Rep. Gregory Harris

Filed: 3/10/2017

AMENDMENT TO HOUSE BILL 311

AMENDMENT NO. _____. Amend House Bill 311 by replacing everything after the enacting clause with the following:

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

Section 5. Definitions. In this Act:

"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 insurer.

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

"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, the removal of a major health system that causes a network to be significantly different 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 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 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; (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.

"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 that provide health care services.

"Telehealth" has the meaning given to that term in Section 256z.22 of the 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.

Section 10. Network adequacy.

(a) 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 woman's principal health care providers.

An 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 insurer in accordance with any rights or remedies available under applicable State or federal law.

(b) Prior to going to market, insurers must file with the Director for review and approval 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, 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 full-time equivalent 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, or unreasonable travel distance or delay, the insurer shall ensure, directly or indirectly, by terms contained in the payer contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers. In these circumstances, the contractual requirements for

non-preferred provider reimbursements shall apply.

(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.

(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.

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

(1) The ratio of full-time equivalent 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 concerning exchange plans or Medicare Advantage 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 annual review of the adequacy of these standards, along with an assessment of additional specialties to be included in the list under this subsection (c).

(d) The network plan shall demonstrate to the Director, prior to approval, maximum travel and distance 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 concerning exchange plans or Medicare Advantage Plans. 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 annual review of the adequacy of these standards along with an assessment of additional specialties to be included in the list under this subsection (d).

(e) These ratio and time and distance standards apply to

the lowest cost-sharing tier of any tiered network.

(f) The network plan shall demonstrate sufficient inpatient services, including, but not limited to, services of preferred providers who specialize in emergency medicine, anesthesiology, pathology, and radiology.

(g) 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.

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

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

(2) if patterns of care in the service area do not support the need for the requested number of provider or

facility type and the insurer provides data on local patterns of care, such as claims data, referral patterns, or local provider interviews, indicating where the beneficiaries currently seek this type of care or where the physicians currently refer beneficiaries, or both; or

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

(i) 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. Upon notice from the insurer, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act.

Section 15. Notice of nonrenewal or termination. 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 providers care may occur.

Section 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, 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 elects 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.

Section 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. Providers shall notify the network plan electronically or in writing of any changes to their information as listed in the provider directory. The network plan shall update its online provider directory in a manner consistent with the information provided by the

provider within 10 business days after being notified of the change by the provider. Nothing in this paragraph (2) shall void any contractual relationship between the provider and the plan.

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

(4) A network plan shall provide a 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 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; and

(J) board certifications, if applicable.

(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; and

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

(2) for hospitals, telephone number; and

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

(d) The 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;

(C) participating office location or locations;

(D) specialty, if applicable;

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

(F) whether accepting new patients.

(2) for hospitals:

(A) hospital name;

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

(C) participating hospital location and telephone number; and

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

(A) facility name;

(B) facility type;

(C) types of services performed; and

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

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

(f) The Director may conduct periodic audits of the accuracy of provider directories.

Section 30. Administration and enforcement.

(a) 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 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, including, but not limited to, compliance audits, such as market conduct examinations, and issuance of cease and desist orders, fines, or other penalties for violations of any provision of this Act.

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

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