



## 100TH GENERAL ASSEMBLY

### State of Illinois

2017 and 2018

HB0311

by Rep. Gregory Harris

#### SYNOPSIS AS INTRODUCED:

New Act

Creates the Network Adequacy and Transparency Act. Provides that administrators and insurers, prior to going to market, must file with the Department of Insurance for review and approval a description of the services to be offered through a network plan, with certain criteria included in the description. Provides that the network plan shall demonstrate to the Department, prior to approval, a minimum ratio of full-time equivalent providers to plan beneficiaries and maximum travel and distance standards for plan beneficiaries, which shall be established annually by the Department based upon specified sources. Provides that the Department shall conduct quarterly audits of network plans to verify compliance with network adequacy standards. Establishes certain notice requirements. Provides that a network plan shall provide for continuity of care for its beneficiaries under certain circumstances and according to certain requirements. Provides that a network plan shall post electronically a current and accurate provider directory and make available in print, upon request, a provider directory subject to certain specifications. Provides that the Department is granted specific authority to issue a cease and desist order against, fine, or otherwise penalize any insurer or administrator for violations of any provision of the Act. Makes other changes. Effective January 1, 2018.

LRB100 05356 RPS 15367 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 1. Short title. This Act may be cited as the  
5 Network Adequacy and Transparency Act.

6 Section 5. Definitions. In this Act:

7 "Administrator" means any person, partnership, or  
8 corporation, other than a risk-bearing entity, that arranges,  
9 contracts with, or administers contracts with a provider under  
10 which insureds or beneficiaries are provided an incentive to  
11 use the services of the provider. "Administrator" also includes  
12 (i) any person, partnership, or corporation, other than a  
13 risk-bearing entity, that enters into a contract with another  
14 administrator to enroll beneficiaries or insureds in a network  
15 plan marketed as an independently identifiable program based on  
16 marketing materials or member benefit identification cards and  
17 (ii) an employer.

18 "Beneficiary" means an individual, an enrollee, an  
19 insured, a participant, or any other person entitled to  
20 reimbursement for covered expenses of or the discounting of  
21 provider fees for health care services under a program in which  
22 the beneficiary has an incentive to utilize the services of a  
23 provider that has entered into an agreement or arrangement with

1 an administrator, as defined in subsection (g) of Section 370g  
2 of the Illinois Insurance Code.

3 "Department" means the Department of Insurance.

4 "Director" means the Director of Insurance.

5 "Insurer" means any entity that offers individual or group  
6 accident and health insurance, including, but not limited to,  
7 health maintenance organizations, preferred provider  
8 organizations, exclusive provider organizations, and other  
9 plan structures requiring network participation, excluding the  
10 medical assistance program under the Illinois Public Aid Code  
11 and the State employees group health insurance program.

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

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

23 "Network plan" means an individual or group policy of  
24 accident and health insurance that either requires a covered  
25 person to use or creates incentives, including financial  
26 incentives, for a covered person to use providers managed,

1 owned, under contract with, or employed by the insurer.

2 "Ongoing course of treatment" means (1) treatment for a  
3 life-threatening condition, which is a disease or condition for  
4 which likelihood of death is probable unless the course of the  
5 disease or condition is interrupted; (2) treatment for a  
6 serious acute condition, defined as a disease or condition  
7 requiring complex ongoing care that the covered person is  
8 currently receiving, such as chemotherapy, radiation therapy,  
9 or post-operative visits; (3) a course of treatment for a  
10 health condition that a treating provider attests that  
11 discontinuing care by that provider would worsen the condition  
12 or interfere with anticipated outcomes; or (4) the third  
13 trimester of pregnancy through the post-partum period.

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

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

23 "Tiered network" means a network that identifies and groups  
24 some or all types of provider and facilities into specific  
25 groups to which different provider reimbursement, covered  
26 person cost-sharing or provider access requirements, or any

1 combination thereof, apply for the same services.

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

5 Section 10. Network adequacy.

6 (a) An insurer or administrator providing a network plan  
7 shall file all of the following with the Director:

8 (1) The method of marketing the network plan.

9 (2) Written policies and procedures for maintaining a  
10 network that is sufficient in numbers and appropriate types  
11 of providers, including those that serve predominantly  
12 low-income, medically underserved individuals, to ensure  
13 that all covered services to beneficiaries, including  
14 adults and children, low-income persons, persons with  
15 serious, chronic, or complex health conditions or physical  
16 or mental disabilities, or persons with limited English  
17 proficiency, will be accessible without unreasonable  
18 travel or delay.

19 (3) Written policies and procedures for the selection  
20 and tiering, if any, of providers, including each health  
21 care professional specialty. Selection and tiering  
22 standards shall not:

23 (A) allow an insurer or administrator to  
24 discriminate against high-risk populations by  
25 excluding and tiering providers because they are

1 located in geographic areas that contain populations  
2 or providers presenting a risk of higher than average  
3 claims, losses, or health care services utilization;

4 (B) exclude providers because they treat or  
5 specialize in treating populations presenting a risk  
6 of higher than average claims, losses, or health care  
7 services utilization; or

8 (C) discriminate, with respect to participation  
9 under the health benefit plan, against any provider who  
10 is acting within the scope of the provider's license or  
11 certification under applicable State law or rules.

12 (i) The provisions of this subdivision (C) do  
13 not require an insurer or administrator or the  
14 networks with which it contracts to employ  
15 specific providers acting within the scope of  
16 their licenses or certifications under applicable  
17 State law who may meet the selection criteria of  
18 the insurers or administrators or the networks  
19 with which they contract or to contract with or  
20 retain more providers acting within the scope of  
21 their license or certification under applicable  
22 State law than are necessary to maintain a  
23 sufficient provider network.

24 (ii) The provisions of this subdivision (C)  
25 may not be construed to require an insurer or  
26 administrator to contract with any provider

1 willing to abide by the terms and conditions for  
2 participation established by the carrier.

3 (iii) The provisions of this subdivision (C)  
4 shall not be construed to prohibit an insurer or  
5 administrator from declining to select a provider  
6 who fails to meet the other legitimate selection  
7 criteria developed in compliance with this Act.

8 (D) An insurer or administrator shall not offer an  
9 inducement to a provider that would encourage or  
10 otherwise incentivize the provider to deliver less  
11 than medically necessary services to a covered person.

12 (E) An insurer or administrator shall not prohibit  
13 a preferred provider from discussing any specific or  
14 all treatment options with beneficiaries irrespective  
15 of the insurer's position on those treatment options or  
16 from advocating on behalf of beneficiaries within the  
17 utilization review, grievance, or appeals processes  
18 established by the administrator or insurer in  
19 accordance with any rights or remedies available under  
20 applicable State or federal law.

21 (4) The written policies and procedures for  
22 determining when the plan is closed to new providers  
23 desiring to enter into a network plan.

24 (5) The written policies and procedures for adding  
25 providers to meet patient needs based on increases in the  
26 number of beneficiaries, changes in the

1 patient-to-provider ratio, changes in medical and health  
2 care capabilities, and increased demand for services.

3 (6) The written policies and procedures for making  
4 referrals within and outside the network.

5 (7) Written policies and procedures on how the network  
6 plan will provide 24-hour, 7-day per week access to  
7 network-affiliated primary care, emergency services, and  
8 woman's principal health care providers.

9 (b) Prior to going to market, administrators and insurers  
10 must file with the Director for review and approval a  
11 description of the services to be offered through a network  
12 plan. The description shall include all of the following:

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

16 (2) The names, addresses, phone numbers, and  
17 specialties of the providers who have entered into  
18 preferred provider agreements under the network plan.

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

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

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



1 rendered under the network plan are reasonably accessible  
2 and available to beneficiaries. The description shall  
3 address all of the following:

4 (A) the type of health care services to be provided  
5 by the network plan;

6 (B) the ratio of full-time equivalent physicians  
7 and other providers to beneficiaries, by specialty and  
8 including primary care physicians and facility-based  
9 physicians when applicable under the contract,  
10 necessary to meet the health care needs and service  
11 demands of the currently enrolled population;

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

14 (D) a description for each network hospital of the  
15 percentage of physicians in each of these specialties,  
16 (i) emergency medicine, (ii) anesthesiology, (iii)  
17 pathology, (iv) radiology, (v) neonatology, and (vi)  
18 hospitalists, who practice in the hospital are in the  
19 insurer's or administrator's network.

20 (6) A provision ensuring that whenever a beneficiary  
21 has made a good faith effort, as evidenced by accessing the  
22 provider directory and calling the provider when possible,  
23 to utilize preferred providers for a covered service and it  
24 is determined the administrator or insurer does not have  
25 the appropriate preferred providers due to insufficient  
26 number, type, or unreasonable travel distance or delay, the

1 administrator or insurer shall ensure, directly or  
2 indirectly, by terms contained in the payer contract, that  
3 the beneficiary will be provided the covered service at no  
4 greater cost to the beneficiary than if the service had  
5 been provided by a preferred provider. This paragraph (6)  
6 does not apply to a beneficiary who willfully chooses to  
7 access a non-preferred provider for health care services  
8 available through the administrator's panel of preferred  
9 providers. In these circumstances, the contractual  
10 requirements for non-preferred provider reimbursements  
11 shall apply.

12 (7) The procedures for paying benefits when particular  
13 physician specialties are not available within the  
14 provider network.

15 (8) A provision that the beneficiary shall receive  
16 emergency care coverage such that payment for this coverage  
17 is not dependent upon whether the emergency services are  
18 performed by a preferred or non-preferred provider and the  
19 coverage shall be at the same benefit level as if the  
20 service or treatment had been rendered by a preferred  
21 provider. For purposes of this paragraph (8), "the same  
22 benefit level" means that the beneficiary is provided the  
23 covered service at no greater cost to the beneficiary than  
24 if the service had been provided by a preferred provider.

25 (9) A limitation that, if the plan provides that the  
26 beneficiary will incur a penalty for failing to pre-certify

1 inpatient hospital treatment, the penalty may not exceed  
2 \$1,000 per occurrence in addition to the plan cost sharing  
3 provisions.

4 (c) The network plan shall demonstrate to the Director,  
5 prior to approval, a minimum ratio of full-time equivalent  
6 providers to plan beneficiaries as required by the Department.

7 (1) The ratio of full-time equivalent physician or  
8 other providers to plan beneficiaries shall be established  
9 annually by the Department based upon the guidance from the  
10 federal Centers for Medicare and Medicaid Services  
11 concerning exchange plans or Medicare Advantage Plans.  
12 These ratios at a minimum must include physicians or other  
13 providers as follows:

- 14 (A) Primary Care;
- 15 (B) Pediatrics;
- 16 (C) Cardiology;
- 17 (D) Gastroenterology;
- 18 (E) General Surgery;
- 19 (F) Neurology;
- 20 (G) OB/GYN;
- 21 (H) Oncology/Radiation;
- 22 (I) Ophthalmology;
- 23 (J) Urology;
- 24 (K) Behavioral Health;
- 25 (L) Allergy/Immunology;
- 26 (M) Chiropractic;

- 1 (N) Dermatology;
- 2 (O) Endocrinology;
- 3 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;
- 4 (Q) Infectious Disease;
- 5 (R) Nephrology;
- 6 (S) Neurosurgery;
- 7 (T) Orthopedic Surgery;
- 8 (U) Physiatry/Rehabilitative;
- 9 (V) Plastic Surgery;
- 10 (W) Pulmonary;
- 11 (X) Rheumatology;
- 12 (Y) Anesthesiology;
- 13 (Z) Pain Medicine;
- 14 (AA) Pediatric Specialty Services;
- 15 (BB) Outpatient Dialysis; and
- 16 (CC) HIV.

17 (2) The Director shall establish a process for the  
18 annual review of the adequacy of these standards, along  
19 with an assessment of additional specialties to be included  
20 in the list under this subsection (c).

21 (d) The network plan shall demonstrate to the Director,  
22 prior to approval, maximum travel and distance standards for  
23 plan beneficiaries, which shall be established annually by the  
24 Department based upon the guidance from the federal Centers for  
25 Medicare and Medicaid Services concerning exchange plans or  
26 Medicare Advantage Plans. These standards shall consist of the

1 maximum minutes or miles to be traveled by a plan beneficiary  
2 for each county type, such as large counties, metro counties,  
3 or rural counties as defined by Department rule.

4 (1) The maximum travel time and distance standards must  
5 include standards for each physician and other provider  
6 category listed in paragraph (1) of subsection (c).

7 (2) The network plan must demonstrate, prior to  
8 approval, that it has contracted with physicians who  
9 specialize in emergency medicine, anesthesiology,  
10 pathology, and radiology and hospitalists, in sufficient  
11 numbers at any in-network facility or in-network hospital  
12 included in such plan so that patients enrolled in the plan  
13 have reasonable access to these in-network physician  
14 specialists.

15 (3) The network plan must demonstrate, prior to  
16 approval, that it has contracted with physicians who  
17 specialize in pediatric hospital-based services, including  
18 emergency medicine, anesthesiology, pathology, radiology,  
19 and hospitalists, in sufficient numbers at any in-network  
20 facility or in-network hospital included in such plan so  
21 that pediatric patients enrolled in the plan have  
22 reasonable access to these in-network physician  
23 specialists.

24 (4) The Director shall establish a process for the  
25 annual review of the adequacy of these standards along with  
26 an assessment of additional specialties to be included in

1 the list under this subsection (d).

2 (e) These ratio and time and distance standards apply to  
3 the lowest cost-sharing tier of any tiered network.

4 (f) Insurers and administrators who are not able to comply  
5 with the provider ratios and time and distance standards  
6 established by the Department may request an exception to these  
7 requirements from the Department. The Department may grant an  
8 exception in the following circumstances:

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

18 (2) if patterns of care in the service area do not  
19 support the need for the requested number of provider or  
20 facility type and the insurer or administrator provides  
21 data on local patterns of care, such as claims data,  
22 referral patterns, or local provider interviews,  
23 indicating where the beneficiaries currently seek this  
24 type of care, where the physicians currently refer  
25 beneficiaries, or both.

26 (g) Insurers and administrators are required to report to

1 the Director any material change to an approved network plan  
2 within 15 days after the change occurs and any change that  
3 would result in failure to meet the requirements of this Act.  
4 Upon notice from the insurer or administrator, the Director  
5 shall reevaluate the network plan's compliance with the network  
6 adequacy and transparency standards of this Act.

7 (h) The Director shall conduct quarterly audits of all  
8 network plans to verify compliance with network adequacy  
9 standards. These audits shall include surveys to be sent to  
10 plan beneficiaries and providers for the purpose of assessing  
11 network plan compliance with the provisions of this Section.

12 Section 15. Notice of nonrenewal or termination. A network  
13 plan must give at least 60 days' notice of nonrenewal or  
14 termination of a provider to the provider and to the  
15 beneficiaries served by the provider. The notice shall include  
16 a name and address to which a beneficiary or provider may  
17 direct comments and concerns regarding the nonrenewal or  
18 termination and the telephone number maintained by the  
19 Department for consumer complaints. Immediate written notice  
20 may be provided without 60 days' notice when a provider's  
21 license has been disciplined by a State licensing board or when  
22 the network plan reasonably believes direct imminent physical  
23 harm to patients under the providers care may occur.

24 Section 20. Transition of services.

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

3 (1) If a beneficiary's physician or hospital provider  
4 leaves the network plan's network of providers for reasons  
5 other than termination of a contract in situations  
6 involving imminent harm to a patient or a final  
7 disciplinary action by a State licensing board and the  
8 provider remains within the network plan's service area,  
9 the network plan shall permit the beneficiary to continue  
10 an ongoing course of treatment with that provider during a  
11 transitional period for the following duration:

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

16 (B) if the beneficiary has entered the third  
17 trimester of pregnancy at the time of the provider's  
18 disaffiliation, a period that includes the provision  
19 of post-partum care directly related to the delivery.

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

24 (A) the provider receives continued reimbursement  
25 from the network plan at the rates and terms and  
26 conditions applicable prior to the start of the



1 transitional period;

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

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

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

17 (b) The termination or departure of a beneficiary's  
18 physician or hospital provider from a network plan shall  
19 constitute a qualifying event, allowing beneficiaries to  
20 select a new network plan outside of a standard open enrollment  
21 period within 60 days of notice of termination or departure.

22 (c) A network plan shall provide for continuity of care for  
23 new beneficiaries as follows:

24 (1) If a new beneficiary whose provider is not a member  
25 of the network plan's provider network, but is within the  
26 network plan's service area, enrolls in the network plan,

1 the network plan shall permit the beneficiary to continue  
2 an ongoing course of treatment with the beneficiary's  
3 current physician during a transitional period:

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

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

11 (2) If a beneficiary elects to continue to receive care  
12 from such provider pursuant to paragraph (1) of this  
13 subsection (c), such care shall be authorized by the  
14 network plan for the transitional period in accordance with  
15 the following:

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

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

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

26 (3) The provisions of this Section governing health

1 care provided during the transition period do not apply if  
2 the beneficiary has successfully transitioned to another  
3 provider participating in the network plan, if the  
4 beneficiary has already met or exceeded the benefit  
5 limitations of the plan, or if the care provided is not  
6 medically necessary.

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

11 Section 25. Network transparency.

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

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

22 (2) The network plan shall provide updates to the  
23 online provider directory within 10 business days after  
24 knowing a change is necessary.

25 (3) The network plan shall audit monthly at least 25%

1 of its provider directories for accuracy, make any  
2 corrections necessary, and retain documentation of the  
3 audit. The network plan shall submit the audit annually to  
4 the Director. As part of these audits, the network plan  
5 shall contact any provider in its network that has not  
6 submitted a claim to the plan or otherwise communicated his  
7 or her intent to continue participation in the plan's  
8 network within a 6-month period.

9 (4) A network plan shall provide a print copy of a  
10 current provider directory or a print copy of the requested  
11 directory information upon request of a beneficiary or a  
12 prospective beneficiary. Print copies must be updated  
13 monthly or provide an errata that reflects changes in the  
14 provider network, to be updated monthly.

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

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

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

25 (C) if applicable, in plain language, how the  
26 network plan designates the different provider tiers

1 or levels in the network and identifies for each  
2 specific provider, hospital, or other type of facility  
3 in the network which tier each is placed, for example,  
4 by name, symbols, or grouping, in order for a  
5 beneficiary-covered person or a prospective  
6 beneficiary-covered person to be able to identify the  
7 provider tier; and

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

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

21 (7) A provider directory, whether in electronic or  
22 print format, shall accommodate the communication needs of  
23 individuals with disabilities, and include a link to or  
24 information regarding available assistance for persons  
25 with limited English proficiency.

26 (b) For each network plan, a network plan shall make

1 available through an electronic provider directory the  
2 following information in a searchable format:

3 (1) for health care professionals:

4 (A) name;

5 (B) gender;

6 (C) participating office locations;

7 (D) specialty, if applicable;

8 (E) medical group affiliations, if applicable;

9 (F) facility affiliations, if applicable;

10 (G) participating facility affiliations, if  
11 applicable;

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

14 (I) whether accepting new patients; and

15 (J) board certifications, if applicable.

16 (2) for hospitals:

17 (A) hospital name;

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

20 (C) participating hospital location; and

21 (D) hospital accreditation status; and

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

23 (A) facility name;

24 (B) facility type;

25 (C) types of services performed; and

26 (D) participating facility location or locations.

1 (c) For the electronic provider directories, for each  
2 network plan, a network plan shall make available all of the  
3 following information in addition to the searchable  
4 information required in this Section:

5 (1) for health care professionals:

6 (A) contact information; and

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

9 (2) for hospitals, telephone number; and

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

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

15 (1) for health care professionals:

16 (A) name;

17 (B) contact information;

18 (C) participating office location or locations;

19 (D) specialty, if applicable;

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

22 (F) whether accepting new patients.

23 (2) for hospitals:

24 (A) hospital name;

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

1 (C) participating hospital location and telephone  
2 number; and

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

4 (A) facility name;

5 (B) facility type;

6 (C) types of services performed; and

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

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

18 (f) The Director shall conduct semi-annual audits of the  
19 accuracy of provider directories to ensure plan compliance.

20 Section 30. Administration and enforcement.

21 (a) Insurers and administrators, as defined in this Act,  
22 have a continuing obligation to comply with the requirements of  
23 this Act. Other than the duties specifically created in this  
24 Act, nothing in this Act is intended to preclude, prevent, or  
25 require the adoption, modification, or termination of any



1 utilization management, quality management, or claims  
2 processing methodologies of an insurer or administrator.

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

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

9 (d) The Director is hereby granted specific authority to  
10 issue a cease and desist order against, fine, or otherwise  
11 penalize any insurer or administrator for violations of any  
12 provision of this Act.

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

15 Section 99. Effective date. This Act takes effect January  
16 1, 2018.