1) primary care physician, general practice, family practice, internal medicine, or primary nurse practitioner − 1:1,000;

2) allergy/immunology − 1:15,000;

3) cardiology − 1:10,000;

4) chiropractic − 1:10,000;

5) dermatology − 1:10,000;

6) endocrinology − 1:10,000;

7) ENT/otolaryngology − 1:15,000;

8) gastroenterology − 1:10,000;

9) general surgery − 1:5,000;

10) gynecology or OB/GYN − 1:2,500;

11) infectious diseases − 1:15,000;

12) nephrology − 1:10,000;

13) neurology − 1:20,000;

14) oncology/radiation − 1:15,000;

15) ophthalmology − 1:10,000;

16) orthopedic surgery − 1:10,000;

17) physiatry/rehabilitative medicine − 1:15,000;

18) plastic surgery − 1:20,000;

19) behavioral health − 1:5,000;

20) pulmonology − 1:10,000;

21) rheumatology − 1:10,000;

22) urology − 1:10,000;

23) acute inpatient hospital with emergency services available 24 hours a day, 7 days a week – one per county; and

24) inpatient or residential behavioral health facility − one per county;

f) Facilities lists and related exception requests, as follows:

1) Insurers must complete and attach the Network Adequacy County Facilities template found on the Department’s website at https://idoi.illinois.gov/content/dam/soi/en/web/insurance/sites/insurance/companies/documents/network-adequacy-county-facilities.xls, identifying all contracted acute inpatient hospitals and contracted inpatient or residential behavioral health facilities for each county in the network. If an insurer does not have a contracted acute inpatient hospital or a contracted inpatient or residential behavioral health facility in a county in which the insurer is marketing the network plan, the county must be marked as NA (not applicable) or left blank on the template;

2) For any county that the insurer seeks to include in its service area that does not have a contracted acute inpatient hospital or a contracted inpatient or residential behavioral health facility, the insurer must request an exception under Section 10(g) of the Act using the Network Adequacy Exception Form (https://idoi.illinois.gov/content/dam/soi/en/web/insurance/sites/insurance/companies/documents/networkadequacyexceptionform.pdf). For inpatient or residential behavioral health facilities, an exception may only be requested with respect to the minimum provider ratio;

g) Written policies and procedures describing the following aspects of the network plan:

1) how the network plan will add preferred providers to meet patient needs based on increases in the number of beneficiaries, changes in patient‐to‐provider ratio, changes in medical and health care capabilities, and increased demand for services;

2) for HMOs, the referral procedures for providers within and outside the network; and

3) 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 as set forth in Section 10(a)(3) of the Act;

h) *Geographic maps* of the proposed service area for the network plans that use the network *by county and* *ZIP code, including marked locations for preferred providers.* (Section 10(b)(1) of the Act) A separate geographic map with marked locations must be provided for each provider specialty type for which the Department enforces any time and distance standards under this Section or Section 10(d-5) of the Act. Each map must include all preferred providers under the network plan, including all contracted network groups, except that, for network plans with tiered networks that are not solely offered as group health plans, the map must only include preferred providers from the lowest cost-sharing tier. Each map must display all preferred providers of the provider specialty type with a dot point indicator marking the specific location of each preferred provider of that type and must highlight the areas that are covered by circles whose radii originate from each preferred provider's dot using both the time and the distance standards for the applicable provider specialty type in the county type or types that the preferred provider will serve. The map may omit overlapping boundary lines among two or more circles;

i) A list of all preferred providers, identified by specialty type, for each network to be submitted via the Illinois Network Adequacy (Tiered) Collection Template located on the Department’s website at https://idoi.illinois.gov/content/dam/soi/en/web/insurance/sites/insurance/companies/documents/appendixa4networkadequacycollectiontemplate.xls. All applicable fields must be completed in full. This is a separate requirement from the requirement to file provider directories. The template requires the following information:

1) on the Providers tab, the insurer’s federal Health Insurance Oversight System (HIOS) Issuer ID, if applicable, and the Issuer State, as well as each provider’s National Provider Identifier (NPI) Number, provider name prefix, first name, middle initial (if applicable), last name, name suffix, physician or non-physician status, specialty type, street address, second line of street address (if applicable), city, state, county, ZIP code, network IDs, and provider tier;

2) on the Non-ECP Facilities tab, for each facility provider that is not an “essential community provider” as defined in 45 CFR 156.235(c) (March 31, 2022) (no later editions or amendments), the facility’s NPI Number, facility name, facility type, street address, second line of street address (if applicable), city, state, county, ZIP code, network IDs, and provider tier;

3) on the Dental Network tab, each dental provider’s NPI Number, provider name prefix, first name, middle initial (if applicable), last name, name suffix, physician or non-physician status, specialty type, street address, second line of street address (if applicable), city, state, county, ZIP code, and network IDs;

j) The number of network plan participants anticipated to be covered by the network plan, as well as the aggregate participants anticipated for all of the filing insurer's network plans that use the network. An insurer may satisfy this requirement by filing the Proposed Enrollment Template (https://idoi.illinois.gov/content/dam/soi/en/web/insurance/sites/insurance/companies/documents/proposedenrollmenttemplate.xls) it has used in the annual certification process for a qualified health plan (see 42 U.S.C. 18021(a)(1));

k) Samples of any notices of nonrenewal or termination that will be sent to providers and beneficiaries served by those providers (see Section 15 of the Act);

l) Language from policy forms about non-emergency health care services from non-preferred providers, as follows:

1. For network plans not issued by an HMO, a provision that *the beneficiary will be provided a covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider* if *the beneficiary has made a good faith effort* by accessing the provider directory, calling the network plan, and calling the provider, *to utilize preferred providers for* that *service and it is determined that the insurer does not have appropriate preferred providers due to insufficient number, type, or unreasonable travel distance or delay*. This provision shall comply with all applicable requirements and exceptions under Section 10(b)(6) of the Act; and
2. for an HMO network plan, language specifying the procedure for a primary care physician to follow to refer the beneficiary to a non-preferred provider when a specialist is not available within the HMO network. This provision shall comply with all applicable requirements and exceptions under Section 10(b)(6) of the Act;

m) For each network plan that will use the network, language from the policy forms providing *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* requirement, “*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*. (Section 10(b)(7) of the Act) Additionally, this provision must comply with all requirements described or incorporated under Section 10(b)(7) of the Act;

n) If a network plan imposes precertification penalties for inpatient hospital stays, language from the policy form complying with Section 10(b)(8) of the Act;

o) For each network plan that will utilize the network, language from the provider contract demonstrating that preferred providers are not prohibited from *discussing any specific or all treatment options with beneficiaries irrespective of the insurer's position on those treatment options, or from advocating on behalf of beneficiaries within the utilization review, grievance, or appeals processes established by the insurer in accordance with any rights or remedies available under applicable State or federal law*; (Section 10(a) of the Act)

p) *A description of how health care services to be rendered under the network plan are reasonably accessible and available to beneficiaries,* including the type of health care services to be provided by the network plan. *The description shall address all of the following:*

1) *the type of health care services to be provided by the network plan;* (Section 10(b)(5) of the Act)

2) *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;*

3) *the travel and distance standards for network beneficiaries in county service areas; and*

4) the availability of telehealth care, including *how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable* (Section 10(b)(5) of the Act);

q) Any exceptions requested for the network plan’s compliance with any provider ratio, time and distance, or appointment waiting time standards specified or implemented under Section 10 of the Act, which shall be filed using the Network Adequacy Exception Form available on the Department’s website at https://insurance2.illinois.gov/HealthInsurance/NetworkAdequacyExcemptionForm.pdf. The insurer must disclose on this form the following information:

1) insurer contact information, including the insurer’s legal name, address, city, state, ZIP code, contact name, contact phone number, and email address;

2) for network plans that do not meet one or more of this Part's time and distance standards in any county, the following information:

A) Contact information for the next closest preferred provider or facility with that specialty, including name, address, city, state, county, ZIP code, and phone number, and the distance and time that beneficiaries would have to travel beyond the required criteria to reach that provider (Section 10(g)(1) of the Act); and

B) Any providers or facilities that would satisfy the time and distance standards if they were contracted for use with the network plan;

3) if the insurer believes that *patterns of care in the service area do not support the need for* compliance with the required ratio for a specific provider or facility type, all applicable 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,* and an explanation of how the data supports the insurer’s position (Section 10(g)(2) of the Act);

4) any network deficiencies in any county with respect to the time and distance or appointment waiting time standards established by Section 10(d-5) of the Act. No exceptions will be granted to the requirements of Section 10(d-5) of the Act; and

5) any other circumstances that the insurer believes justify an exception to the provider ratios or time and distance standards specified in this Part, along with supporting documentation. With respect to time and distance standards, the Department may take into consideration other obstacles to a network plan's timely compliance, including, but not limited to, the following factors that may, but are not required to, be submitted on any federal QHP template or justification form that lists substantially similar factors:

A) no provider can satisfy the time and distance standards for beneficiaries residing in some or all areas of the county because of unpassable topographical features, such as bodies of water or mountainous areas where bridges, tunnels, or other reasonably direct roads are not in close proximity;

B) no provider of the specialty type within the county's time and distance standards is licensed, accredited, or certified by the State;

C) all providers of the specialty type within the county's time and distance standards contract exclusively with another insurer, whether directly or through their contracted network group;

D) no providers of the specialty type within the county's time and distance standards directly or indirectly contract with any commercial insurer;

E) no providers of the specialty type practice within the county's time and distance standards;

F) good faith contracting offers to providers of the specialty type or potential contracted network groups have been rejected by the provider or group;

G) the network is still under development with respect to the specialty type but will be in compliance by the start of open enrollment or the start of the plan or policy year; or

H) the preferred providers within the county's time and distance standards for the specialty type have recently moved, retired, or closed; and

r) A completed Network Adequacy Checklist, available on the Department’s website (https://idoi.illinois.gov/content/dam/soi/en/web/insurance/companies/documents/NetworkAdequacyTransparencyChecklist.pdf), in which the insurer must:

1) identify itself by its legal entity name and the SERFF Tracking Number of the filing made under this Section; and

2) write the word "Affirmed", the name of the document where the requirement is satisfied, and any applicable page, tab, or section in the document, next to every requirement on the checklist applicable to the network plan.

s) For a network plan issued or renewed during 2023 that does not use the same network as any Department-approved QHP from the same insurer for the same year, an insurer may submit a filing no later than July 1, 2023 that combines the annual filings described in this Section for both 2023 and 2024 issuance and renewals.

1) For 2023 issuances and renewals, the combination filing shall demonstrate the network plan's compliance and request exceptions based on the network status on the filing date.

2) For 2024 issuances and renewals, the combination filing shall demonstrate the network plan's compliance and request exceptions based on the network conditions anticipated to exist by the issue or renewal date. An insurer may rely on network status on the filing date whenever the conditions are anticipated to remain materially unchanged by the issue or renewal date.

3) An insurer shall expressly distinguish in a cover letter or by computer filename which filed documents are intended to apply to both 2023 and 2024 or just to one of those years. The filing does not need to include duplicates of any policy form provision, provider contract, internal policy or procedure, provider list, provider directory, or map if, as of the filing date, the contents are not expected to change from 2023 to 2024.

4) Provider lists and directories filed for 2023 issuances and renewals must be the most recent editions as of the filing date. Provider lists and directories for 2024 must include any providers contracted to be in the network by the start of the plan or policy year.

5) This combination filing option is not available for any network plan offered in 2023 for which the insurer previously submitted a filing that demonstrated its degree of compliance and requested exceptions from the time and distance standards specified in the 2023 Letter.