Rep. Sue Scherer

Filed: 3/30/2022

AMENDMENT TO HOUSE BILL 1463

AMENDMENT NO. _____. Amend House Bill 1463 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Administrative Procedure Act is amended by adding Section 5-45.21 as follows:

(5 ILCS 100/5-45.21 new)

Sec. 5-45.21. Emergency rulemaking; Network Adequacy and Transparency Act. To provide for the expeditious and timely implementation of the Network Adequacy and Transparency Act, emergency rules implementing federal standards for provider ratios, travel time and distance, and appointment wait times if such standards apply to health insurance coverage regulated by the Department of Insurance and are more stringent than the State standards extant at the time the final federal standards are published may be adopted in accordance with Section 5-45 by the Department of Insurance. The adoption of emergency

rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

Section 10. The Illinois Insurance Code is amended by changing Sections 132, 132.5, 155.35, 402, 408, 511.109, 512-3, 512-5, and 513b3 and by adding Section 512-11 as follows:

(215 ILCS 5/132) (from Ch. 73, par. 744)

Sec. 132. Market conduct and non-financial examinations.

(a) Definitions.

As used in this Section:

"Desk examination" means an examination conducted by market conduct surveillance personnel at a location other than the regulated person's premises. A "desk examination" is usually performed at the Department's offices with the insurer providing requested documents by hard copy, microfiche, discs, or other electronic media for review without an on-site examination.

"Market analysis" means a process whereby market conduct surveillance personnel collect and analyze information from filed schedules, surveys, data calls, required reports, and other sources in order to develop a baseline understanding of the marketplace and to identify patterns or practices of regulated persons that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.

"Market conduct action" means any of the full range of activities that the Director may initiate to assess and address the market practices of regulated persons, including, but not limited to, market analysis and market conduct examinations. "Market conduct action" does not include the Department's consumer complaint process outlined in 50 Ill. Adm. Code 926; however, the Department may initiate market conduct actions based on information gathered during that process. Examples of "market conduct action" include, but are not limited to:

(1) correspondence with the company or person;

(2) interviews with the company or person;

(3) information gathering;

(4) reviews of policies and procedures;

(5) interrogatories;

(6) reviews of self-evaluations and voluntary compliance programs of the person or company;

(7) self-audits; and

(8) market conduct examinations.

"Market conduct examination" or "examination" means any type of examination described in the NAIC Market Regulation Handbook that may be used to assess a regulated person's compliance with the laws, rules, and regulations applicable to the examinee. "Market conduct examination" includes comprehensive examinations, targeted examinations, and follow-up examinations. Market conduct examinations may be

conducted as desk examinations, on-site examinations, or a combination of those 2 types of examinations.

"Market conduct surveillance" means market analysis or a market conduct action.

"Market conduct surveillance personnel" means those individuals employed or retained by the Department and designated by the Director to collect, analyze, review, or act on information in the insurance marketplace that identifies patterns or practices of insurers. "Market conduct surveillance personnel" includes all persons identified as an examiner in the insurance laws or rules of this State if the Director has designated those persons to assist the Director in ascertaining the non-financial business practices, performance, and operations of a company or person subject to the Director's jurisdiction.

"NAIC" means the National Association of Insurance Commissioners.

"On-site examination" means an examination conducted at the insurer's home office or the location where the records under review are stored.

(b) Examinations. ~~(1)~~

The Director, for the purposes of ascertaining the non-financial business practices, performance, and operations of any company, may make examinations of:

(1) ~~(a)~~ any company transacting or being organized to transact business in this State;

(2) ~~(b)~~ any person engaged in or proposing to be engaged in the organization, promotion, or solicitation of shares or capital contributions to or aiding in the formation of a company;

(3) ~~(c)~~ any person having a contract, written or oral, pertaining to the management or control of a company as general agent, managing agent, or attorney-in-fact;

(4) ~~(d)~~ any licensed or registered producer, firm, or administrator, or any person, organization, or corporation making application for any licenses or registration;

(5) ~~(e)~~ any person engaged in the business of adjusting losses or financing premiums; or

(6) ~~(f)~~ any person, organization, trust, or corporation having custody or control of information reasonably related to the operation, performance, or conduct of a company or person subject to the jurisdiction of the Director.

(c) Market analysis and market conduct actions.

(1) The Director may perform market analysis by gathering and analyzing information from data currently available to the Director, information from surveys or reports that are submitted regularly to the Director or required in a data call, information collected by the NAIC, and information from a variety of other sources in both the public and private domain in order to develop a baseline understanding of the marketplace and to identify

for further review practices that deviate from the norm or that may pose a potential risk to the insurance consumer. The Director shall use the NAIC Market Regulation Handbook as a guide in performing market analysis.

(2) If the Director determines that further inquiry into a particular person or practice is needed, the Director may consider one or more market conduct actions. The Director shall inform the examinee in writing of the type of market conduct action selected and shall use the NAIC Market Regulation Handbook as a guide in performing the market conduct action. The Director may coordinate a market conduct action and findings of this State with market conduct actions and findings of other states.

(3) Nothing in this Section requires the Director to conduct market analysis prior to initiating any market conduct action.

(4) Nothing in this Section restricts the Director to the type of market conduct action initially selected. The Director shall inform the examinee in writing of any change in the type of market conduct action being conducted.

(d) Access to books and records; oaths and examinations.

~~(2)~~ Every examinee ~~company or person being examined~~ and its officers, directors, and agents must provide to the Director convenient and free access at all reasonable hours at its office or location to all books, records, documents,

including consumer communications, and any or all papers relating to the business, performance, operations, and affairs of the examinee ~~company~~. The officers, directors, and agents of the examinee ~~company or person~~ must facilitate the market conduct action ~~examination~~ and aid in the action ~~examination~~ so far as it is in their power to do so.

The Director and any authorized market conduct surveillance personnel ~~examiner~~ have the power to administer oaths and examine under oath any person relative to the business of the examinee ~~company being examined~~. Any delay of more than 5 business days in the transmission of requested documents without an extension approved by the Director or designated market conduct surveillance personnel is a violation of this Section.

(e) Examination report.

~~(3)~~ The market conduct surveillance personnel ~~examiners~~ designated by the Director under Section 402 must make a full and true report of every examination made by them, which contains only facts ascertained from the books, papers, records, or documents, and other evidence obtained by investigation and examined by them or ascertained from the testimony of officers or agents or other persons examined under oath concerning the business, affairs, conduct, and performance of the examinee ~~company or person~~. The report of examination must be verified by the oath of the examiner in charge thereof, and when so verified is prima facie evidence

in any action or proceeding in the name of the State against the company, its officers, or agents upon the facts stated therein.

(f) Examinee acceptance of examination report.

The Department and the examinee shall adhere to the following timeline, unless a mutual agreement is reached to modify the timeline:

(1) The Department shall deliver the draft report to the examinee within 60 days after completion of the examination. "Completion of the examination" means the date the Department confirms in writing that the examination is completed. Nothing in this Section prevents the Department from sharing an earlier draft of the report with the examinee before confirming that the examination is completed.

(2) If the examinee chooses to respond with written submissions or rebuttals, the examinee must do so within 30 days after receipt of any draft report delivered after the completion of the examination.

(3) After receipt of any written submissions or rebuttals, the Department shall issue a final report. At any time, the Department may share draft corrections or changes to the report with the examinee before issuing a final report, and the examinee shall have 30 days to respond to the draft.

(4) The examinee shall, within 10 days after the

issuance of the final report, accept the final report or request a hearing in writing. Failure to take either action within 10 days shall be deemed an acceptance of the final report. If the examinee accepts the examination report, the Director shall continue to hold the content of the examination report as private and confidential for a period of 30 days, except to the extent provided for in subsection (h) and in paragraph (10) of subsection (g). Thereafter, the Director shall open the report for public inspection if no court of competent jurisdiction has stayed its publication.

(g) Written hearing.

Notwithstanding anything to the contrary in this Code or Department rules, if the examinee requests a hearing, the following procedures apply:

(1) The examinee shall request the hearing in writing and shall specify the issues in the final report that the examinee is challenging. The examinee is limited to challenging the issues that were previously challenged in the examinee's written submission and rebuttal or supplemental submission and rebuttal as provided pursuant to paragraphs (2) and (3) of subsection (f).

(2) The hearing shall be conducted by written arguments submitted to the Director.

(3) Discovery is limited to the market conduct surveillance personnel's work papers that are relevant to

the issues the examinee is challenging. The relevant market conduct surveillance personnel's work papers shall be deemed admitted into and included in the record. No other forms of discovery, including depositions and interrogatories, are allowed, except upon written agreement of the examinee and the Department's counsel.

(4) Only the examinee and the Department's counsel may submit written arguments.

(5) The examinee shall submit its written argument within 30 days after the Department's counsel serves a formal notice of hearing.

(6) The Department's counsel shall submit its written response within 30 days after the examinee submits its written argument.

(7) The Director shall issue a decision accompanied by findings and conclusions resulting from the Director's consideration and review of the written arguments, the final report, relevant market conduct surveillance personnel work papers, and any written submissions or rebuttals. The Director's order is a final agency action and shall be served upon the examinee by electronic mail together with a copy of the final report pursuant to Section 10-75 of the Illinois Administrative Procedure Act.

(8) Any portion of the final examination report that was not challenged by the examinee is incorporated into

the decision of the Director.

(9) Findings of fact and conclusions of law in the Director's final agency action are prima facie evidence in any legal or regulatory action.

(10) If an examinee has requested a hearing, the Director shall continue to hold the content of any examination report or other final agency action of a market conduct examination as private and confidential for a period of 49 days after the final agency action. After the 49-day period expires, the Director shall open the final agency action for public inspection if a court of competent jurisdiction has not stayed its publication.

(h) Nothing in this Section prevents the Director from disclosing at any time the content of an examination report, preliminary examination report, or results, or any matter relating to a report or results, to the division or to the insurance division of any other state or agency or office of the federal government at any time if the division, agency, or office receiving the report or related matters agrees and has the legal authority to hold it confidential in a manner consistent with this Section.

(i) Confidentiality.

(1) The Director and any other person in the course of market conduct surveillance shall keep confidential all documents pertaining to the market conduct surveillance, including working papers, third-party models, or products,

complaint logs, and copies of any documents created by, produced by, obtained by, or disclosed to the Director, market conduct surveillance personnel, or any other person in the course of market conduct surveillance conducted pursuant to this Section, and all documents obtained by the NAIC as a result of this Section. The documents shall remain confidential after termination of the market conduct surveillance, are not subject to subpoena, are not subject to discovery or admissible as evidence in private civil litigation, are not subject to disclosure under the Freedom of Information Act, and shall not be made public at any time or used by the Director or any other person, except as provided in paragraphs (3), (4), and (6) of this subsection and in subsection (l).

(2) The Director, the Department, and any other person in the course of market conduct surveillance shall keep confidential any self-evaluation or voluntary compliance program documents disclosed to the Director or other person by an examinee and the data collected via the NAIC market conduct annual statement. The documents are not subject to subpoena, are not subject to discovery or admissible as evidence in private civil litigation, are not subject to disclosure under the Freedom of Information Act, and shall not be made public or used by the Director or any other person, except as provided in paragraphs (3), (4), and (6) of this subsection, in subsection (l), or in

Section 155.35 of this Code.

(3) Notwithstanding paragraphs (1) and (2), and consistent with paragraph (5), in order to assist in the performance of the Director's duties, the Director may:

(A) share documents, materials, communications, or other information, including the confidential and privileged documents, materials, or information described in this subsection, with other State, federal, alien, and international regulatory agencies and law enforcement authorities and the NAIC, its affiliates, and subsidiaries, if the recipient agrees to and has the legal authority to maintain the confidentiality and privileged status of the document, material, communication, or other information;

(B) receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the NAIC and its affiliates or subsidiaries, and from regulatory and law enforcement officials of other domestic, alien, or international jurisdictions, authorities, and agencies, and shall maintain as confidential or privileged any document, material, communication, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, communication,

or information;

(C) enter into agreements governing the sharing and use of information consistent with this Section; and

(D) when the Director performs any type of market conduct surveillance that does not rise to the level of a market conduct examination, make the final results of the market conduct surveillance, in an aggregated format, available for public inspection in a manner deemed appropriate by the Director.

(4) Nothing in this Section limits:

(A) the Director's authority to use, if consistent with subsection (5) of Section 188.1, any final or preliminary examination report, any market conduct surveillance or examinee work papers or other documents, or any other information discovered or developed during the course of any market conduct surveillance, in the furtherance of any legal or regulatory action initiated by the Director that the Director may, in the Director's sole discretion, deem appropriate; or

(B) the ability of an examinee to conduct discovery in accordance with paragraph (3) of subsection (g).

(5) Disclosure to the Director of documents, materials, communications, or information required as part

of any type of market conduct surveillance does not waive any applicable privilege or claim of confidentiality in the documents, materials, communications, or information.

(6) If the Director deems fit, the Director may publicly acknowledge the existence of an ongoing examination before filing the examination report but shall not disclose any other information protected under this subsection.

(j) Corrective actions; sanctions.

(1) As a result of any market conduct action other than market analysis, the Director may order the examinee to take any action the Director considers necessary or appropriate in accordance with the report of examination or any hearing thereon, including, but not limited to, requiring the regulated person to undertake corrective actions to cease and desist an identified violation or institute processes and practices to comply with applicable standards, requiring reimbursement or restitution to persons harmed by the regulated person's violation, or imposing civil penalties, for acts in violation of any law, rule, or prior lawful order of the Director. Civil penalties imposed as a result of a market conduct action shall be consistent, reasonable, and justifiable.

(2) If any other provision of this Code or any other law or rule under the Director's jurisdiction prescribes

an amount or range of penalties for a violation of a particular statute, that provision shall apply. If no penalty is already provided by law or rule for a violation and the violation is quantifiable, then the Director may order a penalty of up to $3,000 for every act in violation of any law, rule, or prior lawful order of the Director. If the examination report finds a violation by the examinee that the report is unable to quantify, such as, an operational policy or procedure that conflicts with applicable law, then the Director may order a penalty of up to $10,000 for that violation. A violation of subsection (d) is punishable by a fine of $2,000 per day up to a maximum of $500,000.

(k) Participation in national market conduct databases.

The Director shall collect and report market data to the NAIC's market information systems, including, but not limited to, the Complaint Database System, the Examination Tracking System, and the Regulatory Information Retrieval System, or other successor NAIC products as determined by the Director. Information collected and maintained by the Department for inclusion in these NAIC market information systems shall be compiled in a manner that meets the requirements of the NAIC.

~~(4) The Director must notify the company or person made the subject of any examination hereunder of the contents of the verified examination report before filing it and making the report public of any matters relating thereto, and must~~

~~afford the company or person an opportunity to demand a hearing with reference to the facts and other evidence therein contained.~~

~~The company or person may request a hearing within 10 days after receipt of the examination report by giving the Director written notice of that request, together with a statement of its objections. The Director must then conduct a hearing in accordance with Sections 402 and 403. He must issue a written order based upon the examination report and upon the hearing within 90 days after the report is filed or within 90 days after the hearing.~~

~~If the examination reveals that the company is operating in violation of any law, regulation, or prior order, the Director in the written order may require the company or person to take any action he considers necessary or appropriate in accordance with the report of examination or any hearing thereon. The order is subject to judicial review under the Administrative Review Law. The Director may withhold any report from public inspection for such time as he may deem proper and may, after filing the same, publish any part or all of the report as he considers to be in the interest of the public, in one or more newspapers in this State, without expense to the company.~~

~~(5) Any company which or person who violates or aids and abets any violation of a written order issued under this Section shall be guilty of a business offense and may be fined~~

~~not more than $5,000. The penalty shall be paid into the General Revenue fund of the State of Illinois.~~

(Source: P.A. 87-108.)

(215 ILCS 5/132.5) (from Ch. 73, par. 744.5)

Sec. 132.5. Examination reports.

(a) General description. All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the company, its agents, or other persons examined or as ascertained from the testimony of its officers, agents, or other persons examined concerning its affairs and the conclusions and recommendations as the examiners find reasonably warranted from those facts.

(b) Filing of examination report. No later than 60 days following completion of the examination, the examiner in charge shall file with the Department a verified written report of examination under oath. Upon receipt of the verified report, the Department shall transmit the report to the company examined, together with a notice that affords the company examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(c) Adoption of the report on examination. Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the Director shall fully consider and review the report, together with any written submissions

or rebuttals and any relevant portions of the examiners work papers and enter an order:

(1) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation, or prior order of the Director, the Director may order the company to take any action the Director considers necessary and appropriate to cure the violation.

(2) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information and refiling under subsection (b).

(3) Calling for an investigatory hearing with no less than 20 days notice to the company for purposes of obtaining additional documentation, data, information, and testimony.

(d) Order and procedures. All orders entered under paragraph (1) of subsection (c) shall be accompanied by findings and conclusions resulting from the Director's consideration and review of the examination report, relevant examiner work papers, and any written submissions or rebuttals. The order shall be considered a final administrative decision and may be appealed in accordance with the Administrative Review Law. The order shall be served upon the company by certified mail, together with a copy of the

adopted examination report. Within 30 days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

Any hearing conducted under paragraph (3) of subsection (c) by the Director or an authorized representative shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the Director's review of relevant work papers or by the written submission or rebuttal of the company. Within 20 days of the conclusion of any hearing, the Director shall enter an order under paragraph (1) of subsection (c).

The Director shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the company limited to the examiner's work papers that tend to substantiate any assertions set forth in any written submission or rebuttal. The Director or his representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation, whether under the control of the Department, the company, or other persons. The documents produced shall be included in the record, and testimony taken by the Director or his representative shall be under oath and preserved for the

record. Nothing contained in this Section shall require the Department to disclose any information or records that would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

The hearing shall proceed with the Director or his representative posing questions to the persons subpoenaed. Thereafter the company and the Department may present testimony relevant to the investigation. Cross-examination shall be conducted only by the Director or his representative. The company and the Department shall be permitted to make closing statements and may be represented by counsel of their choice.

(e) Publication and use. Upon the adoption of the examination report under paragraph (1) of subsection (c), the Director shall continue to hold the content of the examination report as private and confidential information for a period of 35 days, except to the extent provided in subsection (b). Thereafter, the Director may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

Nothing contained in this Code shall prevent or be construed as prohibiting the Director from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of any other state or country or to law enforcement officials of this or any other state or agency of

the federal government at any time, so long as the agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this Code.

In the event the Director determines that regulatory action is appropriate as a result of any examination, he may initiate any proceedings or actions as provided by law.

(f) Confidentiality of ancillary information. All working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the Director or any other person in the course of any examination must be given confidential treatment, are not subject to subpoena, and may not be made public by the Director or any other persons, except to the extent provided in subsection (e). Access may also be granted to the National Association of Insurance Commissioners. Those parties must agree in writing before receiving the information to provide to it the same confidential treatment as required by this Section, unless the prior written consent of the company to which it pertains has been obtained.

~~This subsection (f) applies to market conduct examinations described in Section 132 of this Code.~~

(Source: P.A. 100-475, eff. 1-1-18.)

(215 ILCS 5/155.35)

Sec. 155.35. Insurance compliance self-evaluative

privilege.

(a) To encourage insurance companies and persons conducting activities regulated under this Code, both to conduct voluntary internal audits of their compliance programs and management systems and to assess and improve compliance with State and federal statutes, rules, and orders, an insurance compliance self-evaluative privilege is recognized to protect the confidentiality of communications relating to voluntary internal compliance audits. The General Assembly hereby finds and declares that protection of insurance consumers is enhanced by companies' voluntary compliance with this State's insurance and other laws and that the public will benefit from incentives to identify and remedy insurance and other compliance issues. It is further declared that limited expansion of the protection against disclosure will encourage voluntary compliance and improve insurance market conduct quality and that the voluntary provisions of this Section will not inhibit the exercise of the regulatory authority by those entrusted with protecting insurance consumers.

(b)(1) An insurance compliance self-evaluative audit document is privileged information and is not admissible as evidence in any legal action in any civil, criminal, or administrative proceeding, except as provided in subsections (c) and (d) of this Section. Documents, communications, data, reports, or other information created as a result of a claim involving personal injury or workers' compensation made

against an insurance policy are not insurance compliance self-evaluative audit documents and are admissible as evidence in civil proceedings as otherwise provided by applicable rules of evidence or civil procedure, subject to any applicable statutory or common law privilege, including but not limited to the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

(2) If any company, person, or entity performs or directs the performance of an insurance compliance audit, an officer or employee involved with the insurance compliance audit, or any consultant who is hired for the purpose of performing the insurance compliance audit, may not be examined in any civil, criminal, or administrative proceeding as to the insurance compliance audit or any insurance compliance self-evaluative audit document, as defined in this Section. This subsection (b)(2) does not apply if the privilege set forth in subsection (b)(1) of this Section is determined under subsection (c) or (d) not to apply.

(3) A company may voluntarily submit, in connection with examinations conducted under this Article, an insurance compliance self-evaluative audit document to the Director, or his or her designee, as a confidential document under subsection (i) of Section 132 or subsection (f) of Section 132.5 of this Code, as applicable, without waiving the privilege set forth in this Section to which the company would otherwise be entitled; provided, however, that the provisions

in Sections 132 and ~~subsection (f) of Section~~ 132.5 permitting the Director to make confidential documents public ~~pursuant to subsection (c) of Section 132.5~~ and grant access to the National Association of Insurance Commissioners shall not apply to the insurance compliance self-evaluative audit document so voluntarily submitted. Nothing contained in this subsection shall give the Director any authority to compel a company to disclose involuntarily or otherwise provide an insurance compliance self-evaluative audit document.

(c)(1) The privilege set forth in subsection (b) of this Section does not apply to the extent that it is expressly waived by the company that prepared or caused to be prepared the insurance compliance self-evaluative audit document.

(2) In a civil or administrative proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege set forth in subsection (b) of this Section is asserted, if the court determines one of the following:

(A) the privilege is asserted for a fraudulent purpose;

(B) the material is not subject to the privilege; or

(C) even if subject to the privilege, the material shows evidence of noncompliance with State and federal statutes, rules and orders and the company failed to undertake reasonable corrective action or eliminate the noncompliance within a reasonable time.

(3) In a criminal proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege described in subsection (b) of this Section is asserted, if the court determines one of the following:

(A) the privilege is asserted for a fraudulent purpose;

(B) the material is not subject to the privilege;

(C) even if subject to the privilege, the material shows evidence of noncompliance with State and federal statutes, rules and orders and the company failed to undertake reasonable corrective action or eliminate such noncompliance within a reasonable time; or

(D) the material contains evidence relevant to commission of a criminal offense under this Code, and all of the following factors are present:

(i) the Director, State's Attorney, or Attorney General has a compelling need for the information;

(ii) the information is not otherwise available; and

(iii) the Director, State's Attorney, or Attorney General is unable to obtain the substantial equivalent of the information by any means without incurring unreasonable cost and delay.

(d)(1) Within 30 days after the Director, State's Attorney, or Attorney General makes a written request by certified mail for disclosure of an insurance compliance

self-evaluative audit document under this subsection, the company that prepared or caused the document to be prepared may file with the appropriate court a petition requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Section or subject to disclosure. The court has jurisdiction over a petition filed by a company under this subsection requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged or subject to disclosure. Failure by the company to file a petition waives the privilege.

(2) A company asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall include in its request for an in camera hearing all of the information set forth in subsection (d)(5) of this Section.

(3) Upon the filing of a petition under this subsection, the court shall issue an order scheduling, within 45 days after the filing of the petition, an in camera hearing to determine whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Section or subject to disclosure.

(4) The court, after an in camera review, may require disclosure of material for which the privilege in subsection (b) of this Section is asserted if the court determines, based

upon its in camera review, that any one of the conditions set forth in subsection (c)(2)(A) through (C) is applicable as to a civil or administrative proceeding or that any one of the conditions set forth in subsection (c)(3)(A) through (D) is applicable as to a criminal proceeding. Upon making such a determination, the court may only compel the disclosure of those portions of an insurance compliance self-evaluative audit document relevant to issues in dispute in the underlying proceeding. Any compelled disclosure will not be considered to be a public document or be deemed to be a waiver of the privilege for any other civil, criminal, or administrative proceeding. A party unsuccessfully opposing disclosure may apply to the court for an appropriate order protecting the document from further disclosure.

(5) A company asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection (d) shall provide to the Director, State's Attorney, or Attorney General, as the case may be, at the time of filing any objection to the disclosure, all of the following information:

(A) The date of the insurance compliance self-evaluative audit document.

(B) The identity of the entity conducting the audit.

(C) The general nature of the activities covered by the insurance compliance audit.

(D) An identification of the portions of the insurance

compliance self-evaluative audit document for which the privilege is being asserted.

(e) (1) A company asserting the insurance compliance self-evaluative privilege set forth in subsection (b) of this Section has the burden of demonstrating the applicability of the privilege. Once a company has established the applicability of the privilege, a party seeking disclosure under subsections (c)(2)(A) or (C) of this Section has the burden of proving that the privilege is asserted for a fraudulent purpose or that the company failed to undertake reasonable corrective action or eliminate the noncompliance with a reasonable time. The Director, State's Attorney, or Attorney General seeking disclosure under subsection (c)(3) of this Section has the burden of proving the elements set forth in subsection (c)(3) of this Section.

(2) The parties may at any time stipulate in proceedings under subsections (c) or (d) of this Section to entry of an order directing that specific information contained in an insurance compliance self-evaluative audit document is or is not subject to the privilege provided under subsection (b) of this Section.

(f) The privilege set forth in subsection (b) of this Section shall not extend to any of the following:

(1) documents, communications, data, reports, or other information required to be collected, developed, maintained, reported, or otherwise made available to a

regulatory agency pursuant to this Code, or other federal or State law, rule, or order;

(2) information obtained by observation or monitoring by any regulatory agency; or

(3) information obtained from a source independent of the insurance compliance audit.

(g) As used in this Section:

(1) "Insurance compliance audit" means a voluntary, internal evaluation, review, assessment, or audit not otherwise expressly required by law of a company or an activity regulated under this Code, or other State or federal law applicable to a company, or of management systems related to the company or activity, that is designed to identify and prevent noncompliance and to improve compliance with those statutes, rules, or orders. An insurance compliance audit may be conducted by the company, its employees, or by independent contractors.

(2) "Insurance compliance self-evaluative audit document" means documents prepared as a result of or in connection with and not prior to an insurance compliance audit. An insurance compliance self-evaluation audit document may include a written response to the findings of an insurance compliance audit. An insurance compliance self-evaluative audit document may include, but is not limited to, as applicable, field notes and records of observations, findings, opinions, suggestions,

conclusions, drafts, memoranda, drawings, photographs, computer-generated or electronically recorded information, phone records, maps, charts, graphs, and surveys, provided this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit. An insurance compliance self-evaluative audit document may also include any of the following:

(A) an insurance compliance audit report prepared by an auditor, who may be an employee of the company or an independent contractor, which may include the scope of the audit, the information gained in the audit, and conclusions and recommendations, with exhibits and appendices;

(B) memoranda and documents analyzing portions or all of the insurance compliance audit report and discussing potential implementation issues;

(C) an implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing future noncompliance; or

(D) analytic data generated in the course of conducting the insurance compliance audit.

(3) "Company" has the same meaning as provided in Section 2 of this Code.

(h) Nothing in this Section shall limit, waive, or abrogate the scope or nature of any statutory or common law

privilege including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

(Source: P.A. 90-499, eff. 8-19-97; 90-655, eff. 7-30-98.)

(215 ILCS 5/402) (from Ch. 73, par. 1014)

Sec. 402. Examinations, investigations and hearings. (1) All examinations, investigations and hearings provided for by this Code may be conducted either by the Director personally, or by one or more of the actuaries, technical advisors, deputies, supervisors or examiners employed or retained by the Department and designated by the Director for such purpose. When necessary to supplement its examination procedures, the Department may retain independent actuaries deemed competent by the Director, independent certified public accountants, attorneys, or qualified examiners of insurance companies deemed competent by the Director, or any combination of the foregoing, the cost of which shall be borne by the company or person being examined. The Director may compensate independent actuaries, certified public accountants and qualified examiners retained for supplementing examination procedures in amounts not to exceed the reasonable and customary charges for such services. The Director may also accept as a part of the Department's examination of any company or person (a) a report by an independent actuary deemed competent by the Director or (b) a report of an audit made by an independent certified

public accountant. Neither those persons so designated nor any members of their immediate families shall be officers of, connected with, or financially interested in any company other than as policyholders, nor shall they be financially interested in any other corporation or person affected by the examination, investigation or hearing.

(2) All hearings provided for in this Code shall, unless otherwise specially provided, be held at such time and place as shall be designated in a notice which shall be given by the Director in writing to the person or company whose interests are affected, at least 10 days before the date designated therein. The notice shall state the subject of inquiry and the specific charges, if any. The hearings shall be held in the City of Springfield, the City of Chicago, or in the county where the principal business address of the person or company affected is located.

(Source: P.A. 87-757.)

(215 ILCS 5/408) (from Ch. 73, par. 1020)

Sec. 408. Fees and charges.

(1) The Director shall charge, collect and give proper acquittances for the payment of the following fees and charges:

(a) For filing all documents submitted for the incorporation or organization or certification of a domestic company, except for a fraternal benefit society,

$2,000.

(b) For filing all documents submitted for the incorporation or organization of a fraternal benefit society, $500.

(c) For filing amendments to articles of incorporation and amendments to declaration of organization, except for a fraternal benefit society, a mutual benefit association, a burial society or a farm mutual, $200.

(d) For filing amendments to articles of incorporation of a fraternal benefit society, a mutual benefit association or a burial society, $100.

(e) For filing amendments to articles of incorporation of a farm mutual, $50.

(f) For filing bylaws or amendments thereto, $50.

(g) For filing agreement of merger or consolidation:

(i) for a domestic company, except for a fraternal benefit society, a mutual benefit association, a burial society, or a farm mutual, $2,000.

(ii) for a foreign or alien company, except for a fraternal benefit society, $600.

(iii) for a fraternal benefit society, a mutual benefit association, a burial society, or a farm mutual, $200.

(h) For filing agreements of reinsurance by a domestic company, $200.

(i) For filing all documents submitted by a foreign or

alien company to be admitted to transact business or accredited as a reinsurer in this State, except for a fraternal benefit society, $5,000.

(j) For filing all documents submitted by a foreign or alien fraternal benefit society to be admitted to transact business in this State, $500.

(k) For filing declaration of withdrawal of a foreign or alien company, $50.

(l) For filing annual statement by a domestic company, except a fraternal benefit society, a mutual benefit association, a burial society, or a farm mutual, $200.

(m) For filing annual statement by a domestic fraternal benefit society, $100.

(n) For filing annual statement by a farm mutual, a mutual benefit association, or a burial society, $50.

(o) For issuing a certificate of authority or renewal thereof except to a foreign fraternal benefit society, $400.

(p) For issuing a certificate of authority or renewal thereof to a foreign fraternal benefit society, $200.

(q) For issuing an amended certificate of authority, $50.

(r) For each certified copy of certificate of authority, $20.

(s) For each certificate of deposit, or valuation, or compliance or surety certificate, $20.

(t) For copies of papers or records per page, $1.

(u) For each certification to copies of papers or records, $10.

(v) For multiple copies of documents or certificates listed in subparagraphs (r), (s), and (u) of paragraph (1) of this Section, $10 for the first copy of a certificate of any type and $5 for each additional copy of the same certificate requested at the same time, unless, pursuant to paragraph (2) of this Section, the Director finds these additional fees excessive.

(w) For issuing a permit to sell shares or increase paid-up capital:

(i) in connection with a public stock offering, $300;

(ii) in any other case, $100.

(x) For issuing any other certificate required or permissible under the law, $50.

(y) For filing a plan of exchange of the stock of a domestic stock insurance company, a plan of demutualization of a domestic mutual company, or a plan of reorganization under Article XII, $2,000.

(z) For filing a statement of acquisition of a domestic company as defined in Section 131.4 of this Code, $2,000.

(aa) For filing an agreement to purchase the business of an organization authorized under the Dental Service

Plan Act or the Voluntary Health Services Plans Act or of a health maintenance organization or a limited health service organization, $2,000.

(bb) For filing a statement of acquisition of a foreign or alien insurance company as defined in Section 131.12a of this Code, $1,000.

(cc) For filing a registration statement as required in Sections 131.13 and 131.14, the notification as required by Sections 131.16, 131.20a, or 141.4, or an agreement or transaction required by Sections 124.2(2), 141, 141a, or 141.1, $200.

(dd) For filing an application for licensing of:

(i) a religious or charitable risk pooling trust or a workers' compensation pool, $1,000;

(ii) a workers' compensation service company, $500;

(iii) a self-insured automobile fleet, $200; or

(iv) a renewal of or amendment of any license issued pursuant to (i), (ii), or (iii) above, $100.

(ee) For filing articles of incorporation for a syndicate to engage in the business of insurance through the Illinois Insurance Exchange, $2,000.

(ff) For filing amended articles of incorporation for a syndicate engaged in the business of insurance through the Illinois Insurance Exchange, $100.

(gg) For filing articles of incorporation for a

limited syndicate to join with other subscribers or limited syndicates to do business through the Illinois Insurance Exchange, $1,000.

(hh) For filing amended articles of incorporation for a limited syndicate to do business through the Illinois Insurance Exchange, $100.

(ii) For a permit to solicit subscriptions to a syndicate or limited syndicate, $100.

(jj) For the filing of each form as required in Section 143 of this Code, $50 per form. The fee for advisory and rating organizations shall be $200 per form.

(i) For the purposes of the form filing fee, filings made on insert page basis will be considered one form at the time of its original submission. Changes made to a form subsequent to its approval shall be considered a new filing.

(ii) Only one fee shall be charged for a form, regardless of the number of other forms or policies with which it will be used.

(iii) Fees charged for a policy filed as it will be issued regardless of the number of forms comprising that policy shall not exceed $1,500. For advisory or rating organizations, fees charged for a policy filed as it will be issued regardless of the number of forms comprising that policy shall not exceed $2,500.

(iv) The Director may by rule exempt forms from

such fees.

(kk) For filing an application for licensing of a reinsurance intermediary, $500.

(ll) For filing an application for renewal of a license of a reinsurance intermediary, $200.

(mm) For a network adequacy filing required under the Network Adequacy and Transparency Act, $500, except that the fee for a filing required based on a material change is $100.

(2) When printed copies or numerous copies of the same paper or records are furnished or certified, the Director may reduce such fees for copies if he finds them excessive. He may, when he considers it in the public interest, furnish without charge to state insurance departments and persons other than companies, copies or certified copies of reports of examinations and of other papers and records.

(3) The expenses incurred in any performance examination authorized by law shall be paid by the company or person being examined. The charge shall be reasonably related to the cost of the examination including but not limited to compensation of examiners, electronic data processing costs, supervision and preparation of an examination report and lodging and travel expenses. All lodging and travel expenses shall be in accord with the applicable travel regulations as published by the Department of Central Management Services and approved by the Governor's Travel Control Board, except that out-of-state

lodging and travel expenses related to examinations authorized under Section 132 shall be in accordance with travel rates prescribed under paragraph 301-7.2 of the Federal Travel Regulations, 41 C.F.R. 301-7.2, for reimbursement of subsistence expenses incurred during official travel. All lodging and travel expenses may be reimbursed directly upon authorization of the Director. With the exception of the direct reimbursements authorized by the Director, all performance examination charges collected by the Department shall be paid to the Insurance Producer Administration Fund, however, the electronic data processing costs incurred by the Department in the performance of any examination shall be billed directly to the company being examined for payment to the Technology Management Revolving Fund.

(4) At the time of any service of process on the Director as attorney for such service, the Director shall charge and collect the sum of $20, which may be recovered as taxable costs by the party to the suit or action causing such service to be made if he prevails in such suit or action.

(5) (a) The costs incurred by the Department of Insurance in conducting any hearing authorized by law shall be assessed against the parties to the hearing in such proportion as the Director of Insurance may determine upon consideration of all relevant circumstances including: (1) the nature of the hearing; (2) whether the hearing was instigated by, or for the benefit of a particular party or parties; (3) whether there is

a successful party on the merits of the proceeding; and (4) the relative levels of participation by the parties.

(b) For purposes of this subsection (5) costs incurred shall mean the hearing officer fees, court reporter fees, and travel expenses of Department of Insurance officers and employees; provided however, that costs incurred shall not include hearing officer fees or court reporter fees unless the Department has retained the services of independent contractors or outside experts to perform such functions.

(c) The Director shall make the assessment of costs incurred as part of the final order or decision arising out of the proceeding; provided, however, that such order or decision shall include findings and conclusions in support of the assessment of costs. This subsection (5) shall not be construed as permitting the payment of travel expenses unless calculated in accordance with the applicable travel regulations of the Department of Central Management Services, as approved by the Governor's Travel Control Board. The Director as part of such order or decision shall require all assessments for hearing officer fees and court reporter fees, if any, to be paid directly to the hearing officer or court reporter by the party(s) assessed for such costs. The assessments for travel expenses of Department officers and employees shall be reimbursable to the Director of Insurance for deposit to the fund out of which those expenses had been paid.

(d) The provisions of this subsection (5) shall apply in the case of any hearing conducted by the Director of Insurance not otherwise specifically provided for by law.

(6) The Director shall charge and collect an annual financial regulation fee from every domestic company for examination and analysis of its financial condition and to fund the internal costs and expenses of the Interstate Insurance Receivership Commission as may be allocated to the State of Illinois and companies doing an insurance business in this State pursuant to Article X of the Interstate Insurance Receivership Compact. The fee shall be the greater fixed amount based upon the combination of nationwide direct premium income and nationwide reinsurance assumed premium income or upon admitted assets calculated under this subsection as follows:

(a) Combination of nationwide direct premium income and nationwide reinsurance assumed premium.

(i) $150, if the premium is less than $500,000 and there is no reinsurance assumed premium;

(ii) $750, if the premium is $500,000 or more, but less than $5,000,000 and there is no reinsurance assumed premium; or if the premium is less than $5,000,000 and the reinsurance assumed premium is less than $10,000,000;

(iii) $3,750, if the premium is less than $5,000,000 and the reinsurance assumed premium is

$10,000,000 or more;

(iv) $7,500, if the premium is $5,000,000 or more, but less than $10,000,000;

(v) $18,000, if the premium is $10,000,000 or more, but less than $25,000,000;

(vi) $22,500, if the premium is $25,000,000 or more, but less than $50,000,000;

(vii) $30,000, if the premium is $50,000,000 or more, but less than $100,000,000;

(viii) $37,500, if the premium is $100,000,000 or more.

(b) Admitted assets.

(i) $150, if admitted assets are less than $1,000,000;

(ii) $750, if admitted assets are $1,000,000 or more, but less than $5,000,000;

(iii) $3,750, if admitted assets are $5,000,000 or more, but less than $25,000,000;

(iv) $7,500, if admitted assets are $25,000,000 or more, but less than $50,000,000;

(v) $18,000, if admitted assets are $50,000,000 or more, but less than $100,000,000;

(vi) $22,500, if admitted assets are $100,000,000 or more, but less than $500,000,000;

(vii) $30,000, if admitted assets are $500,000,000 or more, but less than $1,000,000,000;

(viii) $37,500, if admitted assets are $1,000,000,000 or more.

(c) The sum of financial regulation fees charged to the domestic companies of the same affiliated group shall not exceed $250,000 in the aggregate in any single year and shall be billed by the Director to the member company designated by the group.

(7) The Director shall charge and collect an annual financial regulation fee from every foreign or alien company, except fraternal benefit societies, for the examination and analysis of its financial condition and to fund the internal costs and expenses of the Interstate Insurance Receivership Commission as may be allocated to the State of Illinois and companies doing an insurance business in this State pursuant to Article X of the Interstate Insurance Receivership Compact. The fee shall be a fixed amount based upon Illinois direct premium income and nationwide reinsurance assumed premium income in accordance with the following schedule:

(a) $150, if the premium is less than $500,000 and there is no reinsurance assumed premium;

(b) $750, if the premium is $500,000 or more, but less than $5,000,000 and there is no reinsurance assumed premium; or if the premium is less than $5,000,000 and the reinsurance assumed premium is less than $10,000,000;

(c) $3,750, if the premium is less than $5,000,000 and the reinsurance assumed premium is $10,000,000 or more;

(d) $7,500, if the premium is $5,000,000 or more, but less than $10,000,000;

(e) $18,000, if the premium is $10,000,000 or more, but less than $25,000,000;

(f) $22,500, if the premium is $25,000,000 or more, but less than $50,000,000;

(g) $30,000, if the premium is $50,000,000 or more, but less than $100,000,000;

(h) $37,500, if the premium is $100,000,000 or more.

The sum of financial regulation fees under this subsection (7) charged to the foreign or alien companies within the same affiliated group shall not exceed $250,000 in the aggregate in any single year and shall be billed by the Director to the member company designated by the group.

(8) Beginning January 1, 1992, the financial regulation fees imposed under subsections (6) and (7) of this Section shall be paid by each company or domestic affiliated group annually. After January 1, 1994, the fee shall be billed by Department invoice based upon the company's premium income or admitted assets as shown in its annual statement for the preceding calendar year. The invoice is due upon receipt and must be paid no later than June 30 of each calendar year. All financial regulation fees collected by the Department shall be paid to the Insurance Financial Regulation Fund. The Department may not collect financial examiner per diem charges from companies subject to subsections (6) and (7) of this

Section undergoing financial examination after June 30, 1992.

(9) In addition to the financial regulation fee required by this Section, a company undergoing any financial examination authorized by law shall pay the following costs and expenses incurred by the Department: electronic data processing costs, the expenses authorized under Section 131.21 and subsection (d) of Section 132.4 of this Code, and lodging and travel expenses.

Electronic data processing costs incurred by the Department in the performance of any examination shall be billed directly to the company undergoing examination for payment to the Technology Management Revolving Fund. Except for direct reimbursements authorized by the Director or direct payments made under Section 131.21 or subsection (d) of Section 132.4 of this Code, all financial regulation fees and all financial examination charges collected by the Department shall be paid to the Insurance Financial Regulation Fund.

All lodging and travel expenses shall be in accordance with applicable travel regulations published by the Department of Central Management Services and approved by the Governor's Travel Control Board, except that out-of-state lodging and travel expenses related to examinations authorized under Sections 132.1 through 132.7 shall be in accordance with travel rates prescribed under paragraph 301-7.2 of the Federal Travel Regulations, 41 C.F.R. 301-7.2, for reimbursement of subsistence expenses incurred during official travel. All

lodging and travel expenses may be reimbursed directly upon the authorization of the Director.

In the case of an organization or person not subject to the financial regulation fee, the expenses incurred in any financial examination authorized by law shall be paid by the organization or person being examined. The charge shall be reasonably related to the cost of the examination including, but not limited to, compensation of examiners and other costs described in this subsection.

(10) Any company, person, or entity failing to make any payment of $150 or more as required under this Section shall be subject to the penalty and interest provisions provided for in subsections (4) and (7) of Section 412.

(11) Unless otherwise specified, all of the fees collected under this Section shall be paid into the Insurance Financial Regulation Fund.

(12) For purposes of this Section:

(a) "Domestic company" means a company as defined in Section 2 of this Code which is incorporated or organized under the laws of this State, and in addition includes a not-for-profit corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act, a health maintenance organization, and a limited health service organization.

(b) "Foreign company" means a company as defined in Section 2 of this Code which is incorporated or organized

under the laws of any state of the United States other than this State and in addition includes a health maintenance organization and a limited health service organization which is incorporated or organized under the laws of any state of the United States other than this State.

(c) "Alien company" means a company as defined in Section 2 of this Code which is incorporated or organized under the laws of any country other than the United States.

(d) "Fraternal benefit society" means a corporation, society, order, lodge or voluntary association as defined in Section 282.1 of this Code.

(e) "Mutual benefit association" means a company, association or corporation authorized by the Director to do business in this State under the provisions of Article XVIII of this Code.

(f) "Burial society" means a person, firm, corporation, society or association of individuals authorized by the Director to do business in this State under the provisions of Article XIX of this Code.

(g) "Farm mutual" means a district, county and township mutual insurance company authorized by the Director to do business in this State under the provisions of the Farm Mutual Insurance Company Act of 1986.

(Source: P.A. 100-23, eff. 7-6-17.)

(215 ILCS 5/511.109) (from Ch. 73, par. 1065.58-109)

(Section scheduled to be repealed on January 1, 2027)

Sec. 511.109. Examination.

(a) The Director or the Director's ~~his~~ designee may examine any applicant for or holder of an administrator's license in accordance with Sections 132 through 132.7 of this Code. If the Director or the examiners find that the administrator has violated this Article or any other insurance-related laws or rules under the Director's jurisdiction because of the manner in which the administrator has conducted business on behalf of an insurer or plan sponsor, then, unless the insurer or plan sponsor is included in the examination and has been afforded the same opportunity to request or participate in a hearing on the examination report, the examination report shall not allege a violation by the insurer or plan sponsor and the Director's order based on the report shall not impose any requirements, prohibitions, or penalties on the insurer or plan sponsor. Nothing in this Section shall prevent the Director from using any information obtained during the examination of an administrator to examine, investigate, or take other appropriate regulatory or legal action with respect to an insurer or plan sponsor.

(b) (Blank). ~~Any administrator being examined shall provide to the Director or his designee convenient and free access, at all reasonable hours at their offices, to all books, records, documents and other papers relating to such~~

~~administrator's business affairs.~~

(c) (Blank). ~~The Director or his designee may administer oaths and thereafter examine any individual about the business of the administrator.~~

(d) (Blank). ~~The examiners designated by the Director pursuant to this Section may make reports to the Director. Any report alleging substantive violations of this Article, any applicable provisions of the Illinois Insurance Code, or any applicable Part of Title 50 of the Illinois Administrative Code shall be in writing and be based upon facts obtained by the examiners. The report shall be verified by the examiners.~~

(e) (Blank). ~~If a report is made, the Director shall either deliver a duplicate thereof to the administrator being examined or send such duplicate by certified or registered mail to the administrator's address specified in the records of the Department. The Director shall afford the administrator an opportunity to request a hearing to object to the report. The administrator may request a hearing within 30 days after receipt of the duplicate of the examination report by giving the Director written notice of such request together with written objections to the report. Any hearing shall be conducted in accordance with Sections 402 and 403 of this Code. The right to hearing is waived if the delivery of the report is refused or the report is otherwise undeliverable or the administrator does not timely request a hearing. After the hearing or upon expiration of the time period during which an~~

~~administrator may request a hearing, if the examination reveals that the administrator is operating in violation of any applicable provision of the Illinois Insurance Code, any applicable Part of Title 50 of the Illinois Administrative Code or prior order, the Director, in the written order, may require the administrator to take any action the Director considers necessary or appropriate in accordance with the report or examination hearing. If the Director issues an order, it shall be issued within 90 days after the report is filed, or if there is a hearing, within 90 days after the conclusion of the hearing. The order is subject to review under the Administrative Review Law.~~

(Source: P.A. 84-887.)

(215 ILCS 5/512-3) (from Ch. 73, par. 1065.59-3)

Sec. 512-3. Definitions. For the purposes of this Article, unless the context otherwise requires, the terms defined in this Article have the meanings ascribed to them herein:

(a) "Third party prescription program" or "program" means any system of providing for the reimbursement of pharmaceutical services and prescription drug products offered or operated in this State under a contractual arrangement or agreement between a provider of such services and another party who is not the consumer of those services and products. Such programs may include, but need not be limited to, employee benefit plans whereby a consumer receives

prescription drugs or other pharmaceutical services and those services are paid for by an agent of the employer or others.

(b) "Third party program administrator" or "administrator" means any person, partnership or corporation who issues or causes to be issued any payment or reimbursement to a provider for services rendered pursuant to a third party prescription program, but does not include the Director of Healthcare and Family Services or any agent authorized by the Director to reimburse a provider of services rendered pursuant to a program of which the Department of Healthcare and Family Services is the third party.

(c) "Health care payer" means an insurance company, health maintenance organization, limited health service organization, health services plan corporation, or dental service plan corporation authorized to do business in this State.

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 5/512-5) (from Ch. 73, par. 1065.59-5)

Sec. 512-5. Fiduciary and Bonding Requirements. A third party prescription program administrator shall (1) establish and maintain a fiduciary account, separate and apart from any and all other accounts, for the receipt and disbursement of funds for reimbursement of providers of services under the program, or (2) post, or cause to be posted, a bond of indemnity in an amount equal to not less than 10% of the total estimated annual reimbursements under the program.

The establishment of such fiduciary accounts and bonds shall be consistent with applicable State law. If a bond of indemnity is posted, it shall be held by the Director of Insurance for the benefit and indemnification of the providers of services under the third party prescription program.

An administrator who operates more than one third party prescription program may establish and maintain a separate fiduciary account or bond of indemnity for each such program, or may operate and maintain a consolidated fiduciary account or bond of indemnity for all such programs.

The requirements of this Section do not apply to any third party prescription program administered by or on behalf of any health care payer ~~insurance company, Health Care Service Plan Corporation or Pharmaceutical Service Plan Corporation authorized to do business in the State of Illinois~~.

(Source: P.A. 82-1005.)

(215 ILCS 5/512-11 new)

Sec. 512-11. Examination. The Director or the Director's designee may examine any applicant for or holder of an administrator's registration in accordance with Sections 132 through 132.7 of this Code. If the Director or the examiners find that the administrator has violated this Article or any other insurance-related laws or rules under the Director's jurisdiction because of the manner in which the administrator has conducted business on behalf of a separately incorporated

health care payer, then, unless the health care payer is included in the examination and has been afforded the same opportunity to request or participate in a hearing on the examination report, the examination report shall not allege a violation by the health care payer and the Director's order based on the report shall not impose any requirements, prohibitions, or penalties on the health care payer. Nothing in this Section shall prevent the Director from using any information obtained during the examination of an administrator to examine, investigate, or take other appropriate regulatory or legal action with respect to a health care payer.

(215 ILCS 5/513b3)

Sec. 513b3. Examination.

(a) The Director, or the Director's ~~his or her~~ designee, may examine a registered pharmacy benefit manager in accordance with Sections 132 through 132.7 of this Code. If the Director or the examiners find that the pharmacy benefit manager has violated this Article or any other insurance-related laws or rules under the Director's jurisdiction because of the manner in which the pharmacy benefit manager has conducted business on behalf of a health insurer or plan sponsor, then, unless the health insurer or plan sponsor is included in the examination and has been afforded the same opportunity to request or participate in a

hearing on the examination report, the examination report shall not allege a violation by the health insurer or plan sponsor and the Director's order based on the report shall not impose any requirements, prohibitions, or penalties on the health insurer or plan sponsor. Nothing in this Section shall prevent the Director from using any information obtained during the examination of an administrator to examine, investigate, or take other appropriate regulatory or legal action with respect to a health insurer or plan sponsor.

(b) (Blank). ~~Any pharmacy benefit manager being examined shall provide to the Director, or his or her designee, convenient and free access to all books, records, documents, and other papers relating to such pharmacy benefit manager's business affairs at all reasonable hours at its offices.~~

(c) (Blank). ~~The Director, or his or her designee, may administer oaths and thereafter examine the pharmacy benefit manager's designee, representative, or any officer or senior manager as listed on the license or registration certificate about the business of the pharmacy benefit manager.~~

(d) (Blank). ~~The examiners designated by the Director under this Section may make reports to the Director. Any report alleging substantive violations of this Article, any applicable provisions of this Code, or any applicable Part of Title 50 of the Illinois Administrative Code shall be in writing and be based upon facts obtained by the examiners. The report shall be verified by the examiners.~~

(e) (Blank). ~~If a report is made, the Director shall either deliver a duplicate report to the pharmacy benefit manager being examined or send such duplicate by certified or registered mail to the pharmacy benefit manager's address specified in the records of the Department. The Director shall afford the pharmacy benefit manager an opportunity to request a hearing to object to the report. The pharmacy benefit manager may request a hearing within 30 days after receipt of the duplicate report by giving the Director written notice of such request together with written objections to the report. Any hearing shall be conducted in accordance with Sections 402 and 403 of this Code. The right to a hearing is waived if the delivery of the report is refused or the report is otherwise undeliverable or the pharmacy benefit manager does not timely request a hearing. After the hearing or upon expiration of the time period during which a pharmacy benefit manager may request a hearing, if the examination reveals that the pharmacy benefit manager is operating in violation of any applicable provision of this Code, any applicable Part of Title 50 of the Illinois Administrative Code, a provision of this Article, or prior order, the Director, in the written order, may require the pharmacy benefit manager to take any action the Director considers necessary or appropriate in accordance with the report or examination hearing. If the Director issues an order, it shall be issued within 90 days after the report is filed, or if there is a hearing, within 90~~

~~days after the conclusion of the hearing. The order is subject to review under the Administrative Review Law.~~

(Source: P.A. 101-452, eff. 1-1-20.)

Section 15. The Network Adequacy and Transparency Act is amended by changing Sections 3, 5, 10, 15, 20, 25, and 30 and by adding Sections 35 and 40 as follows:

(215 ILCS 124/3)

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

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

(215 ILCS 124/5)

Sec. 5. Definitions. In this Act:

"Authorized representative" means a person to whom a

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

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

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

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

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

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

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

Accountability Act.

"Health insurance coverage" has the meaning ascribed to that term in Section 5 of the Illinois Health Insurance Portability and Accountability Act. "Health insurance coverage" does not include any coverage or benefits under Medicare or under the medical assistance program established under Article V of the Illinois Public Aid Code.

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

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

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

of this Act or the Department's rules for network adequacy and transparency.

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

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

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

care from the provider within the meaning of 42 U.S.C. 300gg-113(b)(1)(B); (6) being scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider with respect to such a surgery; or (7) being determined to be terminally ill, as determined under 42 U.S.C. 1395x(dd)(3)(A), and receiving treatment for such illness from such provider.

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

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

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

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

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

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

"Tiered network" means a network that identifies and

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

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

(Source: P.A. 102-92, eff. 7-9-21; revised 10-5-21.)

(215 ILCS 124/10)

Sec. 10. Network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) A provision ensuring that whenever a beneficiary has made a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize preferred providers for a covered service and it is determined the insurer does not have the appropriate preferred providers due to insufficient number, type, or unreasonable travel distance or delay, the issuer ~~insurer~~ shall ensure, directly or indirectly, by terms contained in the payer contract, that

the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. This paragraph (6) does not apply to: (A) a beneficiary who willfully chooses to access a non-preferred provider for health care services available through the panel of preferred providers, or (B) a beneficiary enrolled in a health maintenance organization. In these circumstances, the contractual requirements for non-preferred provider reimbursements shall apply.

(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.

(9) For a network plan in the individual or small group market other than a grandfathered health plan, evidence that the network plan:

(A) contracts with at least 35% of the essential community providers in the service area of the network plan that are available to participate in the provider network of the network plan, as calculated using the methodology contained in the most recent Letter to Issuers in the Federally-facilitated Marketplaces issued by the federal Centers for Medicare and Medicaid Services. The Director may specify a different percentage by rule.

(B) offers contracts in good faith to all available Indian health care providers in the service area of the network plan, including, without limitation, the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations, as defined in 25 U.S.C. 1603, which apply the special terms and conditions necessitated by federal statutes and regulations as referenced in the Model Qualified Health Plan Addendum for Indian Health Care Providers issued by the federal Centers for Medicare and Medicaid Services.

(C) offers contracts in good faith to at least one essential community provider in each category of essential community provider, as contained in the most

recent Letter to Issuers in the Federally-facilitated Marketplaces, in each county in the service area of the network plan, where an essential community provider in that category is available and provides medical or dental services that are covered by the network plan. To offer a contract in good faith, a network plan must offer contract terms comparable to the terms that an issuer would offer to a similarly situated provider that is not an essential community provider, except for terms that would not be applicable to an essential community provider, including, without limitation, because of the type of services that an essential community provider provides. A network plan must be able to provide verification of such offers if the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services requests to verify compliance with this policy.

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

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

not establish ratios for vision or dental providers who provide services under dental-specific or vision-specific benefits, except to the extent provided under federal law for stand-alone dental plans. The Department shall consider establishing ratios for the following physicians or other providers:

(A) Primary Care;

(B) Pediatrics;

(C) Cardiology;

(D) Gastroenterology;

(E) General Surgery;

(F) Neurology;

(G) OB/GYN;

(H) Oncology/Radiation;

(I) Ophthalmology;

(J) Urology;

(K) Behavioral Health;

(L) Allergy/Immunology;

(M) Chiropractic;

(N) Dermatology;

(O) Endocrinology;

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

(Q) Infectious Disease;

(R) Nephrology;

(S) Neurosurgery;

(T) Orthopedic Surgery;

(U) Physiatry/Rehabilitative;

(V) Plastic Surgery;

(W) Pulmonary;

(X) Rheumatology;

(Y) Anesthesiology;

(Z) Pain Medicine;

(AA) Pediatric Specialty Services;

(BB) Outpatient Dialysis; and

(CC) HIV.

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

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

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

(4) Prior to the enactment of an applicable Department rule or the promulgation of federal standards for qualified health plans or stand-alone dental plans, the minimum ratios for any network plan issued, delivered, amended, or renewed during 2023 shall be the following, expressed in terms of providers to beneficiaries for health care professionals and in terms of providers per county for facilities:

(A) primary care physician, general practice, family practice, internal medicine, pediatrician, primary care physician assistant, or primary care nurse practitioner - 1:500;

(B) allergy/immunology - 1:15,000;

(C) cardiology - 1:10,000;

(D) chiropractic - 1:10,000;

(E) dermatology - 1:10,000;

(F) endocrinology - 1:10,000;

(G) ENT/otolaryngology - 1:15,000;

(H) gastroenterology - 1:10,000;

(I) general surgery - 1:5,000;

(J) gynecology or OB/GYN - 1:2,500;

(K) infectious diseases - 1:15,000;

(L) nephrology - 1:10,000;

(M) neurology - 1:20,000;

(N) oncology/radiation - 1:15,000;

(O) ophthalmology - 1:10,000;

(P) orthopedic surgery - 1:10,000;

(Q) physiatry/rehabilitative medicine - 1:15,000;

(R) plastic surgery - 1:20,000;

(S) behavioral health - 1:5,000;

(T) pulmonology - 1:10,000;

(U) rheumatology - 1:10,000;

(V) urology - 1:10,000;

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

(X) inpatient or residential behavioral health facility - one per county.

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

The maximum travel time and distance standards must

include standards for each physician and other provider category listed for which ratios have been established.

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

Notwithstanding any other law or Department rule, the maximum travel and distance standards and appointment wait time standards shall be no greater than any such standards established for qualified health plans in Federally-Facilitated Exchanges by federal law or by the federal Centers for Medicare and Medicaid Services, even if the network plan is issued in the large group market or is otherwise not issued through an exchange. Federal standards for stand-alone dental plans shall only apply to such network plans. In the absence of an applicable Department rule, the federal standards shall apply for the time period specified in the federal law, regulation, or guidance. If the Centers for Medicare and Medicaid Services establish standards that are more stringent than the standards in effect under any Department rule, the Department may amend its rules to conform to the more stringent federal standards.

If the federal area designations for the maximum time or distance or appointment wait time standards required are changed by the most recent Letter to Issuers in the Federally-facilitated Marketplaces, the Department shall post

on its website notice of such changes and may amend its rules to conform to those designations if the Director deems appropriate.

(d-5)(1) Every issuer ~~insurer~~ shall ensure that beneficiaries have timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the provisions of paragraph (4) of subsection (a) of Section 370c of the Illinois Insurance Code. Issuers ~~Insurers~~ shall use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions and those for the access to treatment for medical and surgical conditions. As such, the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits pursuant to the parity requirements of Section 370c.1 of the Illinois Insurance Code and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Notwithstanding the foregoing, the network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions shall, at a minimum, satisfy the following requirements:

(A) For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry, and Will, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(B) For beneficiaries residing in Illinois counties other than those counties listed in subparagraph (A) of this paragraph, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a

beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive outpatient treatment for mental, emotional, nervous, or substance use disorders or conditions. Beneficiaries shall not be required to wait longer than 10 business days between requesting an initial appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment or to wait longer than 20 business days between requesting a repeat or follow-up appointment and being seen by the facility or provider of mental, emotional, nervous, or substance use disorders or conditions for outpatient treatment; however, subject to the protections of paragraph (3) of this subsection, a network plan shall not be held responsible if the beneficiary or provider voluntarily chooses to schedule an appointment outside of these required time frames.

(2) For beneficiaries residing in all Illinois counties, network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions means a beneficiary shall not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential treatment for mental, emotional, nervous, or substance use disorders or conditions.

(3) If there is no in-network facility or provider

available for a beneficiary to receive timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions in accordance with the network adequacy standards outlined in this subsection, the issuer ~~insurer~~ shall provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in this subsection.

(4) If the federal Centers for Medicare and Medicaid Services establish or law requires more stringent standards for qualified health plans in the Federally-Facilitated Exchanges, the federal standards shall control for the time period specified in the federal law, regulation, or guidance, even if the network plan is issued in the large group market or is otherwise not issued through an exchange.

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

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

(g) Except for the requirements set forth in subsection (d-5), issuers ~~insurers~~ who are not able to comply with the provider ratios and time and distance or appointment wait time

standards established under this Act ~~by the Department~~ may request an exception to these requirements from the Department. The Department may grant an exception in the following circumstances:

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

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

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

(h) Issuers ~~Insurers~~ are required to report to the Director any material change to an approved network plan within 15 days after the change occurs and any change that

would result in failure to meet the requirements of this Act. The issuer shall submit a revised version of the complete network adequacy filing based on the material change, and the issuer shall attach versions with the changes indicated for each document that was revised from the previous version of the filing. Upon notice from the issuer ~~insurer~~, the Director shall reevaluate the network plan's compliance with the network adequacy and transparency standards of this Act. For every day past 15 days that the issuer fails to submit a revised network adequacy filing to the Director, the Director shall order a fine of $1,000 per day.

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

(j) If the Director determines that a network is inadequate in any county and no exception has been granted under subsection (g) and the issuer does not have a process in place to comply with subsection (d-5), the Director may prohibit the network plan from being issued or renewed within

that county until the Director determines that the network is adequate apart from processes and exceptions described in subsections (d-5) and (g). Nothing in this subsection shall be construed to terminate any beneficiary's health insurance coverage under a network plan before the expiration of the beneficiary's policy period if the Director makes a determination under this subsection after the issuance or renewal of the beneficiary's policy or certificate because of a material change. Policies or certificates issued or renewed in violation of this subsection shall subject the issuer to a civil penalty of $1,000 per policy.

(Source: P.A. 102-144, eff. 1-1-22.)

(215 ILCS 124/15)

Sec. 15. Notice of nonrenewal or termination.

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

may occur. The notice to the beneficiary shall provide the individual with an opportunity to notify the issuer of the individual's need for transitional care.

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

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

(215 ILCS 124/20)

Sec. 20. Transition of services.

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

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

network plan shall permit the beneficiary to continue an ongoing course of treatment with that provider during a transitional period for the following duration:

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

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

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

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

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

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

obtaining preauthorizations for treatment.

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

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

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

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

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

(2) If a beneficiary, or a beneficiary's authorized representative, elects in writing to continue to receive

care from such provider pursuant to paragraph (1) of this subsection (b), such care shall be authorized by the network plan for the transitional period in accordance with the following:

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

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

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

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

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

(d) A provider shall comply with the requirements of 42

U.S.C. 300gg-138.

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

(215 ILCS 124/25)

Sec. 25. Network transparency.

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

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

(2) The network plan shall update the online provider directory at least monthly. An issuer's failure to update a network plan's directory shall subject the issuer to a civil penalty of $5,000 per month. Providers shall notify the network plan electronically or in writing of any changes to their information as listed in the provider directory, including the information required in subparagraph (K) of paragraph (1) of subsection (b). If a provider is no longer accepting new patients, the provider must give notice to the issuer within 5 business days after deciding to cease accepting new patients, or within

5 business days after the effective date of this amendatory Act of the 102nd General Assembly, whichever is later. The network plan shall update its online provider directory in a manner consistent with the information provided by the provider within 2 ~~10~~ business days after being notified of the change by the provider. Nothing in this paragraph (2) shall void any contractual relationship between the provider and the plan.

(3) At least once every 90 days, the ~~The~~ network plan shall audit each ~~periodically at least 25%~~ of its print and online provider directories for accuracy, make any corrections necessary, and retain documentation of the audit. The network plan shall submit the audit to the Director upon request. As part of these audits, the network plan shall contact any provider in its network that has not submitted a claim to the plan or otherwise communicated his or her intent to continue participation in the plan's network. The audits shall comply with 42 U.S.C. 300gg-115(a)(2), except that "provider directory information" shall include all information required to be included in a provider directory pursuant to this Act.

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

changes in the provider network must be updated quarterly.

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

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

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

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

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

(6) A network plan shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this State. The network plan shall include in both its

electronic and print directories a customer service email address and telephone number or electronic link that beneficiaries or the general public may use to notify the network plan of inaccurate provider directory information and contact information for the Department's Office of Consumer Health Insurance.

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

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

(1) for health care professionals:

(A) name;

(B) gender;

(C) participating office locations;

(D) specialty, if applicable;

(E) medical group affiliations, if applicable;

(F) facility affiliations, if applicable;

(G) participating facility affiliations, if applicable;

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

(I) whether accepting new patients;

(J) board certifications, if applicable; and

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

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

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

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

(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,

including for each location where the health care professional is at the location at least 3 days per week.

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

(1) for health care professionals:

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

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

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

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

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

(1) for health care professionals:

(A) name;

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

(C) participating office location or locations, including for each location where the health care professional is at the location at least 3 days per week;

(D) specialty, if applicable;

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

(F) whether accepting new patients; and

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

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

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

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

(2) for hospitals:

(A) hospital name;

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

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

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

(A) facility name;

(B) facility type;

(C) types of services performed; and

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

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

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

(g) To the extent not otherwise provided in this Act, an issuer shall comply with the requirements of 42 U.S.C. 300gg-115, except that "provider directory information" shall

include all information required to be included in a provider directory pursuant to this Section.

(Source: P.A. 102-92, eff. 7-9-21.)

(215 ILCS 124/30)

Sec. 30. Administration and enforcement.

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

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

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

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

(e) In accordance with Section 5-45.21 of the Illinois Administrative Procedure Act, the Department may adopt emergency rules to implement federal standards for provider ratios, travel time and distance, and appointment wait times if such standards apply to health insurance coverage regulated

by the Department and are more stringent than the State standards extant at the time the final federal standards are published.

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

(215 ILCS 124/35 new)

Sec. 35. Provider requirements. Providers shall comply with 42 U.S.C. 300gg-138 and 300gg-139 and the regulations promulgated thereunder, as well as Section 20 and paragraph (2) of subsection (a) of Section 25 of this Act, except that "provider directory information" includes all information required to be included in a provider directory pursuant to Section 25 of this Act. To the extent a provider is licensed by the Department of Financial and Professional Regulation or by the Department of Public Health, that agency shall have the authority to investigate, examine, process complaints, issue subpoenas, examine witnesses under oath, issue a fine, or take disciplinary action against the provider's license for violations of these requirements in accordance with the provider's applicable licensing statute.

(215 ILCS 124/40 new)

Sec. 40. Confidentiality.

(a) All records in the custody or possession of the Department are presumed to be open to public inspection or copying unless exempt from disclosure by Section 7 or 7.5 of

the Freedom of Information Act. Except as otherwise provided in this Section or other applicable law, the filings required under this Act shall be open to public inspection or copying.

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

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

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

(3) geographic maps of network providers;

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

(5) provider directories.

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

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

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

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

(215 ILCS 134/20)

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

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

(215 ILCS 134/25)

Sec. 25. Transition of services.

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

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

(A) of 90 days from the date of the notice of provider's ~~physician's~~ termination from the health care plan to the enrollee of the provider's ~~physician's~~ disaffiliation from the health care plan if the enrollee has an ongoing course of treatment; or

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

~~physician's~~ disaffiliation, that includes the provision of post-partum care directly related to the delivery.

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

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

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

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

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

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

(B) directly notifies enrollees currently

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

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

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

If the prescribing provider certifies to the health care plan either in writing or electronically that the

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

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

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

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

Nothing in this item (3) prevents a health care plan from removing a drug from its formulary or denying an enrollee coverage if the United States Food and Drug Administration has issued a statement about the drug that calls into question the clinical safety of the drug, the drug manufacturer has notified the United States Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as required by Section 506C of the Federal Food, Drug, and Cosmetic Act, as codified in 21 U.S.C. 356c, or the drug manufacturer has removed the drug from the market.

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

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

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

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

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

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

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

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

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

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

(c) In no event shall this Section be construed to require

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

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

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

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