

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 3. Applicability of Act. This Act applies to an
7 individual or group policy of accident and health insurance
8 with a network plan amended, delivered, issued, or renewed in
9 this State on or after January 1, 2019.

10 Section 5. Definitions. In this Act:

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

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

1 an insurer.

2 "Department" means the Department of Insurance.

3 "Director" means the Director of Insurance.

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

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 employer or risk-bearing entity relating to health care
17 services that may be rendered to beneficiaries under a network
18 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 "Telehealth" has the meaning given to that term in Section
24 356z.22 of the Illinois Insurance Code.

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

1 "Tiered network" means a network that identifies and groups
2 some or all types of provider and facilities into specific
3 groups to which different provider reimbursement, covered
4 person cost-sharing or provider access requirements, or any
5 combination thereof, apply for the same services.

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

9 Section 10. Network adequacy.

10 (a) An insurer providing a network plan shall file a
11 description of all of the following with the Director:

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

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

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

23 An insurer shall not prohibit a preferred provider from
24 discussing any specific or all treatment options with
25 beneficiaries irrespective of the insurer's position on those

1 treatment options or from advocating on behalf of beneficiaries
2 within the utilization review, grievance, or appeals processes
3 established by the insurer in accordance with any rights or
4 remedies available under applicable State or federal law.

5 (b) Insurers must file for review a description of the
6 services to be offered through a network plan. The description
7 shall include all of the following:

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

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

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

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

22 (5) A description of how health care services to be
23 rendered under the network plan are reasonably accessible
24 and available to beneficiaries. The description shall
25 address all of the following:

26 (A) the type of health care services to be provided

1 by the network plan;

2 (B) the ratio of physicians and other providers to
3 beneficiaries, by specialty and including primary care
4 physicians and facility-based physicians when
5 applicable under the contract, necessary to meet the
6 health care needs and service demands of the currently
7 enrolled population;

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

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

14 (6) A provision ensuring that whenever a beneficiary
15 has made a good faith effort, as evidenced by accessing the
16 provider directory, calling the network plan, and calling
17 the provider, to utilize preferred providers for a covered
18 service and it is determined the insurer does not have the
19 appropriate preferred providers due to insufficient
20 number, type, or unreasonable travel distance or delay, the
21 insurer shall ensure, directly or indirectly, by terms
22 contained in the payer contract, that the beneficiary will
23 be provided the covered service at no greater cost to the
24 beneficiary than if the service had been provided by a
25 preferred provider. This paragraph (6) does not apply to:

26 (A) a beneficiary who willfully chooses to access a

1 non-preferred provider for health care services available
2 through the panel of preferred providers, or (B) a
3 beneficiary enrolled in a health maintenance organization.
4 In these circumstances, the contractual requirements for
5 non-preferred provider reimbursements shall apply.

6 (7) A provision that the beneficiary shall receive
7 emergency care coverage such that payment for this coverage
8 is not dependent upon whether the emergency services are
9 performed by a preferred or non-preferred provider and the
10 coverage shall be at the same benefit level as if the
11 service or treatment had been rendered by a preferred
12 provider. For purposes of this paragraph (7), "the same
13 benefit level" means that the beneficiary is provided the
14 covered service at no greater cost to the beneficiary than
15 if the service had been provided by a preferred provider.

16 (8) A limitation that, if the plan provides that the
17 beneficiary will incur a penalty for failing to pre-certify
18 inpatient hospital treatment, the penalty may not exceed
19 \$1,000 per occurrence in addition to the plan cost sharing
20 provisions.

21 (c) The network plan shall demonstrate to the Director a
22 minimum ratio of providers to plan beneficiaries as required by
23 the Department.

24 (1) The ratio of physicians or other providers to plan
25 beneficiaries shall be established annually by the
26 Department in consultation with the Department of Public

1 Health based upon the guidance from the federal Centers for
2 Medicare and Medicaid Services. The Department shall
3 consider establishing ratios for the following physicians
4 or other providers:

5 (A) Primary Care;

6 (B) Pediatrics;

7 (C) Cardiology;

8 (D) Gastroenterology;

9 (E) General Surgery;

10 (F) Neurology;

11 (G) OB/GYN;

12 (H) Oncology/Radiation;

13 (I) Ophthalmology;

14 (J) Urology;

15 (K) Behavioral Health;

16 (L) Allergy/Immunology;

17 (M) Chiropractic;

18 (N) Dermatology;

19 (O) Endocrinology;

20 (P) Ears, Nose, and Throat (ENT)/Otolaryngology;

21 (Q) Infectious Disease;

22 (R) Nephrology;

23 (S) Neurosurgery;

24 (T) Orthopedic Surgery;

25 (U) Physiatry/Rehabilitative;

26 (V) Plastic Surgery;

- 1 (W) Pulmonary;
- 2 (X) Rheumatology;
- 3 (Y) Anesthesiology;
- 4 (Z) Pain Medicine;
- 5 (AA) Pediatric Specialty Services;
- 6 (BB) Outpatient Dialysis; and
- 7 (CC) HIV.

8 (2) The Director shall establish a process for the
9 review of the adequacy of these standards, along with an
10 assessment of additional specialties to be included in the
11 list under this subsection (c).

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

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

24 The Director shall establish a process for the review of
25 the adequacy of these standards along with an assessment of
26 additional specialties to be included in the list under this

1 subsection (d).

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

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

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

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

24 (2) if patterns of care in the service area do not
25 support the need for the requested number of provider or
26 facility type and the insurer provides data on local

1 patterns of care, such as claims data, referral patterns,
2 or local provider interviews, indicating where the
3 beneficiaries currently seek this type of care or where the
4 physicians currently refer beneficiaries, or both; or

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

7 (h) Insurers are required to report to the Director any
8 material change to an approved network plan within 15 days
9 after the change occurs and any change that would result in
10 failure to meet the requirements of this Act. Upon notice from
11 the insurer, the Director shall reevaluate the network plan's
12 compliance with the network adequacy and transparency
13 standards of this Act.

14 Section 15. Notice of nonrenewal or termination.

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

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

4 Section 20. Transition of services.

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

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

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

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

24 (2) Notwithstanding the provisions of paragraph (1) of
25 this subsection (a), such care shall be authorized by the

1 network plan during the transitional period in accordance
2 with the following:

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

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

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

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

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

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

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

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

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

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

12 Section 25. Network transparency.

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

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

23 (2) The network plan shall update the online provider
24 directory at least monthly. Providers shall notify the
25 network plan electronically or in writing of any changes to

1 their information as listed in the provider directory. The
2 network plan shall update its online provider directory in
3 a manner consistent with the information provided by the
4 provider within 10 business days after being notified of
5 the change by the provider. Nothing in this paragraph (2)
6 shall void any contractual relationship between the
7 provider and the plan.

8 (3) The network plan shall audit periodically at least
9 25% of its provider directories for accuracy, make any
10 corrections necessary, and retain documentation of the
11 audit. The network plan shall submit the audit to the
12 Director upon request. As part of these audits, the network
13 plan shall contact any provider in its network that has not
14 submitted a claim to the plan or otherwise communicated his
15 or her intent to continue participation in the plan's
16 network.

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

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

26 (A) in plain language, a description of the

1 criteria the plan has used to build its provider
2 network;

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

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

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

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

1 Consumer Health Insurance.

2 (7) A provider directory, whether in electronic or
3 print format, shall accommodate the communication needs of
4 individuals with disabilities, and include a link to or
5 information regarding available assistance for persons
6 with limited English proficiency.

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

10 (1) for health care professionals:

11 (A) name;

12 (B) gender;

13 (C) participating office locations;

14 (D) specialty, if applicable;

15 (E) medical group affiliations, if applicable;

16 (F) facility affiliations, if applicable;

17 (G) participating facility affiliations, if
18 applicable;

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

21 (I) whether accepting new patients; and

22 (J) board certifications, if applicable.

23 (2) for hospitals:

24 (A) hospital name;

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

- 1 (C) participating hospital location; and
2 (D) hospital accreditation status; 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 (c) For the electronic provider directories, for each
9 network plan, a network plan shall make available all of the
10 following information in addition to the searchable
11 information required in this Section:

- 12 (1) for health care professionals:
13 (A) contact information; and
14 (B) languages spoken other than English by
15 clinical staff, if applicable;
16 (2) for hospitals, telephone number; and
17 (3) for facilities other than hospitals, telephone
18 number.

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

- 22 (1) for health care professionals:
23 (A) name;
24 (B) contact information;
25 (C) participating office location or locations;
26 (D) specialty, if applicable;

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

3 (F) whether accepting new patients.

4 (2) for hospitals:

5 (A) hospital name;

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

8 (C) participating hospital location and telephone
9 number; and

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

11 (A) facility name;

12 (B) facility type;

13 (C) types of services performed; and

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

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

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

1 Section 30. Administration and enforcement.

2 (a) Insurers, as defined in this Act, have a continuing
3 obligation to comply with the requirements of this Act. Other
4 than the duties specifically created in this Act, nothing in
5 this Act is intended to preclude, prevent, or require the
6 adoption, modification, or termination of any utilization
7 management, quality management, or claims processing
8 methodologies of an insurer.

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

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

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

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